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Documentation

DND Primary Care Paramedicine

Module: 01

Section: 14

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Objectives

- Identify the components of a EMS patient care report.
- Review standard formats in use with patient care reports
- Special considerations in PCR documentation
- Consequences of inappropriate Documentation

Patient Care Report (PCR)

- Used to effectively document essential elements of patient assessment, care and transport
- A legal document that, next to providing good patient care, is the paramedic's best protection from liability action
- Reflection on you as a professional
- Ensures continuity of care for the patient

Why Write a Patient Care Report

- Written, legal record of incident
- Used for medical audit and quality improvement
- Billing and administration
- Data collection and research

Recording Information

- After performing the history and physical examination, the health care practitioner must:
  - Organize
  - Synthesize
  - Record the data
  - Record the problems identified
  - Record the diagnostic evaluation
  - Record the plan of care

Recording Information (Cont.)

- Electronic Patient Care Reports (ePCR) may require even higher standards of documentation excellence
- The patient's record is a legal document
  - Court
  - Payment determinations
- Present the data legibly, accurately, and in a manner that is representative of the examination

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GENERAL GUIDELINES

General Guidelines

- Take brief notes during examination
- Make full recording as soon as possible after examination
- Make a concise outline
- Avoid the use of abbreviations and acronyms when possible
- Document observations and what patient tells you, not your interpretations
- Record expected and unexpected findings

General Guidelines

- It is unacceptable to copy other providers' documented work and enter it into your own documentation as if you did the work
- Text copied from another person's note must always be attributed to the source

Electronic Patient Care Record (ePCR)

- While potentially being a very effective tool, the ability to easily copy and paste or carry forward (CPCF) text from one note to another has become the latest hazard in electronic medical documentation
  - Can impact patient safety
  - Can perpetuate erroneous or outdated information
  - Can pose significant legal and regulatory challenges

Characteristics of Good Documentation

- Appropriate medical terminology, spelling and grammar
- Correct abbreviations and acronyms
- Accurate and consistent times
- Thoroughly documented actions
- Pertinent negatives
- Identification of additional resources and personnel on scene

Patient Care Report

- Will include:
  - All dates and response times
  - A description of any difficulties encountered while in route and during patient treatment, extrication, or transport
  - Observations at the scene
  - A description of any prior medical care provided (and by whom)
  - Times of all significant occurrences, interventions or directives

Patient Care Report

- Provides for a recording of the following incident times:
  - Time of call
  - Time of dispatch
  - Time of arrival at the scene
  - Time at patient's side
  - Time of vital sign assessments
  - Time(s) of medication administration and certain medical procedures as defined by local protocol
  - Time of departure from the scene
  - Time of arrival at the medical facility (when transporting a patient)
  - Time back in service

Elements of a Properly Written EMS Document

- A properly written EMS document is:
  - Accurate
  - Legible
  - Timely
  - Unaltered
  - Free of nonprofessional or extraneous information
- Assume responsibility for self-assessment of all documentation

Accurate and Complete

- All pertinent information must be provided in both the narrative and checkbox sections of the report
  - Completing all areas of the report (even if a section was unused) demonstrates a precise and comprehensive document
  - Ensure that medical terms, abbreviations, and acronyms are properly used and correctly spelled

Legible

- Handwriting should be read by others without difficulty
  - Checkbox markings should be clear and consistent from the top page of the report to all underlying pages
  - Many EMS systems are transitioning to electronic PCR's

Timely

- Ideally, documentation should be completed immediately after the patient interaction
- Delays in recording can result in omissions or errors and may be interpreted as negligence

Unaltered

- If errors are made while writing the report, draw a single line through the error, and date and initial it
  - Any alterations to a completed report should be accompanied by an appropriate "revision/correction" supplement with the date and time of revision
- With electronic PCR's (ePCR), once finalized the form is complete and cannot be adjusted.

Free of Nonprofessional Information

- The PCR (ePCR) must be free of:
  - Jargon
  - Slang
  - Personal bias
  - Libelous or slanderous remarks
  - Irrelevant opinion or impression
- Apply these principles of documentation to computer-generated PCRs

The Narrative

- Typically divided into three sections:
  - Subjectivité : Any information gathered when exploring the patients history
  - Objectivité : General impressions and information gathered through your assessment
  - Évaluation/Management: Your working assessment and management plan

The Narrative

- Provides a description of the call
  - Will be carefully detailed and written
  - Avoid use of slang or medical abbreviations that are not universally accepted
- Document concisely and clearly
  - Use simple words
  - Avoid:
    - Uncommon abbreviations
    - Unnecessary terms
    - Duplication of information

Pertinent Statements

- Pertinent oral statements made by patients and other on-scene people should be recorded
  - Record statements that may have an impact on subsequent patient care or resolution of the situation
- Use of quotations
  - Put in quotation marks any statements made by patients or others that relate to possible criminal activity or admissions of suicidal intention

"Pertinent Negatives"

- "Pertinent negative" findings
  - Those that warrant no medical care or intervention but which by seeking them, show evidence of the thoroughness of the paramedic's examination and history of the event
  - “No change in chest discomfort with deep respiration”

Additional information

- Record support services used
  - Helicopter, coroner, rescue/extrication, etc.
- Record use of mutual aid services
- Failed skills!

