EMS Documentation

Nor-Cal EMS

2021

Skill Development

- Developing your documentation skills are as important as any other patient care skill.
- Roger Munger, PhD – On the Write Track

Objectives for Documentation

- Improve patient care.
- Improve critical and clinical thinking.
- Protect the field provider, provider agency, and the medical director from liability.
- Demonstrate that documentation forms the backbone of many operational issues in EMS.

General Introduction

- The responsibilities of the Prehospital Provider go beyond the triage and assessment, treatment and management, and transport of a patient to the hospital.

- The Prehospital Provider must prepare a patient care report, to document what was completed in the prehospital setting; for when it will be reviewed later for a variety of reasons.

Importance of Documentation and Goals

- Should be to provide as near perfect and complete patient care record as possible.
- Convey vital information: patient history, physical examination, treatment, as well as any response of lack thereof to treatment.

Why Do We Document?

- A prehospital care report (PCR) has many important functions:
  - Continuity of care (Our credibility)
  - Legal documentation
  - Education
  - Provides documentation of the event should the prehospital provider is exposed to infectious agent or violence.

Why Do We Document?

- A prehospital care report (PCR) has many important functions:
  - Administrative
  - Research
  - Evaluation and quality improvement
  - Metrics to determine quality and reimbursement
  - Provides data for changes in public health

Why do we document?

- Medical uses
  - Helps to ensure continuity of care once the patient is delivered to the emergency department (Alternative Destinations)
- Legal uses
  - Although not *the most* important reason, one of the very important reasons for documentation is that your record may be used in legal proceedings.

Do You Have Independent Recall of That Patient?

- When testifying in court you will be asked to recall that "minor" traffic accident victim from two years (hundreds of calls later) ago.
- The only tangible evidence is that PCR.
- May help prevent a lawsuit from being filed.
- Will it be your friend or foe in regards to medical malpractice?

Remember….

- Prehospital Care Reports are legal documents therefore they must be kept confidential!
- California confidentiality laws are more restrictive than HIPAA.

Why do we document?

- Education and Research
  - Will be used by researchers to demonstrate the applicability of certain medical interventions
  - Clinical Outcomes
  - Metrics devised to monitor “quality”
  - Once quality is evaluated then comes reimbursement

People Truly Read What You Write

- In trauma care, the Emergency Physicians and Trauma Surgeons value your observations and insights.
- The Trauma Registrars look for valuable data elements to be entered into the trauma registry.
- Each Trauma Center submits data (from the registry) into the National Trauma Data Bank (NTDB).
- The data from the NTDB is used by organizations such as the Centers for Disease Control (CDC) and American College of Surgeons (ACS).
- It is critically evaluated for how to improve field triage of injured patients and evaluate the long term outcomes from initial injuries.
- It becomes part of the permanent medical record.

Why do we document?

- Quality Improvement
  - Reviews of documentation are an integral part of the quality improvement process.
  - Remedial and continued education courses for prehospital provider in your area/EMS service may be based upon needs revealed by call documentation.
  - To Improve Patient Care
  - If you don't document it, then it never happened. Old adage but, believe it!

    In reality, documenting the excellent care being provided helps sharpen your clinical skills.
  - You are the athlete visualizing what you want to occur.

Prehospital Care (PCR)

- Information provided on the PCR should give a clear and accurate picture of what occurred in the prehospital environment
- There are two basic rules to follow:
  - *"If it wasn't written down, it wasn't done."*
  - *"If it wasn't done, don't write it down."*

Lawsuit

- Patient refusals evaluation, treatment/care, transport (left at the scene) account for 50 to 90% of prehospital EMS lawsuits.
- "Objective and logical…documentation is your best defense.
- Roger Munger
- Other high risks incidents are when the patients are altered due to alcohol, illicit drugs and TBI.
- Another high risk scenario are when patients or family members are angry or upset about the care being provided or about the disposition.

