Documentation

Pea Ridge Fire Department EMS refresher

Introduction

- EMS documentation is important.
  - Becomes part of:
    - Patient's medical record
    - Emergency department chart

Introduction

- EMS professional needs to know:
  - What constitutes a report
  - What must be included
  - Who might read the report
  - When it must be completed
  - What terminology may be used

Introduction

- For every call, the PCR should include:
  - Objective information
  - Subjective information
  - Details of patient care

Introduction

- PCRs must be complete, accurate, and legible.

Legal Implications of a PCR

- Reports may include subjective statements from the patient.
  - Cannot include bias or personal opinions
- Omissions and errors can result in:
  - Errors in care
  - Litigation
  - Job loss
  - Poor reputation

Legal Implications of a PCR

- Reports should be:
  - Complete
  - Well written
  - Legible
  - Professional
- Sloppy documentation implies sloppy care!
- HIPAA has ramifications for patient care reporting.

Purposes of Documentation

- The PCR is a record of:
  - The patient's condition upon arrival
  - The care provided
  - Any changes in the patient's condition
  - Condition on arrival at the hospital
- Paints a picture of the scene and mechanism of injury or nature of illness

Minimum Requirements and Billing

- To ensure timely billing:
  - Document procedures performed.
  - Obtain insurance codes.
  - Obtain medical necessity signature.
  - Document reason for ambulance transport.

Table 6-1 Significant Findings That Indicate Medical Necessity for Ambulance Transport

- Patient is transported in an emergency mode (Code 3).
- Patient is in shock.
- Patient needs to be restrained.
- Patient requires emergency treatment while being transported (eg, oxygen therapy, intravenous therapy).
- Patient must be immobilized for transport or fracture management.
- Patient is experiencing an acute myocardial infarction or stroke.
- Patient has uncontrollable hemorrhage.
- Patient is able to be moved only by a stretcher because of a condition.

EMS Research

- Many states now require EMS agencies to submit data to their state EMS office.
  - Patient care data collection can improve EMS system as a whole.
- NEMSIS stores standardized EMS data from each individual state.
  - The goal of NEMSIS is to define EMS care.

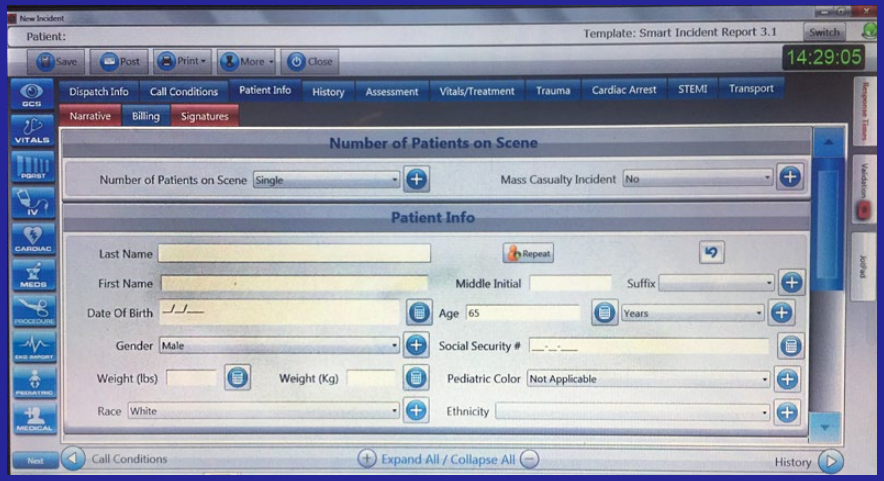
Incident Review and Quality Assurance

- EMS reports may be requested for medical audits and other educational activities.
  - Run reviews
  - May be used to calculate number of times you performed a specific skill
- Always accurately document skills attempted and performed with patient care.

