I. POLICY

A. All communication with EMS personnel for the purpose of providing medical control (OLMC) must be thoroughly documented by Emergency Communications Registered Nurses (ECRNs) or EMS physicians on the NWC EMS System Communications Log.

B. This is a legal medical record and is discoverable through subpoena. The principles that govern documentation on hospital-based records apply equally to the Communications Log.

C. A copy is to become a permanent part of the patient's medical record if the patient is transported to the hospital providing OLMC. The original will be retained and archived by the originating hospital's EMS office.

D. Record storage: Communication logs must be archived in paper or electronic format by each hospital for a minimum of seven years for adult patients and seven years beyond the age of majority for minors. If a call involves a significant exposure of an EMS responder to the blood and/or body fluids of a patient, the Communication Log shall be archived for 30 years beyond the termination of employment of the individual exposed.

II. CONTACT INFO & DEMOGRAPHICS

A. **Date**: Date(s) of call - MM/DD/YY

B. **Time**: Times the call began and ended. Use 24-h military clock.

C. **Provider**: Name of the ambulance service; initials are acceptable if they clearly indicate the identity of the provider agency.

D. **Number:** Ambulance number or local designation

E. **Recordings** May be saved at each hospital's discretion, but it is recommended that they are archived for a minimum of 90 days.

F. **Log #**: Sequential number used to match the Log to the PCR. Each hospital is responsible for their numbering regimen. Communicate number to EMS personnel in lieu of the person's name providing OLMC.

G. **Pt. initials**: **No names are to be stated over radio or phone**. Ask for patient initials.

H. **Age**: Patient's age in years, months, or days

I. **Gender**: **M** for male, or **F** for female

J. **Est. weight:** Estimated weight in kg. is required for all pediatric patients and for those receiving weight-based drug dosing.

III. HISTORY

A. **Chief complaint/history of present illness:** Synopsis of patient's chief complaint(s) and events surrounding the current illness/injury.

B. **PMH:** Mark check boxes that apply; write in all significant others.

1. None: Patient denies any significant past medical history.
2. Unknown: Patient cannot give any history.
3. Asthma: Note severity of disease if known
4. CA: Cancer; note type if known
5. Cardiac: Acute coronary syndromes, valvular dysfunction, electrical disturbance, HF/pulmonary edema, CABG, angioplasty, etc.
6. COPD: Chronic obstructive pulmonary diseases: emphysema, chronic bronchitis
7. CVA: Any history of stroke or TIA
8. Diabetes: Diabetes mellitus; note if type 1; type 2 or gestational if known
9. HTN: Hypertension

10. Psych: Any history of mental illness
11. Seizure: Claims history of any type of seizure activity.
12. DNR/POLST: Determine that all legally required elements are present before checking box.

C. **Medications**: List pertinent medications prescribed for the patient.

D. **Allergies**: List any known allergies to medications, foods, or other substances that may precipitate an allergic reaction.

E. **Pain:** Quantify pain on a numeric scale of 0-10 with 0 meaning pain free and 10 indicating the most severe pain ever experienced. If Wong-Baker faces scale is used, indicate in chief complaint or comments.

IV. **PHYSICAL EXAM**

A. **Pupils:** Mark check boxes to document the status of pupils upon arrival of EMS providers. Indicate any changes in second row of boxes.

B. **Level of consciousness:** Mark check boxes to indicate the general state of awareness and responsiveness.

1. A & O X 3: Alert and oriented to person, place and time.
2. Verbal: Not alert; but responds to verbal stimulus: requires GCS
3. Pain: Not alert; but responds to painful stimulus: requires GCS
4. Unresponsive: Not alert and does not respond to pain: requires GCS
5. Combative: Patient is agitated and striking out at field personnel.

C. **Respiratory effort**: Mark check boxes to indicate level of ventilatory effort.

1. Normal: Eupnea, no visible effort
2. Labored: Patient working to breathe, may be using accessory muscles
3. Retractive: Visible sternal, intercostal, subcostal, or supraclavicular retractions
4. Absent: No respiratory effort apparent
5. Shallow: Ventilatory depth less than normal

D. **Lung sounds:** Check boxes to indicate comparison of R and L lung sounds

1. Clear: Normal breath sounds
2. Absent: No sounds heard
3. Decreased: Sounds diminished in comparison to opposite side
4. Crackles: Discontinuous, explosive or popping sounds; note specific sites
5. Wheeze: Musical or whistling sound; note specific sites
6. Stridor: High pitched crowing sound on inspiration

