



EMS SPONSOR HOSPITAL POLICY **PATIENT CARE DOCUMENTATION**

Purpose:

To provide uniform standards for critical documentation elements and data capture to facilitate inter-provider communication and quality improvement activities.

Scope:

All Hartford Hospital Sponsored Ambulance and Paramedic-Level EMS Providers

Discussion:

This policy is not intended to be all-inclusive but focuses on specific elements of documentation which have been observed to be inconsistent between different sponsored providers and/or agencies. EMS agencies may (and are encouraged to) develop their own, more expansive and detailed documentation policies specific to their own operations.

The documentation described in this policy provides a variety of benefits. Some elements benefit the EMS provider by helping explain/defend his or her judgment/decision-making. Some elements benefit the individual patient by improving communication and continuity of care. Some elements benefit the system through improved reporting and searching of healthcare data. All are important.

Policy:

An ePCR will be completed on all patient contacts in which a patient receives any assessment, assistance (i.e. 'lift-assist'), advice or treatment by EMS.

A complete set of vital signs is to be obtained on every patient contact. If vitals are unable to be obtained, this must be documented on the ePCR along with a reason. At a minimum, a complete set of vital signs is defined as:

- Time
- Pulse
- Respiratory Rate
- Systolic and Diastolic Blood Pressure
- Pulse oximetry reading
- Pain scale (unresponsive score as zero; non-verbal, use FACES scale)
- Glasgow coma scale

End tidal CO₂, blood glucose, temperature, and other measurements are to be documented if obtained. Vital signs will be repeated and documented at intervals appropriate to the patient's condition (as specified in the approved EMS patient care protocols).

The paramedic on scene is responsible for patient care and medical decision making (regardless of how the call was dispatched) until such time as he or she transfers/downgrades care to another provider. If the paramedic transfers care to a BLS provider, the paramedic must document his or her assessment and medical decision making on the ePCR. This may be documented on the BLS ePCR, as an addendum to the BLS ePCR, or on a separate ePCR depending on the local EMS agency's policy/procedure.

All level EMS providers should document medical decision making to the best of their abilities on the ePCR. When the provider consciously decides to withhold an otherwise indicated treatment or chooses one treatment and/or protocol over another, the reasons for these medical decisions should be noted. This does not need to be complicated or technical and should reflect the provider's thought process. For example, "Patient was complaining of difficulty breathing with SpO₂ of 78%. Considered BVM ventilation but she appeared to have good air movement into her lungs and did not look tired. Non-rebreather at 15 lpm applied and patient closely monitored for improvement or worsening and possible need to switch to BVM."

For every encounter in which a Lifepack or cardiac monitor is utilized to assess or treat a patient, the entire data record (select 'all') shall be uploaded into the ePCR record. If a mechanical failure prevents uploading, this will be documented in the ePCR and appropriate EMS agency management will be notified of the failure. In the case of failure to upload, copies of ECGs, trend summary and vital signs summary are to be printed and scanned into the ePCR.

If the provider agency's ePCR platform does not include ECGs in the record which is faxed to the hospital, the provider must leave hardcopies of ECGs at the hospital prior to leaving for inclusion into the medical record. This is to occur for all patients for whom an ECG was obtained. The ECGs are to be labeled with the patient name, date of birth and medical record number. If the hospital makes patient ID stickers available, these are to be utilized.

All treatments, procedures, medications, specialty notifications, etc. shall be documented in the appropriate data fields (not solely as free-text in the narrative). The narrative should be used to add additional detail regarding complex procedures. If multiple attempts are made at a procedure (e.g. two attempts at intubation by the same provider), each attempt is to be documented separately, regardless of success. For STEMI alerts, the ECG transmission and STEMI alert radio report are to be documented as separate actions.

Reassessment and ongoing assessment findings are to be clearly documented. For any response to an intervention, it is insufficient to simply note "improved" or "worsened". Specific details regarding what clinical findings changed are to be documented. .

Patient weight should ordinarily be documented and shall always be documented whenever administering a medication with weight-based dosing. The documented weight is to be the value for the patient weight the EMS provider was utilizing at time of treatment and not a revised weight obtained later on.