The Patient Refusal

- "documentation must prove ON IT'S FACE, IN WRITING the patient's then-present CAPACITY to understand and appreciate fully the nature of his condition, the choices available to him, and the possible consequences of refusal."
- Gene Gandy

The Patient Refusal

- Do not attempt to talk the patient out of going to the hospital or going to the hospital by private vehicle.
- If you feel strongly that the patient should be seen, make every attempt to convince them they should be seen.
- Assure that the patient is “competent” or has the “capacity” to sign a “refusal of care” or “release at scene” and advise them about all the potential/possible risks in refusing care or transport.

The Patient Refusal

- Document what you told the patient and their response and level of understanding in the narrative.
- Avoid jargon!
- Have the patient repeat back the instructions not just nod their head or say they understand.
- Advise the patient that paramedic training and diagnostics/testing available does not allow you to have a complete differential diagnosis of all the potential life threatening causes.
- Tell the patient the risk includes up to and including permanent disability and death.
- Advise them that they can call 911 back if they should change their mind or their condition worsens.

Documentation

- Dictum: If you don't document it, you are an attorney's best friend.
- When you write a PCR, imagine one day that the document will be enlarged and projected onto a large screen or placed on an easel in a court of law. Displayed for the lawyers and lay public to scrutinize.
- When you critically exam what you are doing, it helps focus and reinforce good habits. Unfortunately the converse is also true.
- Clear, precise, and thoughtful documentation will help you think through difficult clinical processes and situations.

Documentation

- Does not mean that you need to write a “novel” for each patient encounter.
- Think from a clinical standpoint what truly is pertinent. Document both the pertinent negative findings as well as the positives.
- This helps prepare you for the next difficult call and procedure.
- Think of it as mental preparations for the next “big game”.

Documentation

- The patient care record needs to be a reflection of the events that transpired while you were with the patient.
- As clear as mud?

Clear and Precise Documentation

- Whenever possible use direct quotes from the patient.
- This builds credibility into the record and helps document a patient's capacity/competency, affect and attitude.
- Don't use foul language even if quoting the patient and/or family

Be Professional in Your Documentation

- The place for documentation and reporting of inappropriate interpersonal conflicts is the Occurrence Report (UOR).
- Vendettas are not to be played out in a medical-legal document.
- Check your attitudes and inappropriate behavior when you come on duty.

Choose Your Words Carefully

- Use language that is objective, not judgmental or disparaging in nature.
- Avoid words/phrases that imply a preconceived attitude or potential anger-provoking descriptors. This applies to the patient, their families, and their support system.

Choose Your Words Carefully

- Statements written in anger or haste will come back to haunt you later.
- Slander or libel or wrongful death
- Avoid placing blame on the patient or family
- Use phrases such as “non-complaint”

Accuracy

- The PCR needs to be a truthful and accurate chronology and description of the incident and examination.
- Don't embellish the record ever.

Be Concise

- Try to be as succinct as possible and include pertinent positives and negatives.
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Comprehensive

- Again include as much pertinent as necessary to “Paint As Clear A Picture As Possible”
- This does not contradict the issues of being concise.

Sin of Omission

- If you do not document it, the untoward event can't hurt you!
- This fallacy about not documenting an event/action/issue because it might "look bad" is a poor choice and provides a false sense of security.
- Better to document everything and be honest

Timelines

- Make every effort to complete your report as soon after the incident as possible.
- Can add these and they are not considered altering the medical record.
- Not an excuse to CYA, but a clarification of events.

Complete Information

- Fill in all fields
- Assure and record accurate data and times
- Attach any supporting documents or attachments (ECG rhythm strips, Photographs, Capnography waveforms, medication lists, etc)

Always Read the "Completed PCR"

- Reread the PCR prior to submitting it!
- Have your partner read the PCR before submitting it!

