Appendix B: Documentation Standard

An EMS Care report shall be completed for every incident where Fire/EMS personnel participate in, or witness, patient care or assessment. Every individual on scene who has any injury or illness, or identifies themselves as such, is a patient, and when Fire/EMS personnel participate in, or witness, patient care or assessment a patient care report will be documented by Fire/EMS personnel. It is the responsibility of the person in charge to ensure that an accurate, correct, and complete report is done in a timely fashion. The caregiver who had primary patient care and/or contact should write the sections of the report pertaining to patient care.

General Principles of Documentation

A. A patient care report must be completed for every patient contact. This shall include any personal information as can be reasonably obtained, such as: name, sex, DOB or estimated age, address, etc.

B. The following information should be included in the report:

1. Chief Complaint
   - General Appearance
   - Position patient found in
   - Symptoms in the patient's own words (OPQRST)
   - If the mentation is altered or the patient is unconscious, then that is the chief complaint
   - Level of distress
   - Pertinent Negatives (e.g. chest pain, shortness of breath, recent trauma, neural deficits, syncope, loss of consciousness, nausea, dizziness, neck or back pain, etc.)

2. Pertinent history of events leading to the chief complaint.
   - What was the patient doing at the time of the onset of the complaint?
   - Where and How did the injury occur
   - Description of scene (to include description of vehicle for MVC, distance and landing surface for falls)
   - Any changes in the complaint since onset

3. Physical assessment
   - Mentation (How does the patient respond to stimuli)
   - Skin color, moisture, and temperature
   - Head (to include pupils)
   - Neck
   - Spine (traumatic mechanism)
   - Thorax, Chest, Trunk
   - Abdomen
   - Extremities
   - Back

4. Vital signs with time performed
   - Blood Pressure, Pulse Rate, Respiratory Rate, Pain Scale,
   - Pupils, Mentation (Glasgow Coma Scale), Perfusion, Movement of Extremities – document what was assessed

5. Other diagnostic tests

- Blood Glucose Level, Cardiac Rhythm, Abnormalities, 12 Lead, Pulse Oximetry, End Tidal CO_2 Level, and Temperature as appropriate for the agency
- A copy of the 12-lead will be included with the PCR
- A copy of End Tidal CO2 waveform will be included with the PCR

6. Allergies, Medications, and Past Medical History

7. Therapeutic interventions and response to treatment, with time performed.
   - Circulation, Sensation and Movement of Extremities post splinting, including spinal immobilization

8. Disposition of patient
   - Patient condition at time of transfer of care
   - Who patient care was transferred to
   - Was a patient status report given at the time of transfer of care?
   - Amount of fluid infused at time of transfer

9. Anything pertinent you observe on scene or any pertinent interaction with patient or bystanders who witnessed the incident.

10. Patient Contact Time

C. Any physician authorization for direct order procedures will be recorded with the name of the physician

D. When appropriate, a 6 second EKG strip shall be attached to the report

E. The patient narrative shall be written in either the SOAP or CHART format.

<u>Documentation of a Refusal</u>

A. Any patient who is not transported shall have a refusal form completed by the caregiver. Documentation shall include the following:

1. Mentation
   - Alert, oriented to person, place, time and event
   - Logical, coherent and clear speech
2. Behavior
   - Cooperative, obeys command
   - If uncooperative or belligerent, use direct quotes
3. The presence or denial of alcohol or other recreational drugs
4. Steady gait, presence or absence of odor of alcohol
5. Explanation of the potential consequences (in general, and specific to the injury or illness) of refusing treatment and/or transport
6. Patient statement of an understanding of the consequences of refusing treatment or transport
7. Patient informed of potentially dangerous symptoms that may develop
8. Patient instructed to call 911 should they change their mind or if their symptoms persist or change

B. For persons identified as “victims” a PCR or refusal does not have to be done. However, documentation (general response record is agency specific) shall include that aid was offered and if the need arises, they should seek emergency service.

Documentation of use of Restraints

A. Document carefully the reason for the restraint, the type of restraint used, the result of the use of the restraint, and any injuries the patient sustained during the restraint process.
B. Assess and document the circulation, sensation, and movement distal to the restraint, immediately after restraint placement and upon transfer of care.

Documentation of Special Situations

A. Stroke
   1. Cincinnati Pre-hospital Scale must be assessed and documented for all patients with suspected stroke

B. Selective C-Spine Immobilization
   1. Document pertinent negatives regarding mental status, language barriers, etc. according to the protocol.
   2. Document the physical assessment, specifically the spinal nerve root assessment, in detail

C. Intubation
   1. Capnography waveform and amount shall be documented.
   2. A strip will be obtained at the time of the intubation and prior to transfer of care, and included with the PCR.

D. Trauma Team Activation
   1. When a full or limited trauma team activation is done, the type of activation and the time of activation shall be documented