E. **Skin color:** Mark check boxes that apply

1. Normal: No alterations from patient's normal skin tone
2. Cyanotic: Bluish or dusky discoloration
3. Pale/ashen: Skin loses normal color or takes on a grayish appearance
4. Flushed: Skin appears inflamed or red
5. Jaundiced: Skin appears icteric or yellow

F. **Skin moisture:** Mark check boxes that apply

1. Dry: Skin is dry to touch
2. Moist: Skin is slightly damp but not dripping wet
3. Diaphoretic: Skin is very wet
4. Dehydrated: Skin has poor turgor; evidence of fluid volume deficit

G. **Skin temp:** Mark check boxes that apply

1. Normal: Skin is warm, but similar to examiner's temperature
2. Warm: Skin is warmer than normal; possible low grade fever or flushed
3. Hot: Skin is very warm: fever probable
4. Cool/cold: Skin lacks warmth

H. **Capillary refill:** Indicate if capillaries refill in < or > 2 sec if known; only pertinent in children.

I. **Review of systems:** Note significant findings for each system. Include pertinent positives and negatives. Each should have a notation as either showing pathology or being within normal limits (WNL). Mark check boxes whenever they apply.

V. **Glasgow Coma Score**: All patients presenting with an altered mental status; head injury or neurologic condition should have a GCS calculated by hospital personnel based on information from the field. Communicate the score to EMS personnel to help make triage and treatment decisions. Differentiate between the child/adult and infant scoring parameters. Recalculate the score if the patient's mental status changes. Document the time for each score.

VI. **Trauma score:** All trauma patients who meet the triage criteria in the SOP for transport to a Level I or Level II trauma center must have a Revised Trauma Score calculated by the on-line medical control personnel for inclusion on the EMS Communications Log. Recalculate the score if the patient's condition changes subsequent to the baseline evaluation, but **do not delay transport to recalculate.** Document the time for each score.

VII. **Vitals/Rx**

A. All patients **must** have at least one complete set of vital signs documented unless they are refusing all assessment, care and transportation, are too combative to assess prior to application of restraints, or a rationale for omitting the vital signs is documented.

B. **PTC: Prior to calling:** Check this box whenever assessments or interventions were initiated by EMS per SOP **prior to making contact** with the hospital. This will assist in clarifying the scenario of events in order to better reconstruct off-line vs. on-line medical control decisions and accountability.

C. Repeat VS should be documented as needed or requested.

D. **ECG rhythm/12 Lead ECGs:** OLMC personnel are expected to accurately interpret and document cardiac rhythm strips/12-Lead ECGs transmitted from the field. Changes in technology have made it possible for 12- Lead ECGs to be transmitted to hospitals by means other than the UHF radio. The System's expectation is that all hospitals and EMS agencies are working toward acquiring and operationalizing the technology needed to electronically send and receive 12-Lead ECGs prior to patient arrival in order to declare a STEMI alert if indicated. **If a 12-lead is not transmitted, the ECRN should document the interpretation given to them by EMS during the OLMC report.** ECG strips/12-lead ECGs completed by EMS personnel must be attached or appended to the EMS PCR provided to the receiving hospital for the patient's medical record.

E. Defib/W.S.: Indicate the joules at which a patient was cardioverted or defibrillated if known

F. **Drugs/solutions/response:** All interventions and responses to interventions should be noted. Ex: 10% dextrose 25 gm IVPB/ LOC improved to A&O X 3; repeat glucose 130. List drug names, doses and routes.

VIII. **Treatment**

A. **Airway/breathing:** Note interventions to access/maintain an airway:

1. Manual opening: Jaw thrust, modified jaw thrust, chin lift
2. Abd/chest thrusts: Check the box if applied
3. Suction: Check the box if applied
4. Adjunct: OPA, NPA; Intubation; King LTS-D
5. **Intubation:** **S/U:** Note if ultimately successful or unsuccessful for that patient; # of attempts, if known.
   Method used: Indicate ET (Endotracheal), NT (Nasotracheal), IL (In-Line), DAI (drug assisted intubation)
6. In the event that a **cricothyrotomy** is performed, note if needle or surgical approach on the method line and check the special procedures box.

B. **SpO_2:** Vital signs include a baseline (room air) and after O2 pulse oximetry reading on all patients with possible hypoxia.