Prehospital Care Report (PCR)

- General completion guidelines
  - Completely fill out form in its entirety
  - Use proper spelling, phrasing and grammar
    - If not can easily discredit you and indicate that you are careless and therefore the care you delivered is less than optimal/substandard
  - Use only **approved** medical abbreviations
  - Use only terminology that you comprehend and officially accepted medical terms

Narrative

- Creating a detailed picture of the patient and event with your words.
- Document only the objective facts and your presumptive diagnosis (Primary Impression) based upon those ***facts*** in the narrative.

Describe

- All treatments rendered and the patient's response to that treatment.
- Specifically where and when events occurred including a where, when and who for each intervention performed.
- Any changes or not in the patient's condition from the intervention(s).

Essential Components of Documentation

- Chief complaint
- History of present illness/injury
- "SAMPLE" history
- Physical exam findings

Essential Components of Documentation

- Initial and repeat vital signs (Critical patients and after every medication administration)
- Interventions (Pain Medications and Vasoactive Medications)
- Patient response to all interventions

Methods for PCR Charting

- SOAP
  - Subjective
  - Objective
  - Assessment
  - Plan
- CHART
  - Chief complaint
  - History
  - Assessment
  - Rx–treatment
  - Transport

Subjective

- What is perceived or experienced by the patient or reported to you by bystanders.
- Who, what, when, where, how and why (you are the detective)
- Chief complaint
- Associated symptoms both positives and negatives
- Pertinent past medical history
- Current medications (prescription, OTC, and herbal/natural)
- Drug allergies (what is the specific reaction)
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Getting at the Pertinent Issues

- History
  - Onset
  - Location
  - Duration
  - Characteristics
  - Aggravating/Alleviating factors
  - Related symptoms
  - Treatments

Objective

- What you can see, hear, smell and feel
- Scene description and mechanism of injury
- Patient "physical examination" including pertinent positives and negatives

- Initial vital signs and level of consciousness
- Start from the head and work your way to the toes
- Will help you from forgetting certain aspects of the examination

Assessment

- What you think is wrong with the patient
- Drives what protocol you chose
- Include your differential diagnosis, yes EMTs, Paramedics and Nurses have DDX
- Logical plan and the basis for the planned interventions

Differential Diagnosis

- The prehospital provider needs to be focusing on "ruling in" what might be wrong rather than "ruling out" issues.
- Always remember that prehospital medicine does not have the luxury of time.
- Nor does it have all the diagnostic tests that the hospital does.

Plan

- What you have done for the patient
- What treatments you have delivered no matter how insignificant it may seem (verbal reassurance to Push Dose Epinephrine)
- What you anticipate might happen and how are you going to react to the clinical situation

The Hospital Builds on What You Have Performed in the Field (We are a Team)

Chief Complaint

- What the patient/family/bystanders/caregiver tells you the current problem is.
- Can be quoted or paraphrased.
- Why they called 911
- Sometimes it is your best guess
- Document the medical necessity of care being delivered.

History

- Past Medical History (& Surgical if needed)
- Allergies (If possible the reaction)
- Current medications including OTC, prescriptions and herbal/natural
- Relevant history of the events leading up to the present illness or injury
- Use mnemonics such as PQRST, AMPLE, MOI and AEIOUTIPS

Assessment

- Include a scene survey
- Primary survey: ABCDE
- Complete a through evaluation from the head to the toes (secondary survey).
- Neurologic, Head, Neck, Chest, Abdomen, Pelvis, Extremities and skin

Assessment

- Results of assessment(s) and/or diagnostic testing such as ECG, pulse oximetry, blood glucose monitoring and capnography.
- Always document and include a strip of the ECG and capnographic waveform.

Treatment

- What you did for the patient and the results/response to every intervention no matter how large or small

Transport

- What occurred during the transport?
- Were there delays?
- How did the patient's condition change? (stable, worsen, or improve)
- Transfer of care always needs to be documented and the patient's status including last set of vitals.