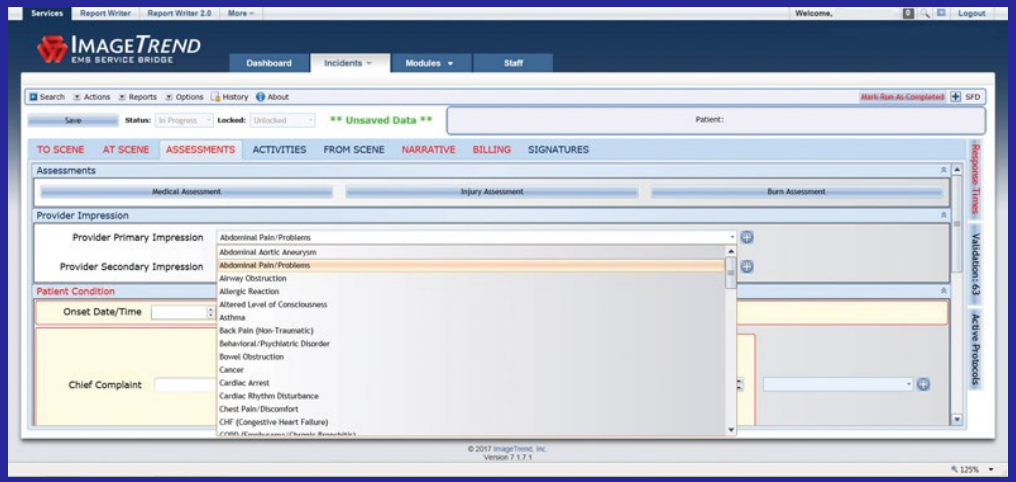
Types of PCRs

- Most EMS reports are electronic.
- Many types of EMS report designs
  - Some services have developed check boxes and drop-down menus instead of narrative sections.
- Regardless of the form, obtain the proper information.

Types of PCRs



Courtesy of Rhonda Hunt.



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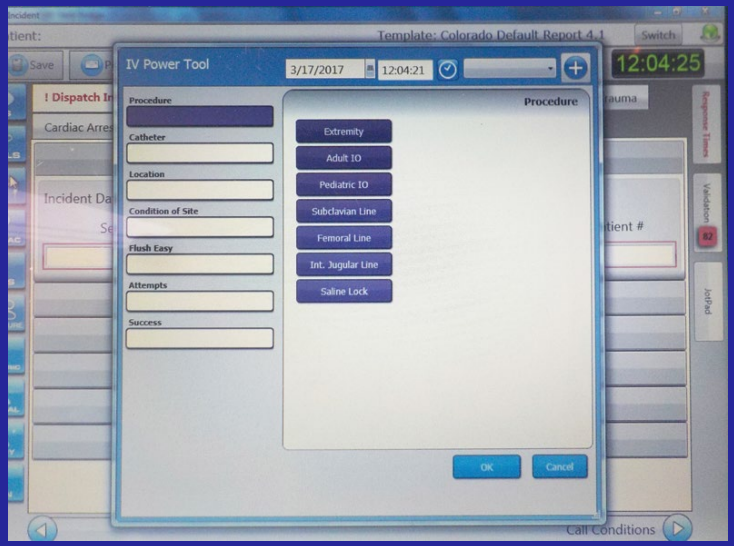


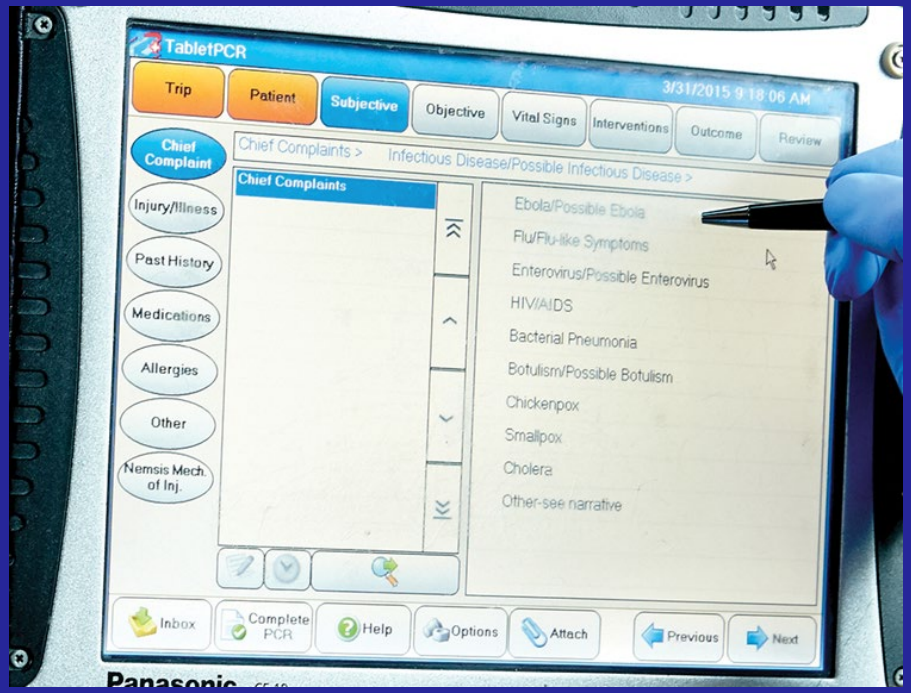
Courtesy of Bryan Ware.

