Chapter 9
Documentation

Learning Objectives

• Describe legal implications associated with written reports
• Explain rationale for gathering data in an EMSS
• Explain rationale for patient care documentation

Learning Objectives

• Explain rationale for using medical terminology correctly
• Explain rationale for using an accurate and synchronous clock so that information can be used for trending
• Know components of the written report; list information to be included
Learning Objectives

- Explain components of written report; list information to be included
- Identify various sections of written report
- Describe information required in each section of written report and how it is entered

Learning Objectives

- Identify various sections of the written report
- Describe what information is required in each section of a written report and how it is entered
- Define special considerations regarding patient refusal
- Discuss all state and/or local record-keeping and reporting requirements

Introduction

- Documentation - essential function
  - Prehospital Care Report (PCR)
    - Valuable part of patient record
    - Documents all aspects of call
    - Linked to patient assessment & care
    - Important part of legal record
Prehospital Care Report

- Medical record
  - Meticulous documentation important

- Legal document
  - Specific, accurate
  - Protection from lawsuits

Prehospital Care Report

- CQI
  - PCRs reviewed to evaluate effectiveness
  - CQI activities
    - Review - response and transport times
    - Documentation of assessment & treatment
    - Follow-up on patients who refused treatment
    - Other patient care issues
  - NEMSIS: National QI & research

Prehospital Care Report

- Continuing education
  - Call review
  - Critiques

- Administrative uses
  - Ambulance distribution
  - Billing
  - Annual reports
Principles of Documentation

- Effectiveness depends on:
  - Accuracy & honesty
  - Clarity
  - Chronology & trends
  - Completeness

Principles of Documentation

- Accuracy & honesty
  - Record chief complaint in patient’s words
  - Dishonesty may compromise patient care
  - When facts not known, use dispatch/other records
  - If error, omission occur
    * Be honest, do not cover up
    * Document what happened, and steps taken to correct it
    * Describe findings (facts), not conclusions
    * Avoid judgment without definitive evidence

Principles of Documentation

- Clarity
  - Write for reader
  - When describing pain/location of wounds, be exact
Principles of Documentation

- **Chronology & trends**
  - Time relationships critical
    - Provides physician with a history of events in order
    - Allows you & physician to identify progressive problems & effective treatment

- **Completeness**
  - Record all assessment, treatment, reassessment
    - Include pertinent positive, negative findings during focused history, physical exam
    - Note events affecting treatment, transport
    - Document treatment by other EMS providers/bystanders
    - Document unusual occurrences
    - Document ambulance passengers
    - If patient property removed, record info
Components of a PCR

- EMSS have various PCR reports, similar components
  - Run data
  - Patient data
  - Patient assessment data
  - Patient treatment data
  - Patient disposition

Components of a PCR

- Run (dispatch) data
  - Date, time of call (most use military time)
  - Crew responding
  - Type of call
  - Sequential times of response
  - Route, cross streets, major thoroughfares
  - If direct call: note call location, nature of problem, callback number
Components of a PCR

- Patient data
  - Basic information
  - If patient becomes unconscious, PCR becomes primary source of basic patient data

- Assessment data
  - Minimum dataset to record
    - Critical signs, symptoms
    - Chief complaint
    - Vital signs
    - Mental status
    - Skin assessment
  - Additional data
    - Continuous reassessment findings
    - Objective findings
    - Subjective findings

- Treatment data
  - Treatment with time relationship
  - Treatment rendered before arrival
  - Extraordinary factors preventing timely treatment
  - Transportation method
  - Time of transport
  - Hospital notification
  - Type of receiving facility
Components of a PCR

- Patient disposition
  - Receiving hospital
  - Special transport mode
  - Rationale for facility selection
  - Reason for not receiving a patient
  - Final disposition of patient at hospital
  - Signature of EMT, receiving nurse/physician

Special Authorization Forms

- Treatment, transport refusal
  - Try to convince patient to accept treatment
  - Inform patient of potential consequences
  - Add refusal statement to preprinted form
  - Patient signature
  - Witness signature
  - Have patient state consequences
  - If patient refuses to sign refusal
  - If patient selects hospital beyond closest
Special Authorization Forms

- Special situations, incident reporting
  - Document lost property
  - Record special incidents
  - Document patient injury during treatment, transport
  - Fulfill state, local reporting requirements

- Correcting errors
  - PCR medical, legal document
  - Use Emergency Medical Services System (EMSS) recommended process
  - If you make an error while writing
  - If an error is found after submission
Special Authorization Forms

- Multiple-casualty incidents
  - Numerous patients, limited time
  - Documentation important to patient care
  - Triage tags
Special Authorization Forms

- Documentation of death
  - Obvious death
    - Irreversible, biological
    - Clinical
    - Record factors of death clearly
  - General statements, such as "DOA," not acceptable
  - Time factors
  - DNR order

Special Authorization Forms

- Emotionally disturbed, minor, unconscious patients
  - Know EMSS policy, defines proper procedure
  - Police officer may accompany emotionally disturbed patient
  - Adult should accompany minors when possible
  - Family member, police officer accompany unconscious patient

Special Authorization Forms

- Dying statements
  - You may be sole witness to patient’s dying words

- Homicide & suicide
  - Carefully document significant findings
  - Do not disturb crime scene unnecessarily
  - Do not move body
  - Report criminal acts to police
Special Authorization Forms

- ePCR
  - Technology driving change
  - Advantages
  - Become familiar with electronic records

- Confidentiality
  - All information recorded on PCR
  - Direct information requests
  - Specific agency reporting of some conditions

- Health Insurance Portability & Accountability Act (HIPAA)
  - Helps ensure consistent standards
  - Mandatory training required
  - Records may be used for quality assurance
Summary

- PCRs serve several functions, including:
  - Patient record
  - Legal document
  - Continuous QA & research data source
  - Education
  - Administrative data source

- PCR sections include run data, patient data, treatment, narrative

Summary

- Document special reporting circumstances with appropriate regional/state form

- Document death by recording physical findings such as decomposition, extreme dependent lividity, rigor mortis, obvious lethal injuries

Summary

- General rules for correcting errors include crossing out error, providing corrected data, initialing next to correction, errors recorded later should include date

- Carefully document patient refusal of care, including signature of patient, witness at scene
Summary

- Document special circumstances, unusual events on PCR
- Triage tags, other time-saving methods may be used to document assessment, care in multiple-casualty incidents
- Electronic reporting options increase legibility, facilitate data collection

Summary

- HIPAA – set of rules that include protection of patient’s privacy

Questions?