C. **EtCO2:** Should be assessed by EMS and noted in OLMC report for all patients with a possible ventilatory, perfusion, or metabolic deficit. This includes, but may not be limited to, those with an advanced airway placed; CPR in progress; post ROSC; those with ventilatory distress; cardiac rhythm disturbances; heart failure, pulmonary edema; pulmonary embolism; shock; and metabolic acidosis; Document number and shape of waveform.

1. **O_2**: Note liters per minute and the oxygen delivery device. Example: O_2 15 L/NRM.
2. **Assist vent rate at:** Note if ventilations require assistance with a BVM; indicate the number of breaths given per minute.
3. If needle pleural decompression or open pneumothorax sealing was required, check the special procedures box and document under comments.

D. **IV/Vasc Access**: Note if peripheral vein or IO and if ultimately successful or unsuccessful; # of attempts, if known; and site.

1. **Fluid:** NS is the only fluid carried on NWC EMSS vehicles. If another fluid is infusing, note under drugs/solutions.
2. **GA**: Size of the venous catheter if known
3. **Rate**: Note rate of IV flow. Example: TKO, wide open, 20 mL/kg.
4. **Amt. infused** Note the total amount infused in the field, if known.

E. **Cap glucose:** Capillary glucose readings should be obtained and noted on all patients with a change in mental status unless an exemption applies. If reading reported by EMS is inconsistent with patient clinical presentation; ask them to repeat the assessment on another site with ideally a different monitor. Document both readings.

IX. **Outcome of run:** The ALS vs. BLS boxes are not meant to connote the type of radio used, but rather the **level of care rendered**.

X. **Release signed:** Note whether or not a release was obtained by EMS personnel on all refusals. See Refusal Policy. Communicate Log numbers to EMS personnel for hospital verification of call.

XI. **AMA**: Check this box if a decisional patient is refusing care and/or transportation against medical advice.

XII. **Petition signed:** Check this box if a patient with a possible mental illness appears to be an immediate threat to themselves or others and a Petition form has been executed.

XIII. **Parent notified:** Check this box if a minor is being transported and a parent has been notified, or an adolescent is refusing and the parent has been notified.

XIV. **Communications:** Note the quality of all radio or phone reception and the quality of ECG transmissions as good, poor or unable. Make a note of explanation when poor or unable are marked for Q/I purposes.

XV. **Transport information**

A. **Nearest hospital:** State law requires patients to be transported to the nearest hospital, trauma center, or stroke center by travel time (See Bypass Policy) unless accommodating for patient choice and approved by OLMC (release is signed) or when alternate transport patterns are previously established (Level I or II Trauma Centers; Comprehensive or Primary Stroke Centers).

B. **Desired hospital:** Indicate destination of choice and ETA if different from nearest hospital.

C. **Receiving hospital:** Indicate the final destination and ETA.

D. **Reason for diversion:** If receiving hospital is not the nearest, note reason for diversion.

E. **Approval box**: In cases where a patient is being transported to other than the nearest hospital (except for pre-existing transport patterns), OLMC must complete a risk/ benefit analysis and indicate medical approval for the extended transport. For more information on this, see Policy T2; Patient Transport, Selection of Receiving Hospital and Policy B1: Patient Bypass.

F. **ECRN**: Nurse providing OLMC. Signatures must include at minimum the full last name and be legible. **If any orders deviate in any way from SOPs, a physician must co-sign the Log**.

1. The only persons approved by EMS Rules to communicate orders to EMS personnel are ECRNs, Provisional ECRNs with supervision, and approved physicians. If non-ECRNs are transmitting orders, but acting under the direct supervision of a physician, they are to declare that orders are being given per Dr, and have him/her co-sign the Communications log.

2. **Provisional ECRNs must be co-signed by the precepting ECRN or physician.**

3. The names of non-ECRNs are not to appear unless a hospital has modified the log to include a signature line for an R.N. who is documenting only. As an alternative, the nurse may strike out "ECRN" and enter "as documented by" and sign his/her name (R.N.). In both cases the physician providing OLMC must co-sign the Log.

G. **MD/DO**: Physician providing OLMC. Name must include at a minimum the full last name and be legible.

H. **Report called to**: If the OLMC hospital is not receiving the patient, report must be called immediately to the receiving nurse or physician. It is not acceptable to call report to a clerk, tech, or orderly.

1. Indicate the name and credentials of the person accepting report.
2. Time: Note the time report was called.