Transfer of Care ! Can be the Difference Between Wining or Losing

Refusal of Care/Release at Scene

Documentation of Patient Refusals

- Document all assessment findings and vital signs
- Risks and benefits of refusing treatment and transport
- Have the patient or responsible person repeat back the explanation and plan.
- Obtain patient signature and witness signature
- Do they have the capacity to refuse?
- Do they have an alternative reasonable plan?

Documentation

- Scene Size-Up
  - MOI
    - Position of patient
    - Approx. speed of vehicle
    - Intrusion
    - Location and extent of damage to car
    - Airbags deployed, seatbelt usage
    - Distance of fall, surface landed on
    - Helmet or no helmet
  - Any clues pertinent to patient condition (examples: environment hot or cold, pill bottles, alcoholcontainers, odors.)

Documentation

- SAMPLE History to include:
  - Signs and Symptoms/ History of present illness to include OPQRST
  - Allergies
  - Medications
    - Prescription
    - Over the counter
    - Herbal
    - Illicit

Documentation Tips

- SAMPLE History to include:
  - Past Medical/Surgical History
  - Last Oral Intake
  - Events
- Medications: (document for each dose)
  - Name of medication
  - Route
  - Dose
  - Time given
  - Patient response to medication

this includes even oxygen

Lets Not "Fake" / Exaggerate the Review of Systems in the HPI

- First, it turns the HPI into a worthless piece of documentation.
- Second, it is fraudulent.
- Third, it undermines your credibility.
- Makes data mining and research impossible.

Documentation Tips

- Complete all checkboxes
  - Make sure checkbox information matches written documentation
  - If doing computer charting…. Beware of automatically populated fields
  - Make sure it is documented in the appropriate place

The Incongruent Physical Examination

- Narrative: “Approximately 4 year old male unresponsive, pale, cool, dry…. Patient has copious amounts of blood coming from mouth and nose, pupils fixed and dilated, unable to assess face or head for wounds due to copious amount of blood”.

The Incongruent Physical Examination

- Physical Examination from the dropdown/pick list area:
- Head: No signs of trauma. No pain upon palpation. No discharge from ears.
- Face: patient has copious amount of blood from mouth and nose.
- Pupils: Pupils are equal and reactive to light
-

Documentation

- Splinting or Spinal Immobilization
  - Chart CMS (capillary refill, motor and sensation) before ***AND*** after application
  - Chart WHAT equipment you used to splint or immobilize a patient

Documentation

- Ongoing Assessment to include:
  - Repeat vital signs
    - Every 5 minutes on unstable/ciritical patients
    - Every 15 minutes on stable patients
  - Response to interventions
  - Any changes in patient status

Always Write the Same PCR

- Get a methodology, pattern, or process that you use for every patient encounter no matter how simple or complex.
- The same formula each time.
- You will avoid leaving out key pieces of information.
- Same phrases for certain conditions.

Take A Big Deep Breath

- EMS documentation does not have to be difficult/hard or tedious.
- Improve your structure over time.
- Writing a decent PCR does not take anymore time than a “crappy one” to save time.
- Remember addendums are time consuming.

We Are Humans

- Prehospital providers work in an almost completely unpredictable environment.
- EMS is not-easily categorized and the type of information that we need to communicate does not fit easily into the structure needed by computers.
- ePCR software developers are many times not clinically oriented.
- We communicate in a fluid conversational format where ideas are not rigid.
- We need context to help assimilate information.

Practice Guidelines

- Practice guidelines are not the law, but they do establish the standards of your peers against which you are measured in a legal action.
- Nursing

Policies and Procedures

- Policies and procedures are what you base your treatment and how you handle clinical situations.
- EMTs and Paramedics

Be Proud of Your Career

- The patient care record (PCR) is a reflection of your skills, knowledge and professionalism.
- Highlight your talents, the careful assessments you perform, and the compassionate care you deliver to your patients.

Thank You