Chapter 16
Documentation

Overview
- Minimum Data Set
- The Prehospital Care Report
  - Functions of the Prehospital Care Report
  - Traditional Format
  - Other Formats
  - Distribution
  - Documentation of Patient Care Errors
  - Correction of Documentation Errors
- Documentation of Patient Refusal
- Special Situations
  - Multiple-Casualty Incidents
  - Special Situation Reports

Minimum Data Set
- Patient information gathered at time of EMT-Basic’s initial contact with patient on arrival at scene, following all interventions, and on arrival at facility
  - Chief complaint
  - Level of consciousness (AVPU)—mental status
  - Systolic blood pressure for patients older than 3 years
  - Skin perfusion (capillary refill) for patients younger than 6 years
  - Skin color and temperature
  - Pulse rate
  - Respiratory rate and effort
Minimum Data Set

- Administrative information
  - Time incident reported
  - Time unit notified
  - Time of arrival at patient
  - Time unit left scene
  - Time of arrival at destination
  - Time of transfer of care
  - Accurate and synchronous clocks

Prehospital Care Report

- Functions of the prehospital care report
  - Continuity of care
    - A form that is not read immediately in the emergency department may very well be referred to later for important information

Prehospital Care Report

- Functions of the prehospital care report
  - Legal document
    - A good report has documented what emergency medical care was provided and the status of the patient on arrival at the scene and any changes on arrival at the receiving facility
    - The person who completed the form ordinarily must go to court with the form
    - Information should include objective and subjective information and be clear
Prehospital Care Report

- Functions of the prehospital care report
  - Educational
    - Used to demonstrate proper documentation and how to handle unusual or uncommon cases

Prehospital Care Report

- Functions of the prehospital care report
  - Administrative
    - Billing
    - Service statistics
    - Research
    - Evaluation and continuous quality improvement

Traditional Format

- Traditional written form with check boxes and a section for narrative
Traditional Format

- Sections
  - Run data
    - Date, times, service, unit, names of crew

Traditional Format

- Sections
  - Patient data
    - Patient name
    - Address
    - Date of birth
    - Insurance information
    - Sex
    - Age
    - Nature of call
    - Mechanism of injury
    - Location of patient
    - Treatment administered prior to arrival
    - Signs and symptoms
    - Care administered
    - Baseline vital signs
    - SAMPLE history
    - Changes in condition

Traditional Format

- Sections
  - Check boxes
    - Be sure to fill in the box completely
    - Avoid stray marks
Traditional Format

- **Sections**
  - Narrative section (if applicable)
    - Describe, don’t conclude
    - Include pertinent negatives
    - Record important observations about the scene (e.g., suicide note, weapon)
    - Avoid radio codes
    - Use abbreviations only if they are standard
    - When information of a sensitive nature is documented, note the source of that information (e.g., communicable diseases)
    - Be sure to spell words correctly, especially medical words
    - For every reassessment, record time and findings

Patient Care Reports

- **Confidentiality**
  - The form itself and the information on the form are considered confidential

Patient Care Reports

- **Distribution**
  - Local and state protocol and procedures will determine where the different copies of the form should be distributed
Documentation of Patient Care

- When an error of omission or commission occurs, the EMT-Basic should not try to cover it up.
- Instead, document what did or did not happen and what steps were taken (if any) to correct the situation.

Documentation of Patient Care

- Falsification of information on the prehospital care report may lead to suspension or revocation of the EMT-Basic’s certification/license.
- Poor patient care may result because other health care providers have a false impression of which assessment findings were discovered or what treatment was given.

Documentation of Patient Care

- Specific areas of difficulty:
  - Vital signs—document only the vital signs that were actually taken.
  - Treatment—if a treatment like oxygen was overlooked, do not chart that the patient was given oxygen.
Correction of Documentation

- Errors discovered while the report form is being written
  - Draw a single horizontal line through the error, initial it, and write the correct information beside it
  - Do not try to obliterate the error—this may be interpreted as an attempt to cover up a mistake

Correction of Documentation

- Errors discovered after the report form is submitted
  - Preferably in a different color ink, draw a single line through the error, initial and date it, and add a note with the correct information
  - If information was omitted, add a note with the correct information, the date, and the EMT-Basic’s initials

Correction of Documentation
Documentation of Patient Refusal

- Competent adult patients have the right to refuse treatment

Documentation of Refusal

- Try to persuade the patient to go to a hospital
- Ensure the patient is able to make a rational, informed decision
- Inform the patient why he or she should go and what may happen to him if he does not
- Consult medical direction

Documentation of Refusal

- Document any assessment findings and emergency medical care given, then have the patient sign a refusal form
- Have a family member, police officer, or bystander sign the form as a witness
Documentation of Refusal

- If the patient refuses to sign the refusal form, have a family member, police officer, or bystander sign the form verifying that the patient refused to sign.

Documentation of Patient Refusal

- Complete the prehospital care report
  - Complete patient assessment
  - Care EMT-Basic wished to provide for the patient
  - Statement that the EMT-Basic explained to the patient the possible consequences of failure to accept care, including potential death
  - Offer alternative methods of gaining care
  - State willingness to return.

Documentation of Patient Refusal

[Image of Patient Refusal Form]
Special Situations

- Multiple-casualty incidents
- When there is not enough time to complete the form before the next call, the EMT-Basic will need to fill out the report later

Special Situations

- The local MCI plan should have some means of recording important medical information temporarily (e.g., triage tag) that can be used later to complete the form
- The standard for completing the form in an MCI is not the same as for a typical call
- The local plan should have guidelines

Special Situation Reports

- Used to document events that should be reported to local authorities or to amplify and supplement primary report
- Should be submitted in timely manner
- Should be accurate and objective
- The EMT-Basic should keep a copy for his own records
- The report, and copies, if appropriate, should be submitted to the authority described by local protocol
Special Situation Reports
- Examples of incidents requiring special reports
  - Exposure
  - Injury
  - Equipment failure
  - Ambulance crash

Continuous Quality Improvement
- Information gathered from the prehospital care report can be used to analyze various aspects of the EMS system
- This information can then be used to improve different components of the system and prevent problems from occurring

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