Chapter 4
Documentation

Lesson 4.1
Importance of Documentation
Learning Objectives

- Identify the purpose of the patient care report.
- Describe the uses of the patient care report.
- Outline the components of an accurate, thorough patient care report.

Reasons for Written Documentation

- Provides tangible, legal incident record
- Used by physicians, nurses in patient care
  - Read to understand initial condition, type of care given in field
- EMS agency, medical direction may
  - Monitor care in field
  - Evaluate individual performance
  - Conduct review conferences
  - Seek other educational forums

Reasons for Written Documentation

- Written documentation provides for
  - Tangible record of incident
  - Legal record of incident
  - Professionalism
  - Medical audit
  - Quality improvement
  - Billing, administration
  - Data collection
Reasons for Personal Care Report (PCR)

- Demonstrate continuity of patient care provided
- Have legal record of care provided
- Assist financial reimbursement, cost recovery for care services, equipment, supplies
- Assist in quality improvement studies, EMS research

Reasons for Personal Care Report (PCR)

- Quality improvement
  - Examples from PCR that may result in policy changes, improve care
  - Minimizing time spent on scene for critical trauma patients
  - Adding new medications to better manage some medical emergencies
  - Changing placement of emergency vehicles during peak response times, certain demographic areas

Reasons for Personal Care Report (PCR)

- Documents unique scene situations that may have affected care
  - Traffic caused long response time
  - Entrapped patient required prolonged extrication
- Aids in tracking care skills of paramedic
  - IV lines, intubations, defibrillations
  - May be required by EMS agency’s training division
  - ALS skills documentation may be required by some states for relicensure, recertification
General Considerations for PCR

- Carefully detailed, legible
- Legal document, part of patient’s medical record
- Avoid slang terms, medical abbreviations that are not universally accepted
General Considerations for PCR

• Required data
  – Dates, response times
  – Difficulties en route
  – Communication difficulties
  – Scene observations
  – Reasons for extended on-scene time
  – Previous care provided
  – Time of extrication
  – Time of patient transport
  – Reason for hospital selection

Why should you note the previous care given by bystanders in your report?

General Considerations for PCR

• Provides legal, accurate recording for incident times
  – Call time
  – Dispatch time
  – Scene arrival time
  – Time at patient’s side
  – Time of vital sign assessments
  – Time(s) of medication administration, certain procedures, defined by local protocol
  – Scene departure time
  – Medical facility arrival time when transporting patient
  – Time back in service
Documentation of specific times on the PCR is important. How can this information be useful?

The Narrative

- Allows for chronological account of call
- Written concisely, clearly using simple words
  - Avoid uncommon abbreviations, unnecessary terms, duplicate information
- Established standard format helps ensure completeness
  - Assists quality improvement reviews

Narrative Components

- Initial contact
- All patient care activities
- Care at scene
- Initial assessment, vital signs
- Chief complaint
- Pertinent significant medical history
- Clock time, hospital contact
- Time of physician orders, advice, physician name

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Narrative Components

• Pertinent positive findings
  – Signs, symptoms that help substantiate patient’s condition

• Pertinent negative findings
  – Warrant no medical care, intervention
  – Paramedic shows evidence of thoroughness of examination, history of event

Narrative Components

• Pertinent oral statements
  – Those made by patient, others on scene
  – Should be recorded
  – Mechanism of injury
  – Patient’s behavior
  – Prior aid before EMS arrival
  – Safety-related information (including weapons)
  – Information of interest, crime scene investigators
  – Disposal, valuable personal property (jewelry, wallets)

Narrative Components

• Use quotation marks for statements made by patients, others relating to possible criminal activity
• Quote admission of suicidal intention
• Document failed skills
  – Unsuccessful attempts at starting IV line, endotracheal intubation
Narrative Components

• Patient status changes
• Patient treatment response
• Vital sign reassessment
• ECG interpretation

Narrative Components

• Diagnostic readings
• Use of support services
• Time, condition of patient on delivery
• Name of receiving health care worker
• Paramedic signature

Narrative Components

• List everyone who delivered care before ER delivery
• Copy of report placed in medical record
  – May be necessary to leave finished copy at receiving hospital
  – Complete in timely fashion
  – If possible, leave report with patient at hospital
Lesson 4.2
Elements of EMS Documentation

Learning Objectives

• Describe the elements of a properly written emergency medical services (EMS) document.
• Describe an effective system for documenting the narrative section of a prehospital patient care report.

