Protocol
G-10

SECTION: G-10

TITLE: EMS Incident Documentation

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EMS INCIDENT DOCUMENTATION

Purpose:
This document provides direction for medical documentation for the Ada County-City Emergency Medical Services System (ACCESS) agencies. It is intended to establish a uniform, system-wide standard for documenting patient encounters.

This document is to ensure that:

- all employees have direction concerning acceptable documentation
- all employees understand the components that must be included in every chart
- the provider's liability is greatly reduced by charting that is consistent, accurate and thorough.

Medical documentation is required any time response personnel contact potentially ill or injured individual(s):

- in response to a dispatched call
- when the individual(s) presents to a 911 agency outside the bounds of the 911 system (a walk-in/medical stand-by)
- is discovered by a 911 agency during non-emergency operations
- When responding to a request by law enforcement

To provide appropriate care, providers shall attempt to determine:

- **Legal capacity** – patient is > 18yrs old and/or has the legal capacity to make their own decisions (emancipated, been pregnant, married, military)
- **Mental capacity** – patient is in a good mental state and has acceptable decision-making ability
    - In order to determine good mental capacity, at a minimum, a patient must be alert and oriented to person, place, time and purpose; must not be a danger to themselves or others; understands risks presented; have no signs of mental incapacity, drug/alcohol intoxication, unsteady gait, slurred speech, etc.
- **Medical capacity** – patient must be free from any medical conditions that may impair their ability to make informed decisions for themselves.
    - Rule-out: head injury, hypoxia, head trauma, metabolic issues (ie: diabetes), environmental issues (ie: heat/cold injury), or any other mind-altering emergencies or recent unexplained loss of consciousness.

Patient Care Report (PCR)
All patient encounters require documentation by each unit that was part of the event, but each encounter has varying levels of expectation.

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PCRs provide:

- A record for continuity of care between pre-hospital providers and ED/hospital staff
- An accurate account of important call details to minimize personal and agency liability
- Quality Assurance (QA) & Quality Improvement (QI) compensation for services (billing)

ACCESS EMS data is used for:

- ACCESS deployment planning
- Meeting State and Federal reporting requirements
- National Fire Incident Reporting System (NFIRS)
- National Emergency Medical Services Information System (NEMSIS)
- Local planning by City & County Governments

The PCR and all associated paperwork should be the only representation of the call that is generated.

- All documentation must be kept confidential and stored, managed or viewed on department owned and secured devices.
- No documentation materials (e.g. written, electronic or photographic) may be stored or accessed on personal devices.
- No documentation materials are for personal use.
- No documentation materials, report information, pictures or other documentation may be posted on social media or other internet sites without pre-approval from Agency Directors or Chiefs and in accordance with local laws and statues.

Charting

A well written chart will allow the provider (author) to easily recall medical and non-medical details of the encounter. The minimum expectation for all encounters is to document information/procedures/assessments conducted by you or your unit. Flowchart items documented and timestamped on your unit's EHR for Mobile to Mobile (MTM) sharing should be deleted once MTM is performed and prior to the chart being locked.

ACCESS currently employs documentation software by ESO in both a web-based and a mobile version. The mobile version is available on a Mobile Data Terminal (MDT) tablet in the apparatus, and it allows crews to document information in any location, upload monitor data and share data with other agencies thru MTM. Charts may be completed on the MDT or on the web. Each chart must be uploaded (sync'd) with the web at the conclusion of the call. All charts are to be completed and locked prior to end of shift.

Generally, ACCESS utilizes a modified SOAP charting method for documentation. In ESO, this is accomplished as:

- ***Subjective*** is captured in the written narrative portion of the Narrative section or in the comments section of the individual Assessment sections
- ***Objective*** is captured in the Assessment and Vitals sections
- ***Assessment*** (field diagnosis) is captured in the Narrative and Assessments sections
- ***Plan*** is captured in the Flowchart and written narrative portion of the Narrative section

Narrative

The Narrative section has a free text field that should be reserved for information told to the provider or information not covered in sufficient detail elsewhere in the chart. It should include several basic elements that may enable a provider to produce an easily understood story with minimal effort.

Narrative elements may include:

- Reason for dispatch
- How the patient was found (environment, body position, etc.)
- Detailed 4 lead/12 lead description/interpretation
- Compliance with medications
- Recent trauma/illness
- Patient safety issues noted
- Hospital destination decision or reason for changing destination
- Patient's mental/personality changes during call
- Anything not documented elsewhere that is pertinent
- Why needed procedures or treatments were not initiated (resistance by the patient, situational conditions, scene factors, etc.)
- Treatments, outcomes or responses that are not detailed in the drop-down menus of EHR

Charting by Exception

By using ESO, providers may elect to employ a method called "*Charting by Exception*" (CBE). CBE is the practice of only documenting unusual or unexpected findings. This type of documentation assumes that all findings are normal unless an abnormal finding is observed.