Types of PCRs

- Agencies are shifting away from paper PCRs.
- Many electronic PCR options available
- Computer-based PCRs should be NEMSIS compliant.

Documentation for Every EMS Call

- Every call requires documentation.
- Minimum data set
  - Standard items documented on every call
    - Run data
    - Patient data



Documentation for Every EMS Call

- Run data
  - Incident times
  - Locations
  - Responding units/crew members
- Patient data
  - Chief complaint
  - LOC/mental status
  - Vital signs
  - Demographics

Documentation for Every EMS Call

- PCR should contain:
  - Objective observations of scene
  - Treatments
  - Effects of treatments
  - Changes in patient's condition
- Service treatments may be scheduled or unexpected.

Transfer of Care

- Document in whose care you left the patient.
  - Avoids allegations of abandonment
  - Some agencies require nurse or physician signatures.
  - Required when you transfer a patient to another agency

Care Prior to Arrival

- Dispatch may direct caller to provide care prior to arrival.
  - Off-duty providers and lay personnel may also provide care.
  - Obtain information as to what care has been provided.
- Document each situation appropriately.

Refusal of Care Reporting

- Competent adult patients have the right to refuse care.
  - Know and understand patient rights and state laws.
- The patient should know:
  - His or her current situation
  - Right to receive and refuse care
  - Consequences of refusal of care

Refusal of Care Reporting

- Patient must understand the consequences of refusing care
- Information must be:
  - Given in a language the patient understands
  - Documented on the PCR
  - Witnessed by an observer
  - Initialed and signed by the patient

Refusal of Care Reporting

- Unresponsive patients may be treated under implied consent.
- Be familiar with individual state laws related to consent.
- Confirm every effort is made to ensure patient's best interests.

Refusal of Care Reporting

- If you disagree with a refusal, know the next steps.
  - Document all contacted parties on PCR.
- You must have a witness to the refusal.
- Evaluate the patient's mental status.
- Remind patient he or she can call EMS later.

Refusal of Care Reporting

- Document everything!
- Propose alternate methods of care.

Table 6-2	Components of a Thorough Patient Refusal Document
Evidence the patient is able to make a rational, informed decision.	
Documentation of complete assessment. If the patient refuses care or does not allow a complete assessment, then document that the patient did not allow for proper assessment and document whatever assessments were completed.	
Discussion with the patient as to what care/transportation you would like to provide.	
Discussion with the patient as to what may happen if he or she does not allow care or transportation. (You should list these consequences clearly and include the possibility of severe illness/injury or death if care or transportation is refused.)	
Discussion with family members/friend/bystanders to encourage the patient to allow care.	
Discussion with medical direction according to local protocol.	
Discussion with the patient regarding other alternatives (such as going to see his or her family physician, or having a family member drive him or her to the hospital).	
Discussion with the patient regarding the willingness of EMS to return if the patient changes his or her mind.	
Signatures: Have a family member, police officer, or bystander sign the form as a witness. If the patient refuses to sign the refusal form, then have a family member, police officer, or bystander sign the form verifying that the patient refused to sign.	

