Chapter 19
Documentation

Learning Objectives

- Describe potential consequences of illegible, incomplete, inaccurate documentation
- Explain role, importance of documentation pertaining to following:
  - Continuity of patient care
  - Quality management
  - Data collection
  - Research
  - Billing, reimbursement

Learning Objectives (Cont'd)

- Explain how to document information received from bystanders, other 3rd-party sources
- Explain how to document scene assessment findings
- Discuss importance of documenting pertinent positive, pertinent negative findings
Learning Objectives (Cont'd)

- Explain importance of using medical terminology appropriately
- Discuss importance of using only locally approved medical abbreviations
- Discuss importance of timely report writing, submission

Learning Objectives (Cont'd)

- Be familiar with different methods used to document, including:
  - Handwritten documentation
  - Electronic, computer-based documentation
  - Dictation
- Discuss importance of documenting with consistent narrative style, identified by local protocol

Learning Objectives (Cont'd)

- Describe differences between subjective, objective documentation elements
- Describe special considerations for documenting patient refusal of care, transport
- Describe special considerations for documenting multiple-casualty incident
Learning Objectives (Cont’d)

- Evaluate completed prehospital care report for:
  - Completeness
  - Thoroughness
  - Accuracy
  - Spelling
  - Grammar
  - Use of medical terminology
  - Use of approved abbreviations

Introduction

- Prehospital care report (PCR)
  - Document written after call completed
  - Outlines all observations, performance
  - Record of events
  - Must be complete, thorough, accurate, legible

Functions of Documentation

- Continuity of care
  - From field to hospital
- Legal
  - Questions about scene
  - Actions of paramedic
- Legislative
  - Justify request for law change, grants/governmental funding
Functions of Documentation (Cont'd)

- Research
  - Scope of practice expansion
  - Retrospective
- Quality management
  - Performance standards
  - Performance improvement
- Billing & reimbursement

Prehospital Care Report

PCR Components

- Identifying Data
  - Name
  - Address
  - Social Security number
  - Date of Birth
PCR Components (Cont’d)

- Source of information
  - Patient
  - Family member
  - Law enforcement
  - Bystander

PCR Components (Cont’d)

- Location of call
  - Residence
  - Business
  - Farm
  - Park
  - Roadway

PCR Components (Cont’d)

- Times
  - Dispatched
  - Arrived on scene
  - Transporting to hospital
  - Arrival at hospital
PCR Components (Cont'd)

- Assessment
  - Description of the scene
  - Chief complaint
  - Initial findings
  - Pertinent positive findings
  - Pertinent negative findings
  - Diagnostic findings

PCR Components (Cont'd)

- Past medical history
  - Allergies
  - Medications
  - Previous diagnoses
  - Previous surgeries
  - Previous similar episodes
  - Family medical history
  - Social history

PCR Components (Cont'd)

- History of present illness
  - Time, onset of illness, injury
  - Patient's activity when injury, illness occurred
  - Pain/discomfort level
  - Pain/discomfort description
  - Provoking, palliative measures
  - Treatment done before EMS arrival
PCR Components (Cont'd)

- Treatment
  - O2
  - IV
  - Medications
  - Intubation
  - Bandaging, splinting

PCR Components (Cont'd)

- Response to treatment
  - Condition improved
  - Symptoms worsened
  - No change in patient condition

PCR Components (Cont'd)

- Transport
  - Destination
  - Mode of transport
  - Facility name
  - Room number
  - Patient belongings
Medical Terminology

- Root word
  - Primary meaning
- Prefix
  - Added to word beginning
- Suffix
  - Added to word ending

Medical Abbreviations

- Save time, space on PCR
- Use locally accepted abbreviations

Errors

- Corrections
  - Put single line through error, initialize
- Multiple errors
  - Unprofessional, rewrite
Errors (Cont'd)

Example of correction

Timeliness

- Completed before leaving hospital
- If busy, many allow 24 hours
- Sooner written, less details lost

Addendums

- Write as soon as realized needed
  - Reason, date written
  - Separate form
- If new report, indicate as rewrite
  - Often, new/old report filed together
Methods of Documentation

- Handwritten documentation
- Computer-based documentation
- Dictation

Documentation Formats

- CHART
  - Chief complaint
  - History
  - Assessment
  - Treatment
  - Transport

Documentation Formats (Cont'd)
Documentation Formats (Cont’d)

- SOAP
  - Subjective findings
  - Objective findings
  - Assessment of condition
  - Plan for treatment, transport
- Narrative
Special Situations

- Multiple patients
  - Separate PCR for each patient

- Refusals
  - Patient does not want to be transported
  - Patient must be awake, alert, oriented, not under influence of substances
  - Paramedic must explain, document potential consequences of refusing transport

Special Situations (Cont’d)

- Cancellations
  - En route
  - On arrival or at scene
  - Document who cancelled

- Multiple-casualty incidents
  - Abbreviated report form may be used
Special Situations (Cont’d)

Triage Tag

Documentation Essentials

- Objective
- Thorough
- Legible
- Timely
- Error-free

Quality Management Process

- Paramedics must be monitored for skill proficiency
  - By agency department
  - By peer review
- Trip audit
  - 100%
  - Selective
Chapter Summary

- Documentation, one of most important parts of paramedic’s job
- Report written by paramedic commonly the only documentation of medical events on scene, during transport

Chapter Summary (Cont’d)

- Documentation can affect:
  - Patient care
  - Legal proceedings
  - Scope of practice
  - Education, training
  - Agency reimbursement

Chapter Summary (Cont’d)

- Written report should
  - Be timely, complete, accurate, legible, objective, error-free
  - Leave no questions in reader’s mind
  - Leave no room for reader interpretation
  - Be written in set format, such as following mnemonics CHART, SOAP or narrative structure
Chapter Summary (Cont’d)

- Reports can be written by hand, entered in computer-based system, completed by dictation
- All interactions with patient should result in written report

Questions?