OC-MEDS - DOCUMENTATION STANDARDS

Orig. Date: 10/28/13

I. AUTHORITY

Title 22, California Code of Regulations, Division 9, Chapter 4, Article 8, Section 100171
California EMS System Core Quality Measures (EMSA #166 – Appendix E)

II. APPLICATION

This policy defines ***minimum*** documentation standards as outlined in state regulations. It further provides guidelines for prehospital documentation to exceed those minimums and provide an accurate history of prehospital assessment, decision-making, intervention and patient response.

III. GENERAL GUIDELINES

A. For continuity of care and for patient safety, the Patient Care Report (PCR), whether on paper or electronic, shall be made available to the receiving center or coroner *as soon as possible, preferably before leaving the receiving facility (or, in the case of field death, before leaving scene).*
   1. Except in rare cases of system downtime or inoperability of tablets, patient care records should be completed in a timely manner.
      a. Refer to agency downtime process.

B. Agency electronic documentation systems must be NEMSIS Silver or Gold compliant in order to ensure required data elements are captured as required by law or regulation

C. Provider agencies may set documentation standards on emergency care rendered and patient response to treatment which are more specific than required by regulation.
   1. Examples may include:
      i. Requirement of narrative assessment documentation in specific cases, such as trauma. May include description of the scene
      ii. Narrative documentation to convey an accurate description of the patient's condition as well as response to interventions
      iii. Narrative documentation of unusual situations not covered in required electronic data element fields
      iv. Use of a checklist in cases of patients signing Against Medical Advice

D. OCEMS may request specific documentation elements related to CQI, Field Study, syndromic surveillance or emergency management data collection.

IV. PARAMEDIC (ALS) DOCUMENTATION: Minimum standards

A. The paramedic is responsible for accurately completing the patient care record which shall contain, ***but not be limited to***, the following information (*Title 22, CCR, Div. 9, Ch. 4, Art. 8, Sec. 100170)*
   1. Date and time of each incident
   2. Time of receipt of the call
   3. Time of dispatch to the scene
   4. Time of arrival at the scene
      a. Local requirement: Patient contact time
   5. Location of the incident
   6. The patient's
      a. Name
      b. Age
      c. Gender
      d. Weight, if necessary for treatment
      e. Address
      f. Chief complaint
      g. Vital signs

7. Appropriate physical assessment
8. Emergency care rendered and patient response to such treatment
    a. Documentation of care rendered should use required electronic data element fields (Example: documenting a 12-lead EKG as a procedure)
    b. In addition to required electronic data element fields, narrative documentation of patient assessment, treatment and response to treatment may be added
    c. Narrative documentation may be used to explain deviation from protocols (Example: holding aspirin because it was taken just prior to the 911 call)
9. Patient disposition, including hand-off information if care transferred to another unit
10. Time of departure from scene
11. Time of arrival at receiving facility, if transported
12. Name of receiving facility, if transported
13. Name(s) and unique identifier number(s) or paramedics
14. Electronic "signature" of the documenting paramedic is done by logging in to the system. The crew member list will appear in the ePCR per agency policy.

B. Other elements as required by OCEMS:
1. Name of agency assuming care if care is released to another ALS unit, BLS care, law enforcement or coroner
2. Time of transfer of care to another agency/unit
3. Provider impression
4. Documentation related to specific interventions as outlined by Medical Director in Standing Orders and other patient care policies.

C. California Emergency Medical Services Authority has developed outcome-based Core Measures. Data elements for these core measures should be addressed in agency documentation standards and include (Reference: *EMSA Document 166*):
1. Trauma
    a. Scene time for trauma
    b. Direct transport to trauma center for patients meeting criteria
2. Acute Coronary Syndrome
    a. Aspirin administration for chest pain/discomfort
    b. 12-lead EKG performance
    c. Scene time for suspected heart attack patients
    d. Advance hospital notification for acute coronary syndrome patients
    e. Direct transport to PCI center for acute coronary syndrome patients
3. Cardiac arrest
    a. AED use prior to EMS arrival
    b. EMS cardiac arrest: ROSC in field
    c. Bystander CPR prior to EMS arrival
4. Stroke
    a. Identification of stroke in the field via pre-hospital stroke screen
    b. Blood glucose level
    c. Scene time for suspected stroke patients
    d. Advance hospital notification for suspected stroke
    e. Direct transport to Stroke Center for stroke patients
5. Respiratory
    a. CPAP given for patients with respiratory distress
    b. Beta2 agonist administration
6. Pediatric
    a. Pediatric asthma patients receiving bronchodilators
    b. Direct transport to pediatric trauma center for those pediatric patients meeting criteria
7. Pain

a. Pain interventions (cold packs, splinting, medication administration)
b. Comparison of first and last pain scale to measure pain decrease

8. Endotracheal intubation
   a. Endotracheal intubation success
   b. End-tidal CO2 performed on intubation
9. Response and Transport
   a. Ambulance response time – both emergency (Code 3) and non-emergency (Code 2)

V. EMT (BLS) DOCUMENTATION (Minimum standards)

A. The EMT is responsible for accurately completing the patient care record which shall contain, *but not be limited to*, the following information
   1. Date and time of each incident
   2. Time of receipt of the call
   3. Time of dispatch to the scene
   4. Time of arrival at the scene
   5. Patient contact time
   6. Location of the incident
   7. The patient's
      a. Name
      b. Age
      c. Gender
      d. Weight, if necessary for treatment
      e. Address
      f. Chief complaint
      g. Primary impression, as determined either by ALS provider transferring care or by the EMT if a BLS-only level call.
      h. Vital signs
   8. Appropriate physical assessment
   9. Basic life support care rendered and patient response to such treatment
      a. Documentation of care rendered should use required electronic data element fields
      b. In addition to required electronic data element fields, narrative documentation of patient assessment, treatment and response to treatment may be added
      c. Narrative documentation may be used to explain usual situations not covered in required electronic data element fields
   10. Patient disposition, including hand-off information if care transferred to another unit
   11. Time of departure from scene
   12. Time of arrival at receiving facility, if transported
   13. Name of receiving facility, if transported
   14. Signature(s) of the EMTs