In ACCESS, CBE will ONLY be used in the "Assessment" portion of EHR to document physical exam finding and NOT for responses to interventions. Strict adherence to use of a comprehensive physical exam, minimizing use of the "Not Assessed" selection in the "Assessment" portion of EHR, and generous use of the "Comments" fields found on the "Assessment" pages is recommended.

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In the Assessment section of ESO, the provider is offered four (4) choices:

- ***Not Assessed (default)*** - the body location was not observed, palpated, or examined in any way.
- ***No Abnormalities**** - the body location has been either observed, palpated, and/or directly examined, and no abnormal findings were noted
- ***Check boxes*** - a selection of any one of these precludes use of either "Not Assessed" or "No Abnormalities", and should be followed with a description in the text field of the body location
    - ✓ = yes
    - ✗ = no

- Use of the "Comments" field in combination with "Not Assessed" or "No Abnormalities" to explain assessments not explained adequately in the checkboxes. Accuracy and descriptive language will help color a descriptive picture for those reviewing the chart.

** The definition of "no abnormality" is patient dependent. You may note that your patient has bilateral, below-the-knee amputations. While in general this is not common, it is normal for this patient. This type of finding should be documented in the comments section or the written narrative and noted as 'normal' for that patient.*

Medical (EHR) Documentation Minimum Expectation (as appropriate based on disposition selected on Incident tab):

- **Incident tab** - all required unit incident information, personnel and appropriate disposition. Lead provider is defined as the provider who conducted and lead patient care.
- **Patient tab** - basic patient information to include name, birthdate, weight, contact address and medical history
- **Vitals tab** – minimum 1 set of vitals (non-transport), 2 sets of vitals (transport) as allowed by patient (minimum BP, Pulse, Resp, AVPU)
- **Flowchart tab** – all interventions performed by your unit personnel with applicable details and correct provider responsible for performing intervention
- **Assessment's tab** - at minimum document a visual assessment. Document other physical exams allowed by the patient
- **Forms tab** – any appropriate forms based on patient complaint, assessment, treatment
- **Narrative tab** – primary impression, detailed written subjective narrative
- **Signatures tab** - Lead Provider signature required

Lift Assist/Non-injury:

For a single-unit, non-injury lift assist, the "***Assist, Public"*** disposition should be used.

- Collect patient name and date of birth on these reports to track repetitive EMS calls/EMS abuse. In the written narrative document details of lift assist and absence of complaint or injury before and after the move. Vitals are not required.
    - Fire agencies: on NFIRS Incident Report, use Incident Type 554 (Assist Invalid) and Action Taken 71 (Assist Physically Disabled). Type "See EHR report" in the narrative section.
- If an assessment is necessary prior to or after the lift assist and the patient refuses any further assessment or treatment, use "***Patient Refused Evaluation/Care (Without Transport)***" disposition and a signed refusal is required. In the written narrative portion of the chart, record lift assist details and the reasons for the assessment before or after the move. At minimum, one set of vitals will be needed.
    - Fire agencies: on NFIRS Incident Report, use Incident Type 554 (Assist Invalid) and Action Taken 71 (Assist Physically Disabled). Type "See EHR report" in the narrative section.
- If transport is determined to be necessary, a transport unit shall be requested and documentation shall be completed using the "***Patient Treated, Transferred Care to Another EMS Professional/Unit" disposition***.
    - Fire agencies: NFIRS Incident Report as usual for EMS calls.

Call Cancelled:

- **Cancelled (No Patient Contact)** – cancelled *after* arrival on-scene by other unit(s) on-scene prior to contact with a patient
- **Cancelled (Prior to Arrival at Scene)** – unit or call was cancelled prior to arrival by Dispatch or another unit enroute or on-scene
- **Cancelled on Scene/No Patient Found** – after arrival, unable to identify any individual desiring assessment, treatment or transport

Treat and Release

Treat and release (refusal) calls are the highest liability for EMS. In the case of most treat and release charts, a documented refusal is required.

See SWO *G-09* for guidance on refusal documentation and *App 31 - Treat and Release Checklists*

PD Assist:

When PD requests assistance from Fire or EMS, 1 of 4 call-types are used:

- **PD-Assist PD Fire Only** – PD is requesting assistance with fire-related needs. Typically, not used for medical needs.
- **PDEMER** – Assist PD Emergent – Dual EMS and Fire response for an emergent need – typically for medical emergencies
- **PDNON** – Assist PD Non Emergent – Closest ACCESS Unit is dispatched – single resource. Commonly used for a medical evaluation.

