



**Our Town EMS**

Continuing Quality Improvement Benchmarks

Daily 100% run sheet evaluation with attention to complete, accurate, and legible documentation of:

- Type and nature of call
- Field diagnosis
- History of this event
- Past medical history
- Initial and repeat vital signs
- Head to toe physical exam
- Treatments given
- Patient response to treatment
- Receiving facility designation
- Transfer of care
- Provider identification

Daily 100% run sheet evaluation with attention to assurance of quality patient care:

- Does the H&P support the field diagnosis?
- Were vital signs assessed manually?
- Were vital signs assessed after each intervention?
- Were treatments delivered according to standing delegated orders?
- Was advanced airway placement confirmed by waveform capnography?
- Was the patient delivered to the appropriate receiving facility?
- Was the transfer of care completed?

A “no” answer to any of these questions will require an Exception Report be prepared on Department letterhead for the medical director.

Fax the exception report and run sheets, with identifiers removed, to EMS-MD.COM™ at (866) 980-0050.

Certification:

I certify that I have read the requirements for the Continuing Quality Improvement program with EMS-MD™.COM and that I shall execute the program with diligence.

Name \_\_\_\_\_ Signature \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_



**Our Town EMS  
Daily Run Sheet Evaluation Exception Report**

Fax the exception report and run sheet(s), with identifiers removed, to EMS-MD.COM™ at (866) 908-0050.

|                                    |  |
|------------------------------------|--|
| Description of call:               |  |
| <i>Age, Gender, Nature of call</i> |  |
|                                    |  |

|  |  |
|--|--|
| Benchmark Exception, check all that apply: |  |
| <input type="checkbox"/>                   | Does the H&P support the field diagnosis?                        |
| <input type="checkbox"/>                   | Were vital signs assessed manually?                              |
| <input type="checkbox"/>                   | Were vital signs assessed after each intervention?               |
| <input type="checkbox"/>                   | Were treatments according to standing delegated orders?          |
| <input type="checkbox"/>                   | Was advanced airway placement confirmed by waveform capnography? |
| <input type="checkbox"/>                   | Was the patient delivered to the appropriate receiving facility? |
| <input type="checkbox"/>                   | Was the transfer of care completed?                              |
| <input type="checkbox"/>                   |  |
| <input type="checkbox"/>                   |  |

|   |  |
|---|--|
| Provider response to exception:                                 |  |
| <i>Rationale or statement as to why the exception occurred.</i> |  |
|   |  |

|   |  |
|---|--|
| Action taken:   |  |
| <i>Department action taken. Disciplinary action or remediation that assures exception will not occur in future.</i> |  |
|   |  |

Provider Name \_\_\_\_\_ Signature \_\_\_\_\_

Reviewer name \_\_\_\_\_ Signature \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_