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STANDARD NARRATIVE FORMATS

Systems of Narrative Writing

- Develop a systematic approach for writing the narrative portion of the patient care report
- Many approaches for writing the narrative can be used, however:
  - Adopt an approach you feel comfortable with
  - Use it consistently to avoid omissions

Narrative Writing Systems

1. SOAP method
2. CHART Method
3. System Review
   - Physical approach from head to toe
   - Review of primary body systems
4. Objective/Subjective Information
5. SAMPLE history
6. Chronological, call incident approach
7. Patient management approach

SOAP

- Subjective
  - What the patient told you
    - Describe the patient's concerns or unexpected findings by their quality or character
    - Useful way to record expected findings is to indicate the absence of symptoms (e.g., "no vomiting, diarrhea, or constipation")
- Objective
  - What you see, hear and touch
    - Relate physical findings to the processes of inspection, palpation, auscultation, and percussion
    - Provide an accurate description of unexpected objective findings

SOAP

- Assessment
  - What you found wrong with the patient during your assessment
    - Your interpretations and conclusions
    - Their rationale
    - Diagnostic strategy
    - Present and anticipated problems
    - Needs of ongoing as well as future care

Plan

- What you plan on doing for the patient
  - Need to invoke diagnostic resources
  - Therapeutic modalities
  - Other professional resources
  - Rationale for these decisions—what you intend to do
- Divided into three sections:
  - Diagnostics
  - Therapeutics
  - Patient education

CHART

- Chief Complaint
- History of incident/present illness
- Assessment
- Rx (treatment)
- Transport

System Review

- Scene assessment
- Primary survey
- Secondary survey
- Treatments
- Transport

Objective/Subjective Information

- Objective information
  - Your general impression and data gained by inspection, palpation, auscultation, percussion, and diagnostic testing.
  - Supported by facts and direct observation
- Subjective information
  - Information that you elicit during your patient's history
  - Cannot be supported by facts (e.g. "the patient appears depressed“)

Wording Objectionable Phrases

- Avoid adding personal opinions or making statements in your documentation that you would not feel comfortable defending with your employer or the legal system.

Wording Objectionable Phrases

- "He was drunk"
  - How do you know that the patient was drunk?
    - Could have had an AMS due to a head injury, a diabetic emergency, a stroke, etc.
  - "Patient had an unusual odor on his breath"
  - "Patient states that he drank 2 cans of beer prior to leaving the party."

Wording Objectionable Phrases

- "He was high"
  - How do you know that the patient was high?
    - Could have had an AMS due to a head injury, a diabetic emergency, a stroke, etc.
  - "Patient admits to using illicit substances"
  - "Patient unable to stand on his own without staggering and has auditory and visual hallucinations"

Documentation

SPECIAL CONSIDERATIONS

Patient Refusal of Care and/or Transport

- Major area of potential liability
  - Patient's retain the right to refuse (competence)
- Documentation must be thorough and include:
  - Advice to the patient regarding benefits or treatment and the risks associated with refusing care
  - Advice rendered by medical direction via the telephone or radio
  - Clinical information that suggests competency
  - Signatures of any witnesses to the event (per protocol)
  - A complete narrative, including quotations or statements made by others
    - Refusal Form
    - PCR/ EPCR

Care and Transportation Not Needed

- Some services allow the paramedics to determine if transport is required
  - Pro: Reduces ambulance utilization
  - Con: high risk then pt refusal
- If, after evaluation of the patient or scene, the paramedic determines that circumstances do not warrant EMS transport:
  - Advise the dispatch center
  - Document the event
- If canceled en-route to the scene:
  - Note canceling authority
    - Dispatch center, EMS supervisor
  - Note time of cancellation

Situations Involving Mass Casualties

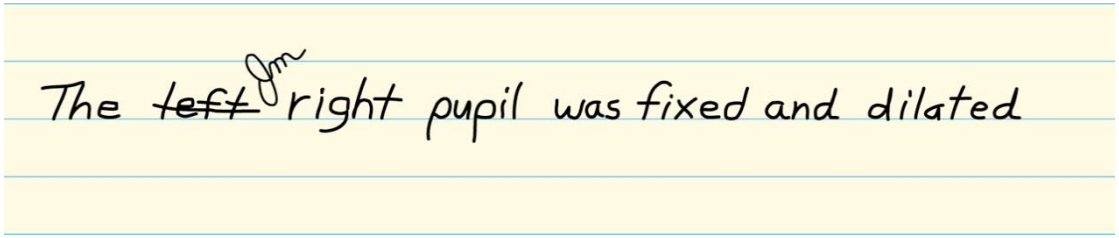
- During a major incident, comprehensive documentation may have to be postponed until patients are triaged and transported for definitive care
- TRIAGE tags transfer necessary information from person to person

Document Revision/Correction

- It may sometimes be necessary to revise or correct a patient care report
  - Most EMS agencies provide separate report forms for this purpose
- If a separate report is needed:
  - Note the purpose of the revision or correction and why the information did not appear on the original document
  - Note the date and time the revision or correction was made
  - Ensure the revision or correction was made by the original author of document
  - Make the revision or correction as soon as the need for it is realized

Document Revision/Correction

- Acceptable methods for making corrections or for adding supplemental information to a document vary by agency
- Some methods include:
  - Making the revision on the original form with initials, date, and time
  - Writing the corrections in narrative
  - Attaching a new report to the original
- Follow local policies for revising and/or correcting reports



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CONSEQUENCES OF INAPPROPRIATE DOCUMENTATION

Consequences of Inappropriate Documentation

- Inappropriate documentation can have both medical and legal consequences.
- An incomplete, inaccurate, or illegible report may cause subsequent caregivers to provide inappropriate care to a patient

Documentation

- Documentation should never become routine or superficial
- Appropriate documentation should be completed in a timely manner and with careful attention to detail

Remember…

If you did not write it down…it didn't happen…

No matter what you say!

Review

- Discussed the components of a EMS patient care report.
- Reviewed standard formats in use with patient care reports
- Identified special considerations in PCR documentation
- Briefly covered some consequences of Inappropriate Documentation