Learning Objectives

• Identify differences necessary when documenting special situations.
• Describe the appropriate method to make revisions or corrections to the patient care report.
• Recognize consequences that may result from inappropriate documentation.
Documentation Elements

• Accurate, complete
  – All relevant information must be provided in narrative, checkbox sections of report
  – Ensure medical terms, abbreviations, acronyms are used properly, spelled correctly

• Legible
  – All writing must be easily read by others
  – Checkbox markings should be clear, consistent from top page to all underlying pages

• Timely
  – Completed immediately after patient care completion
  – Delays can result in omissions, considered negligent patient care

• Unaltered
  – If errors, draw single line through error, date, initial error
  – Changes in completed report should be accompanied by proper “revision/correction” supplement with date, time of revision

• Free of nonprofessional/extraneous information
  – Jargon
  – Slang
  – Personal bias
  – Libelous, slanderous remarks
  – Irrelevant opinion/impression
Documentation Elements

• Apply documentation principles to computer-generated PCRs, other computer-generated forms
• Related documentation should be properly labeled, attached, scanned with report
  – ECG
  – Capnography tracings
  – Photographs
  – Insurance information
How many meanings can you think of for the word *lethargic*? Look it up in the dictionary. Should you use this word to document a patient’s mental status? Why?

**SAMPLE History**
- Signs, symptoms
- Allergies
- Medications
- Past medical history
- Last meal, oral intake
- Events before emergency

**SOAP Format**
- Subjective data
  - Cannot be supported by facts
  - All patient symptoms
  - Chief complaint
  - Associated symptoms
  - History
  - Current medications, allergies
  - Information provided by patient, bystanders, family
SOAP Format

- Objective data
  - Supported by facts
  - Pertinent physical examination information
  - Vital signs
  - Level of consciousness
  - Physical examination findings
  - Electrocardiogram
  - Pulse oximetry readings
  - Blood glucose determinations

SOAP Format

- Assessment data
  - Clinical impression of patient based on subjective, objective data
- Plan patient management
  - Treatment provided
  - Requests for additional treatment

CHART Format

- Chief complaint
  - Patient’s primary account
- History
  - Present illness
  - Significant medical history
  - Current health status
  - Review of systems
CHART Format

- Assessment
  - General impression
  - Vital signs
  - Physical examination
  - Diagnostic tests
  - Field diagnosis

CHART Format

- Rx (treatment)
  - Standing orders, protocols
  - Direct orders from online medical direction
- Transport
  - Effects of interventions
  - Transportation mode
  - Ongoing assessment findings

CHEATED Format

- Chief complaint
  - Reason patient requested EMS assistance
- History
  - Past, present medical history
  - Incident nature
  - Injury mechanism
CHEATED Format

• Examination
  – Physical assessment
• Assessment
  – General impression
  – Diagnosis

CHEATED Format

• Treatment
  – Any care rendered
• Evaluation
  – Patient’s response to care provided
• Disposition
  – Transfer of patient care to another health care professional

Physical Approach from Head-to-Toe

• Use after full head-to-toe physical examination
• Findings noted in same order as in examination
  – Begin by noting findings from head
  – End by noting circulatory findings
Review of Primary Body Systems

• Use when examination performed for chief complaint focused on one body system
  – Chest pain with suspected myocardial infarction
  – Limit findings to cardiorespiratory system
  – Description of pain
  – Vital signs
  – ECG findings
  – Associated breathing difficulties
  – Significant medical history, medication use
  – Allergies

Chronological, Call-Incident Approach

• Begins with noting arrival time at patient’s side
• Initial examination findings
• Time of vital sign assessment, reassessment

Chronological, Call-incident Approach

• Chronological listing of all patient care interventions
• Commonly used for patient with major trauma with extended on-scene time
• Used during cardiac arrest event when numerous medications, electrical therapy administered to patient
Patient Management Approach

- Organize, record complete patient management plan
- Covers from start to finish of emergency response
- Describe how patient was found

Patient Management Approach

- Interventions performed and why
- Important assessment findings
- Provides more complete picture of scene events during care, patient transport