- **PDNOTIFY** – Assist PD NOTIFY AIQ – PD with a possible need, units can stage in quarters for notifications and further requests.

Documentation for PD Assists is based on call actions. PDNON is used when PD is requesting a patient evaluation. ACCESS Providers DO NOT provide medical clearance. Medical clearance is done at the hospital or the jail. ACCESS Providers' job is to rule-out critical issues and provide any emergent care that might be needed.

To document a PD request for a patient evaluation:

- Get patient consent to do an assessment. Unless the patient is in custody, they have the ability to refuse an assessment or care. A visual/verbal assessment can be conducted and documented if patient is uncooperative.
- If cooperative, conduct a thorough patient assessment as usual to include a visual/physical/verbal assessment and full set of vitals.
- Focus on visible injuries, patient complaints and provider suspicions based on mechanism
- Provide care as needed
- Get patient demographics for documentation
- If determined to be a minor but *no care/transport is required*, EHR disposition is "***Assist, Agency"***.
    - Complete all documentation based on actions taken and document assessment findings appropriately (Assessments section and Written Narrative).
    - A signed refusal is recommended if possible. Complete the **PD Medical Evaluation Treat and Release Checklist** (See *App 31 - Treat and Release Checklists)*.
- If determined to be a minor *and care is required*, but transport is not needed or refused, disposition is "**Patient Refused Evaluation/Care (Without Transport)"**
    - A signed refusal is necessary/required.
    - Complete the **PD Medical Evaluation Treat and Release Checklist** (See *App 31 - Treat and Release Checklists)*.
- If transport is needed, request a transport unit respond. Disposition will be **"Patient Treated, Transferred Care to Another EMS Professional/Unit".**
    - DO NOT request a transport unit until determination for transport is made after evaluation.

Forms:
Forms are specialty documentation required for certain call-types.

- **Acute Coronary Syndrome (ACS)** – form is required when patient meets all criteria for acute coronary syndrome (see SWO C-03). Required when Primary or Secondary Impression is: Chest Pain/Discomfort.
- **Advanced Airway** – completed when intubation was attempted or successfully completed. Required when any Intubation or LMA is added to the Flowchart.

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- **Burns** – form for patient with diverse burns more than a single localized injury
- **Cincinnati Stroke Scale** – completed when patient presents with stroke-like symptoms (see SWO M-04). Required when Primary or Secondary Impression is: Stroke.
- **CPR – Cardiopulmonary Resuscitation** – form completed when CPR is performed on patient during the process of the call. Required when the Primary or Secondary Impression is: Cardiac Arrest or Traumatic Circulatory Arrest.
- **Motor Vehicle Collision** – completed as part of documentation for an MVA.
- **Obstetrical** – completed when patient complaint is labor with or without delivery.
- **Spinal Immobilization Screening Tool** – completed when patient is evaluated for spinal immobilization and immobilized or cleared in the field. See SWO App 17 for further guidance.
- **CDC 2011 Trauma Criteria** – completed as part of a significant trauma injury call. Required when Trauma or Medical & Trauma is selected on Narrative page under Clinical Impression - Medical/Trauma.
- **VAN Stroke Assessment** - completed when patient presents with stoke-like symptoms (see SWO M-04) to assess for large-vein occlusion. Required when Primary or Secondary Impression is: Stroke.
- **Studies section forms** - specialty forms for studies/research being performed with anonymous ACCESS data. If required for reporting, specialized training will be offered prior to use.

Tips for Charting

This is a brief list of charting suggestions.

- Consider concise, potent sentences that are complete and provide for easy, smooth reading.
- Avoid excessive use of the word “patient” as in “patient said”, “patient did”, “patient this”, and “patient that”.
- Reread the narrative portion of the chart prior to locking chart to pick-up errors in spelling or grammar and ensure that the chart’s meaning is clear. Attempt to read the document as would a reviewer not on the scene.
- Accept feedback gracefully. Feedback (QA/QI) is useful and necessary in maintaining a high-performance level.
- Check ESO dashboard every day you work. Respond to QA messages quickly and correct report issues immediately. Complete/accurate charts are essential for correct billing, court-ordered record requests and patient personal record requests. Requests cannot be met until charts are reviewed and completed.
- Remember, questions about your care usually have nothing to do with the care itself, but the manner in which it was charted.
- IF IT ISN’T WRITTEN, IT DIDN’T HAPPEN

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