Workplace Injuries and Illnesses

- OSHA guidelines require workplace injuries to be logged.
  - Companies may require additional documentation.
  - Document precautions taken and protective gear worn.
  - Be familiar with state requirements.

Special Circumstances

- Mass-casualty incident (MCI)
- Occupational exposure reports
- Abuse and neglect cases
- Physician's arrival
- Mutual aid services
- Unusual occurrences
- Controlled Substances
- Follow policy of medical director.

PCR Narrative

- Narrative should be:
  - Detailed
  - Accurate and complete
  - Specific
- Narrative section should document:
  - Consultations
  - Orders from medical control
  - Refusal situations

PCR Narrative

- Many methods for narrative documentation exist.
- Know your agency's preferred method.

PCR Narrative

- Chronological order
  - Story format from dispatch until call was completed

Squad called to residence for ill man. On arrival found an alert and oriented 78 yo man sitting on the couch reporting CP. Pt sts this began approximately 30 min prior when he was mowing the lawn. Pt denies any radiation of the pain and rates it at a "7" out of 10 on pain scale. Pt has a known cardiac history with an MI 2 years prior. Pt is compliant with all meds as listed above. Pt denies any SOB or N/V with this episode. V/S stable, lungs CTA, Spo_2 93% RA, Skin pale/warm/dry to touch, PEARRL 4 mm, GCS 15. Pt placed on O_2 @ 15 L/min via NRB. Monitor showed RSR @ 88 bpm without ectopy. IV of NS was established in L AC with 18 g @ TKO (medic 785). 4 × 81 mg ASA were given PO @ 1501 (medic 785). Pt was given 1 SL 0.4 mg nitro @ 1503 with relief down to a "4" on scale (medic 785). V/S still stable. Secondary exam showed negative new findings. Med control contacted with negative orders. Left pt in care of ED staff with report in room 7.

PCR Narrative

- SOAP method
  - Subjective information, Objective information, Assessment, Plan for treatment
  - Documents various aspects of the patient care encounter

(S) Called to scene for 78 yo man complaining of chest pain. Pt states pain began approximately 30 min prior to arrival when he was mowing the lawn. Pt denies any radiation of pain. States pain is "7" out of 10 on pain scale. Pt has known cardiac hx with an MI 2 yrs prior. Pt denies SOB or N/V. Pt has no allergies and is compliant with all meds listed above.

(O) U/A found Pt sitting on the couch. Pt alert and oriented with NARD and strong radial pulse. Pt calm and cooperative. Skin: Pale/warm/dry. Pupils PEARRL 4 mm, GSC 15. Lungs CTA. No noted JVD. Abd soft and nontender. PMS × 4. Secondary exam unremarkable.

(A) Possible MI.

(P) Primary, secondary Hx, V/S as listed above. Assisted pt to cot. Cardiac monitor: showed RSR @ 88 bpm without ectopy. IV: NS 18 g in L AC @ TKO (BW); Spo_2 93% RA, O_2 @ 15 L/min via NRB 100%; 4 × 81 mg ASA given PO, 1 SL 0.4 mg nitro (BW) pain down to "4". Transported to _____. Pt care transferred to ED with report.

PCR Narrative

- CHARTE method
  - Chief complaint, History, Assessment, Treatment (Rx), Transport, and Exceptions

(C) 78 yo man complaining of chest pain without radiation. Pt sts pain is a "7" out of 10 on pain scale.

(H) Pt has a known cardiac history with an MI 2 years prior.

(A) Pt denies any SOB or nausea/vomiting with this episode. Vital signs stable, lungs clear to auscultation, Spo_2 93% RA, skin pale/warm/dry to touch, PEARRL 4 mm, GCS 15. Monitor showed RSR @ 88 bpm without ectopy.

(R) Pt placed on O_2 @ 15 L/min via NRB. IV of NS was established in L AC with 18 g @ TKO (medic 785). 4 × 81 mg ASA were given PO @ 1501 (medic 785). Pt was given 1 SL 0.4 mg nitro @ 1503 (medic 785).

(T) Pt improved during transport, pain went down to a "4" on the scale, V/S remained stable, and patient care was transferred to ED staff.

(E) None.