Special Considerations: Patient Refusal

- Major area of potential liability
- Thorough documentation crucial
  - Physical assessment findings
  - Paramedic’s advice regarding treatment benefits and risks associated with refusing care
  - Advice rendered by medical direction via telephone, radio
  - Clinical information that suggests patient able make health care decisions
  - Event witnesses signatures, according to local protocol
  - Complete narrative, including quotations, statements by others
Care, Transportation Not Needed

• May be result of patient’s condition or canceled request for help
• After evaluation of patient and scene, determine whether circumstances warrant EMS transport
  – Car crash without injuries, patient left scene
  – Advise dispatch center, document event

Care, Transportation Not Needed

• EMS unit canceled en route
  – Make note of canceling authority, cancellation time
  – Thorough documentation protects from potential liability
Interagency/Interfacility Transfers

- Occur when patient care duties assigned to another EMS unit
  - Basic life support unit that has intercepted with ALS unit
  - Fire rescue squad that does not have transport duties, capabilities
  - Air ambulance
  - Documentation, tracking, reporting systems should be established and followed

Interfacility Transfers

- Hospital-to-hospital transfers
- Approved by medical direction
- Arranged by sending hospital to maximize patient safety, care

Interfacility Transfers

- Critical care patients
  - Pediatric trauma patients
  - Severe burn patients
  - Transplant candidates
  - Cardiac patients
  - Patients with life support devices
Interfacility Transfers

• Sending hospital may accompany interfacility transfer
  – Physicians
  – Critical care nurses
  – Respiratory therapists
  – Other specialty care personnel

Interfacility Transfers

• Interfacility transfer forms
  – Document care en route
  – Provide for any standing orders
  – Transfer patient care at new destination
• Patient may be transferred because of insurance requirements, receive specialized care not available at sending hospital

Mass Casualties

• Large number of patients
• Possible delayed comprehensive documentation
  – Until patients triaged, transported for definitive care
• Know, follow local documentation procedures
Exposure or Injury Reporting

- EMS agencies have special forms for documentation for unprotected exposure
  - Developed by local EMS agency, legal advisers
  - Must follow state, federal, OSHA, CDC guidelines
- If exposed, follow agency protocol
  - Immediately contact EMS supervisor, designated officer
  - Seek medical care
  - Thoroughly document event

Document Revision/Correction

- Most EMS agencies provide separate report forms for corrections, revisions
- If separate report needed
  - Note revision/correction purpose, why information did not appear on original document
  - Note date, time revision/correction made
  - Ensure revision/correction made by original author
  - Make as soon as need is realized

Your supervisor asks you to change your documentation so the insurance company will pay for the transport. What would you do?
Document Revision/Correction

- Acceptable methods vary by agency
  - Making change to original form
  - Not used for electronic patient reports unless there is built-in mechanism to track changes
  - Writing corrections in narrative
  - Attaching new report to original
  - Supplemental narratives can be written on separate form
  - Attached to original

Consequences of Inappropriate Documentation

- Inaccurate, incomplete, illegible PCR
  - Cause improper care
  - Thoroughly completed PCR may influence attorney’s decisions for lawsuit
  - Documentation should never become routine, superficial

Paramedic Professional Responsibility

- View documentation as utmost importance
- Assume responsibility for self-assessment of all documentation
- Appreciate importance of good documentation among peers
- Set good example in completing documentation
Summary

• PCR used to document key elements of patient assessment, care, transport
• Three primary reasons for written documentation
  – Medical community in patient’s care uses it
  – Legal record
  – Reimbursement, essential to data collection

Summary

• PCR should include
  – Dates and response times
  – Difficulties encountered
  – Observations at scene
  – Previous medical care provided
  – Chronological description of call
  – Significant times

Summary

• Properly written EMS document is accurate, legible, timely, unaltered, free of nonprofessional or extraneous information
• Many approaches for writing narrative can be used
  – Paramedic should adopt only one approach
    • Use consistently to avoid omissions in report writing

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Summary

• Special documentation is necessary when patient refuses care or transport
• Also needed when care or transportation is not needed
• Special documentation is needed for mass casualty incidents

Summary

• Most EMS agencies have separate forms for revisions or corrections to PCR
• Inappropriate documentation may have medical and legal implications

Questions?