

RUN REPORT CHARTING

PURPOSE:

To establish minimum documentation requirements so that each run report accurately reflects a patient's assessment, history, and the emergency medical care given to that patient.

GUIDELINE:

Every run report will contain the following information:

1. **General Information:** Name of the provider, responding unit, call number, crew members' last names, call date, reason for call, location, destination, first responding units, monitoring MD/, receiving MD, patient (or parent/guardian) signature if treatment or transportation is refused.
2. **Patient Information:** Patient name, address, age, birthdate, sex, and personal physician
3. **Times:** Initial call, enroute, at scene, leave scene, and at destination.
4. **Chief Complaint:** Ideally in the patient's own words, what is their primary complaint? If the patient has none, write "none". If patient cannot give one, describe what the major problem appears to be, such as "unresponsive" or "cardiac arrest."
5. **History of Present Illness:** What events led up to the request for assistance? When did symptoms begin? What was the patient doing when they began? Has anything the patient taken or done changed the complaint? If pain, describe severity, location, type, and radiation. Have there been any previous episodes? Has there been any loss of consciousness? If pregnant, include pregnancy number and due date. Use direct quotes when documenting drug or alcohol use.
(or)
History of Present Injury: What events led up to the request for assistance? What is the mechanism of injury? When did it occur? Include information on speed, accident type, vehicle damage, ejection, entrapment or loss of consciousness. Was safety equipment such as seatbelts, helmets, air bags, or car seats used? Attach instamatic photo if available.
6. **Past Medical History:** List pertinent history, especially heart and lung disease, diabetes, stroke, seizures, recent surgeries, psychological problems, communicable diseases, and DNR/DNI status.
Allergies: List allergies; especially drug, and food or insect if pertinent to call.
Medications: Document all current medications and when last taken, if pertinent. If patient denies any of the above, write "none" or if unknown, write "unknown".
7. **Physical Exam:** How was the patient found (positioning/obvious distress)? What was initial level of consciousness (AVPU)? Was patient oriented to person, place, and time? Document assessment of airway, breathing (dyspnea, lung sounds, JVD, O₂ sats), and circulation (pulses, skin color/temp, bleeding, capillary refill). Document findings of head to toe exam, including wounds, deformity, tenderness, edema, pupils, incontinence, and CMS findings before and after treatment. Include pertinent negatives. Include Glasgow Coma Scale (GCS). If chart is not on form, then document: GCS=12 (E-3, V-4, M-5). If newborn, include one and five minute APGARs.
8. **Treatment:** Document all treatment administered. The following treatments have specific documentation requirements:
 - A. Oxygen: liter flow and route. Example: "NRB mask at 15 lpm".
 - B. I.V.: time, fluid type and size, needle gauge, location, drip rate, amount infused. Example: "16:04 - IV 500 cc NS, 18 g. to @ antecubital, 200 cc fluid challenge, then TKO".
 - C. ECG: rhythm interpretation, rate, and ectopy. Example: "ECG - sinus tach at 120/min w/ 1-2 unifocal PVCs/min.". Attach ECG sample to run report and leave with patient in ER.
ECG (BLS): attach strip only, do not interpret rhythms.
 - D. Medications: time, name, dosage, route, initials of person who administered, and SO (standing order) or VO (verbal order). Example: "15:48 - 25 gm. Glucose into downside of cheek. (SO)".
 - E. Advanced airway: type, size, and evaluation. Example: "Intubated with Combitube, ventilated through #1 port, good bilateral chest rise/lung sounds, absent stomach sounds, passed NG tube through port #2 with release of stomach air".

- F. Defibrillation: time and joules. Example: "18:10 - Defib shock # at 200 J."
9. **Response/Transport:** How did the patient respond to any treatment given? Were there any changes in the patient's condition enroute? How was the patient transported to the hospital (routinely or RLS, and whether stretcher was used)?
 10. **Vital signs:** One complete set of vital signs every 5-10 minutes on each patient, including time, BP, pulse, respirations, and O₂ sats. More are required if patient is unstable (q. 5 min.), or receives medication or treatment that indicates the need to reassess more frequently. If unable to obtain, document why.
 11. **Impression:** What is the provider's impression of what is wrong with the patient?
 12. **Signatures:** Each run report must be signed by the person who wrote it. An ALS or BLS person may write BLS care run reports. ALS care run reports must be written by an ALS person. If the patient is transported, the receiving RN or MD must sign the form. If the patient refuses treatment or transport, they must sign a refusal statement. Document any instructions (verbal or written) given to the patient. If patient is a minor, a parent or guardian must sign the form. If the patient refuses treatment/transport and also refuses to sign, then write "refused" in the box and have someone who witnessed the refusal co-sign the form.

SPECIAL NOTES:

1. All information obtained during the course of patient care delivery is confidential.
2. A run report must be filled out each time an EMS provider offers or provides service to a patient above a simple bandaid. The only exception to this is a mass casualty incident.
3. There should be one run report for each patient. In OB cases, the mother and newborn must each have separate run reports.
4. In severe trauma, where scene times are delayed longer than 10 minutes, document reasons for extended scene times, i.e. extrication or unsecured scene.
5. All reports should be written in black or blue ink.
6. Correct errors by drawing one line through the incorrect item and initialing by it. Example: "Inflated PASG legs ~~and abdomen~~^{TG} at 15:30."
7. Certain runs require additional documentation: Samples of rhythm strips from the manual monitor/defibrillator should be attached on all cardiac arrests.
8. Medical control authorization or a physician name is required on all runs where the patient is not transported. Physician consultation must be documented on all pediatric (< age 12) non-transport.
9. If possible, all documentation should be completed prior to leaving the facility. If you need to leave, and have additional information important to patient care, this must be communicated to the ER staff before leaving. The crew should quickly write on the form something like, "Form not completed due to another call. Verbal report given to _____." When the form is later completed, a copy should be signed, dated, and mailed, faxed, or delivered to the receiving hospital's medical records department as soon as possible.
10. Any suspicious situation regarding child neglect/abuse must be reported according to Wisconsin State Law. Medical control can assist you with this process.



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