PREHOSPITAL DOCUMENTATION

PURPOSE

This policy defines the requirements for patient care documentation and the procedure for completion, distribution and retention of the electronic patient care reports (ePCR) applicable to all EMS transport providers, BLS first responders, and ALS first responders.

DEFINITIONS

Incident: An incident is any response involving EMS personnel to any event in which there is an actual victim or the potential for a victim, regardless of whether or not the responding unit was cancelled en route. This includes all emergency responses, nonemergency responses, walk-in contacts, responses that are cancelled before scene arrival, any pre-arranged ambulance standby and any ambulance transfers originating in region.

Patient: Any person that calls for EMS services or that EMS personnel encounter who demonstrates any known or suspected illness or injury shall be considered a patient.

Patient Contact: Patient contact has occurred if EMS personnel do **any** of the following:

I. Offer medical assistance of any kind to a patient
II. Visualize the patient (objective assessment)
III. Determine the mechanism of injury
IV. Obtain a history of present illness
V. Witness any care rendered by other parties

POLICY

I. ePCRs shall be completed and submitted electronically by all Advanced Life Support (ALS) and/or ambulance transport services at any level providing service within Yolo County.
II. EMS personnel shall complete an ePCR on all EMS incidents or patient contact responses.
III. Intentional failure to complete an ePCR when required, or fraudulent or false documentation on a written patient care report or an ePCR, may result in formal investigative action under the California Health and Safety Code, § 1798.200.
IV. Patient care documentation management is to be compliant with HIPAA and medical record retention requirements.
V. The Local EMS Agency (LEMSA) may request specific documentation elements related to CQI, field study or trials and other emergency management data collection requirements.

DOCUMENTATION REQUIREMENTS

I. EMS personnel shall complete an ePCR on all EMS responses regardless of outcome. This includes responses where a unit responded and there was no patient contact.
II. All available and relevant information shall be accurately documented in the ePCR.

III. The first response agency's completed ePCR must be sent by facsimile transmission, or hand delivered, to the receiving facility or hospital that received the associated patient within four (4) hours.
   A. The first responder agency shall deliver in person, verbal report or a form of field notes, to the transport provider of the assessment including vital signs, SpO_2 (if applicable), history, physical exam and all aid or treatment rendered prior to arrival of transport provider.

IV. The ALS transporting ambulance shall leave a copy of the ePCR (electronic or printed) at the receiving hospital upon delivery of each patient. Within twenty-four (24) hours.
V. BLS/ALS ambulances shall provide access for the Yolo County EMS Agency and receiving hospitals to patient care documentation in computer readable format and suitable for statistical analysis for all ambulance responses.
VI. Documentation requirements may be deferred when emergency response is required but must be completed as soon as possible.

DOCUMENTATION PROCEDURES

I. Personnel providing patient care are responsible for accurately documenting all available and relevant patient information on the ePCR. This requirement includes transport and first responder personnel.
II. Use of abbreviations is not permitted in the narrative section of the record or as defined in automated ePCR pre-designated pick lists.
III. An EMS provider's ePCR should include, at a minimum the following information:
   A. Complete demographic information.
   B. A clear history of the present illness with chief complaint, onset time, associated complaints, pertinent negatives, mechanism of injury, etc. The information should accurately reflect the patient's chief complaint as stated by the patient to the EMS provider and should be sufficient to refresh the clinical situation after it has faded from memory.
   C. An appropriate physical assessment that includes all relevant portions of a head-to-toe physical exam. When appropriate, this information may be supplemented in the narrative section of the ePCR.
   D. At least two (2) complete sets of vital signs for every patient including: pulse, respirations, blood pressure and pulse oximetry. These vital signs should be repeated and documented after drug administration, prior to patient transfer and as needed during transport. For children less than (<) three (3) years of age, blood pressure measurement is not required for all patients, but should be measured if possible, especially in critically ill patients in whom blood pressure measurement may guide treatment decisions.
   E. A pain scale shall be documented for all patients with a GCS greater than (>) 14.
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   F. When CAD to ePCR interface embedded within the ePCR system should be used to populate all ePCR data fields it supplies. When 9-1-1 center times were improperly recorded, these may be properly edited.
   G. When the cardiac monitor is applied, data will be transferred to the ePCR from the device. If transferred automated vital sign values do not correlate with manually obtained values or are not consistent with the patient's clinical condition, providers should manually check vitals and record manual results.

H. For drug administrations, the drug dosage, route, administration time and response shall be documented.
I. A complete list of treatments in chronological order. Response to treatments should also be listed.
J. For patients with extremity injury, neurovascular status must be noted before and after immobilization.
K. For patients with spinal motion restriction, document motor function before and after motion restriction.
L. For IV administration or saline lock placement, the catheter size, site, number of attempts, type of fluid, and flow rate.
M. A cardiac monitor strip should be attached for all patients placed on the cardiac monitor. All 12-Leads should also be included. Any significant rhythm changes should be documented. For cardiac arrests, the initial strip, ending strip, pre and post defibrillation, and pacing attempts, should be attached.
N. Any requested medical control orders, whether approved or denied, should be documented clearly.
O. Any waste of controlled medications should include the quantity wasted, where wasted and name of the person who witnessed the waste. Only agency approved personnel should be utilized to witness controlled substance waste.
P. All personnel information, including signatures.
Q. ALL crewmembers are responsible for, and should review, the content of the ePCR for accuracy.

IV. The ePCR shall be completed and distributed in accordance with this policy.
V. Once the ePCR is completed and posted, the ePCR may not be modified for any reason. Corrections or additions should be in the form of an addendum to the ePCR.

PREHOSPITAL DATA SUBMISSION

I. ePCR data shall be provided to YEMSA in the following manner:
   A. Prehospital Service Providers utilizing an ePCR system shall complete a data sharing agreement with YEMSA.

ADDITIONAL PROVISIONS

I. Multi-casualty incident:
   A. In an MCI, every person who has signs and/or symptoms or complaint of illness or injury shall have a patient assessment completed and documented on an appropriate triage tag.

II. Walk-ins:
   A. Any patient, who walks into a station of an ambulance or fire department manned by EMS personnel and is assessed and/or provided treatment, shall receive a complete patient assessment and shall be reported on an ePCR.

III. Deceased patients:
   A. The ePCR shall be utilized to document the circumstances related to a deceased patient (no resuscitation attempt).

RECORD REVIEW

I. Each agency/provider, receiving facilities, base hospital and the EMS Agency will review patient care records as required by the Yolo County Continuous Quality Improvement (CQI) Committee.

RECORD RETENTION

I. Patient care records must be securely retained for at least seven (7) years or for two (2) years after the patient reaches the age of maturity, whichever is longer. Privacy will be protected by compliance with the Health Insurance Portability and Accountability Act (HIPAA).