15-0102 – Documentation, Reporting, and Retention Policy

Authority

California Health and Safety Code, Division 2.5, § 1797.202, 1797.204, 1797.220 and 1798.

California Code of Regulations, Title 22.

Purpose

To establish patient care report (PCR) documentation and data submission requirements. Further, to help ensure that a PCR (written or electronic) is generated on all patient contacts and is completed thoroughly and in a timely manner. This may include an interim report to be left with the receiving facility.

Policy

1. All EMS providers need to include any additional data elements required by Nor-Cal EMS such as but not limited to Local Optional Scope of Practice (LOSOP) items and Nor-Cal specific quality of care metrics.
2. EMS prehospital providers need to use an electronic health record in a format that is compliant with the current version of NEMSIS being utilized by Nor-Cal EMS. This includes all attachments that document any and all aspects of patient care, including but not limited to electrocardiographs (ECGs), capnography waveforms, and pulse oximetry.
3. BLS (Public Safety First Aid (PSFA), Emergency Medical Responder (EMR), and Emergency Medical Technician (EMT)) non-transport provider personnel shall complete a written or electronic PCR for all calls where direct patient contact is established.
4. If there are multiple providers from a non-transport agency, then a single PCR can be written to summarize the care that was delivered. At a minimum, BLS non-transport provider personnel shall always complete a written or electronic PCR for all incidents involving either of the following circumstances:

    a. Refusal of EMS care completed by BLS personnel without ALS/LALS involvement.
    b. Utilization of any BLS optional skill.

    Note: Patient contact refers to all incidents in which a unit (including but not limited to PSFA, Fire, Emergency Medical Responder, EMT, Paramedic and/or Nurse) is dispatched to an EMS incident and the result of that dispatch is direct contact with the patient(s).

5. ALS/LALS non-transport provider personnel shall complete National EMS Information System (NEMSIS) ePCR; current version of NEMSIS being utilized by Nor-Cal EMS as follows:

    a. If the non-transport provider is cancelled prior to arrival at scene, completion of a PCR by the non-transport provider is not required.
    b. If a non-transport provider arrives on scene and no patient is identified, a PCR shall be completed indicating a minimum of the reported incident location, incident times and reason why no patient was identified.
    c. If transfer of care is done within the same agency, a single PCR documenting the care provided by all personnel on scene is sufficient (this only applies to ground transport agencies and not Air Medical Providers.
    d. If the non-transport provider arrives on scene after the transport provider and no patient contact is established by the non-transport provider, completion of a PCR by the non-transport provider is not required.

6. BLS/LALS/ALS transport provider personnel shall complete NEMSIS compliant ePCR with the current version of NEMSIS being utilized by Nor-Cal EMS as follows:

    a. If the transport provider is cancelled prior to arrival at scene and patient contact, completion of a PCR by the transport provider is not required.
    b. If a transport provider arrives on scene and no patient is identified, a PCR shall be completed indicating a minimum of the reported incident location, incident times and reason why no patient was identified.

c. The transport provider shall complete a PCR for each patient(s) where patient contact/transport is established. If patient care is maintained by a non-transport provider and both units are from the same agency, a single PCR documenting the care provided by all prehospital personnel is sufficient. This does not apply to Air Medical resources.

7. If the transport provider arrives on scene after the non-transport provider and no patient contact is established by the transport provider, completion of a PCR by the transport provider is not required.
8. Public Service requests, without a specific medical complaint (including but not limited to complaints such as falls, chest pain, and inability to walk), do require a PCR or Interim patient care report whether the person was transported or not. This holds true for both non-transport and transport agencies. If there are repeat Public Service requests more than once in a 24-hour period, at least an interim report shall be filed. Consideration for reporting to Adult Protective Services needs to be entertained.
9. Multiple Patient Incidents:

   During an incident involving two or more patients, the initial ALS/LALS provider who establishes patient contact shall complete a NEMSIS compliant e PCR with the current version of NEMSIS being utilized by Nor-Cal EMS. An electronic PCR on each patient will be completed unless one or more of the following special circumstances apply:

   a. Patient contact was limited to triage/basic assessment only, and all pertinent patient assessment and treatment information is documented by the transporting provider.
   b. Patient care was transferred to another provider from the same agency, and all pertinent patient assessment and treatment information is documented by the transporting unit.
   c. The provider receives approval from Nor-Cal EMS not to complete full PCR documentation on each patient (i.e., MCI or disaster).

   Note: In the event that any of these conditions apply, the initial ALS/LALS provider who establishes patient contact shall complete a minimum of one NEMSIS e PCR compliant with the current version of NEMSIS being utilized by Nor-Cal EMS, compliant electronic PCR containing pertinent incident information (incident nature, details, patient count/triage categories, etc.).

10. A PCR is a legal medical record. Prehospital personnel are responsible for providing clear, concise, complete, legible and accurate prehospital documentation. A full legal signature of the individual completing the report is required in the appropriate signature section of the PCR. Any form of falsification of prehospital documentation shall be considered a serious infraction, subject to possible disciplinary action.