PCR Narrative

- Body systems/parts approach
  - A head-to-toe approach
- Use one reporting method consistently.
  - Proper grammar and spelling are essential.
- Include:
  - Pertinent negatives
  - Spoken accounts

Elements of a Properly Written Report

- Information should be comprehensive and concise.
  - Complete all sections, even if not applicable to call.
- Handwritten reports should be:
  - Legible
  - Written in ink
  - Neat and easy to read

Elements of a Properly Written Report

- Place reports in a secure location.
- Complete in a timely manner.
- A written record should be left with the patient.
  - “Drop report” or “transfer reports” may used.
  - Follow state laws and requirements.

Elements of a Properly Written Report

- PCRs should not contain:
  - Jargon
  - Slang
  - Personal opinions
- Be sure your documentation is not libelous.
  - Only true and accurate statements
- Review your report before submitting it.
- Written reports reflect on the paramedic.

The Consequences of Poor Documentation

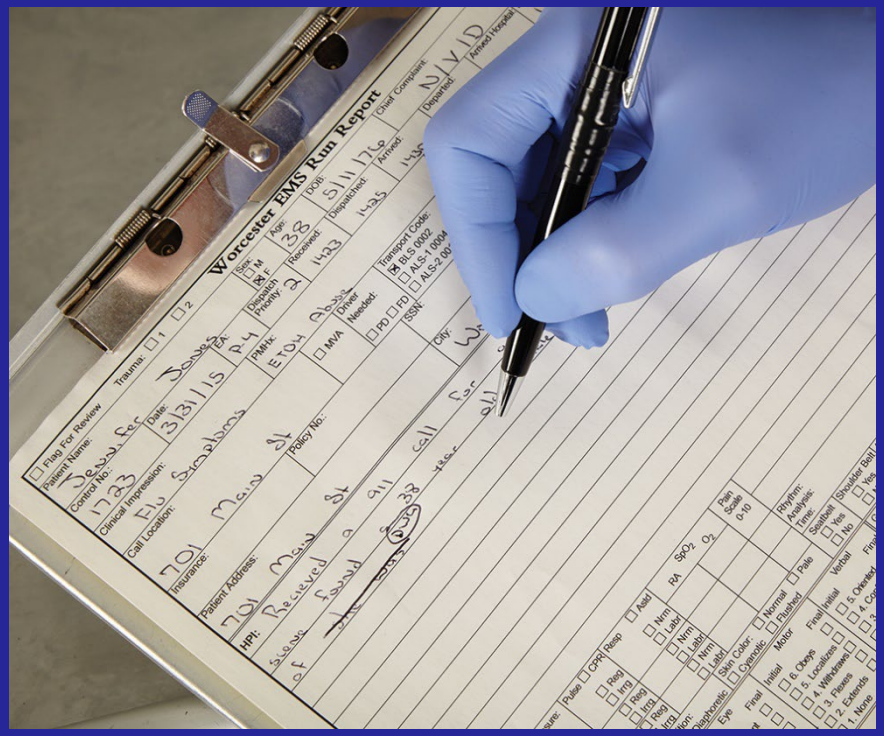
- Inappropriate, inaccurate, and poor documentation can adversely affect patient care.
- Legal implications
- Affects paramedic's reputation
- Part of being a good paramedic is completing paperwork and reports.
- Seek help if needed.

Errors and Falsification

- If a revision must be made:
  - Note the date and time of revision.
  - Include purpose for correction.
  - Never discard the original.
- Only the person who wrote the report can revise it.

Errors and Falsification

- Follow protocol for making corrections.
- The PCR is a legal document.



Errors and Falsification

- Most electronic systems allow for amendments.
- Addendums and supplemental narratives may be needed.
- Billing information may be needed.

Errors and Falsification

- Always be honest and thorough in your documentation.
- Lost reports have huge legal implications.
  - Ensure reports are complete and turned in on time.
  - Do not keep copies of your reports.

Documenting Incident Times

- Accurate timekeeping is essential.
  - Track time of:
    - Call, dispatch, arrival at the scene, time with patient, medication administration, medical procedures, departure from scene, transfer of care, time back in service
  - Use military time.

Thank You

Please move to the next section