PROCEDURE

1. All pertinent standard/mandatory PCR data fields shall be accurately and thoroughly completed.
2. Individual procedures and/or medications shall be thoroughly documented in the appropriate '***treatment***' section of the PCR. This will enable data mining and ensure that all quality metrics can be measured. The individual writing the PCR can mention this in the narrative to establish a complete picture.
3. Pertinent vital signs (BP, pulse, respirations and a pulse oximetry at a minimum, if clinically indicated then include ET CO2 waveforms and EKGs shall be monitored and documented a minimum of every 15 minutes or more frequently if clinically indicated (For critical patients it may be necessary to document vital signs every 5 minutes). Vital signs shall be monitored and documented ***prior to and following any medication administration and/or procedure***.
4. PCR narrative completion requirements:

   a. The narrative section of the PCR shall be completed utilizing one of the following common documentation formats:
   b. 'SOAP' (Subjective, Objective, Assessment, and Plan)
   c. 'CHART' (Complaint, History, Assessment, Rx/pt. medications, and Treatment/Transport)
   d. Chronological order

5. Regardless of the documentation format utilized, the PCR narrative section shall include the following information as pertinent:

   a. Response events
   b. History of Present Illness (HPI) including pertinent positives as well as negatives.

c. On scene events
d. In ambulance events
e. Transport events
f. Transfers of care
g. Receiving hospital arrival and transfer of patient care events (including the time and person transfer of care was given to). This needs to include the last set of vitals prior to patient care turn-over.

6. Detailed patient assessment and treatment information normally documented in other sections of the PCR are not required to be repeated in the narrative section. However, specific findings that require follow up action by patient care personnel shall be appropriately documented in the narrative section.

   Local Optional Scope of Practice items need to be documented in the correct section to allow data mining.

7. When available to prehospital personnel, the following minimum patient care documentation shall be completed by the EMS primary care provider and left at the receiving facility at time of patient delivery (Interim Note):

   a. Routine incident information (date of incident, incident number, call location, EMS unit number, and hospital arrival time).
   b. Patient demographic information (name, gender, age, date of birth, address, city and telephone number).
   c. Chief complaint.
   d. PQRST/time of symptom onset (including time of incident and mechanism of injury for all trauma patients).
   e. Pertinent medical history, medications (including all prescription, over-the-counter (OTC), natural and herbal remedies.
   f. Medication allergies (If possible, the type of reaction (including but not limited to nausea, rash or can't breathe).
   g. Vital signs (including GCS, BP, pulse, respirations, pain scale, cardiac rhythm, ET CO2 waveform and values and Sp02 as appropriate).
   h. Treatment rendered (including time, type of treatment, medication, dose, route, ***response*** and total IV volume infused).
   i. Relevant patient care related documents (DNR/POLST forms, 12 Lead EKGs, cardiac monitor rhythm strips, ETCO2 waveform strips, etc.)
   j. Name, title and ID of the prehospital provider completing the documentation
   k. **Ensure that EMS field personnel only document assessments, procedures and medication performed/given by personnel within their own EMS organizations. Unless they are acting as a scribe for the patient care.**
   l. **Ensure that their EMS field personnel do not document assessments, procedures and medications performed by EMS field personnel from another EMS provider agency.**

   Note: Although it is preferred that a completed PCR be left/completed at the receiving hospital at the time of patient delivery, prehospital personnel may satisfy this requirement with the completion of an interim patient care report.

8. Completed PCRs shall be distributed as follows:

   a. Receiving hospital:

      i. When a complete PCR is not left with the patient at the receiving hospital, the PCR shall be provided/available to the receiving hospital within 24 hours
      ii. When patient care is transferred from a non-transport ALS/LALS provider to another EMS provider, the non-transport provider shall provide/make available a copy of their completed PCR to the receiving hospital within 24 hours

   b. Base hospital:

      i. If a base hospital is utilized for medical control that is not the receiving hospital, a copy of the PCR shall be provided/available to that base hospital within 24 hours

9. Nor-Cal EMS:

If a BLS or ALS optional skill is utilized, a copy of the PCR shall be provided/available to Nor-Cal EMS within seven (7) calendar days.

10. Completed PCRs for adult and emancipated minor patients shall be preserved for a minimum of seven years. Completed PCRs for unemancipated minor patients shall be preserved for at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.
11. Prehospital providers not utilizing the current Nor-Cal EMS selected ePCR software system shall submit electronic PCR data to Nor-Cal EMS in a NEMSIS compliant format (that is currently being used by Nor-Cal EMS). If there needs to be an interface developed and implemented the cost shall be borne by the provider agency. This will allow the transfer of patient care between EMS providers and Nor-Cal EMS data system.
12. EMS provider agencies using their own ePCR program must make any Nor-Cal EMS requested changes or additions to the data elements.

DATA COLLECTION AND CQI REPORTING

1. EMS provider agencies shall adhere to the Nor-Cal EMS approved CQI plan developed by their agency. This needs to be updated and submitted to Nor-Cal EMS yearly.
2. A completely rewritten CQI plan needs to be submitted every 5 years.
3. Provider agencies shall analyze the Nor-Cal EMS mandatory QA and QI metrics. The provider agencies shall send Nor-Cal EMS every quarter summary reports after their data has been analyzed by the provider agency.
4. The following are a partial list of the mandated metrics or reports that need to be analyzed and tracked/trended:

    a. Cardiac arrest patients whether treated by BLS or ALS (transport and non-transport)
    b. Any call where an AED was placed and/or used on a patient
    c. Any call where the patient is transported code 3 to the Receiving Facility
    d. Any call that the provider agency is participating in a trial study or mandated ordinance
    e. Trauma patients
    f. STEMI patients
    g. Stroke patients
    h. Local Optional Scope of Practice medications and/or procedures for BLS and ALS agencies/providers.
    i. Expanded scope of practice such as the following medications: Ibuprofen, Acetaminophen and diphenhydramine.
    j. Communication failure reports
    k. Unusual Occurrence reports