



COMPLETION OF PATIENT CARE RECORDS **DRAFT**

POLICY NO: **6001**

PAGE 1 of 4

EFFECTIVE DATE:

REVISED DATE:

APPROVED: Bryan Cleaver
EMS Administrator

Dr. Mark Luoto
EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.202, 1797.204, 1797.220, 1798 and 1798.220. California Code of Regulations, Title 22, Chapter 2, 3 and 4.

6001.00 PURPOSE

- a. The purpose of the following policies and procedures is to define all requirements regarding the Pre-hospital Care Report (ePCR) completion, reporting, and submission within the Coastal Valleys Emergency Medical Services Region (LEMSA). The electronic ePCR data elements, data system, forms, documents, reports must meet the requirements of CVEMSA Policy 6000-EMS Provider Data Requirements.

6001.01 DEFINITIONS

- a. Incident: An incident is any response involving EMS personnel to any event in which there is an actual victim or the potential for a victim, regardless of whether or not the responding unit was cancelled en route. This includes all emergency responses, non-emergency responses, walk-in responses, responses that are cancelled before scene arrival, any pre-arranged ambulance stand-by and any ambulance transfers originating in LEMSA.
- b. Patient Contact: A patient contact is defined as any contact between an EMT or Paramedic and a potential patient, including Determination of Death Policy eligible contacts, is considered a patient contact and requires completion of an ePCR.

6001.02 POLICY

- a. Pre-hospital Care Reports (ePCR) shall be completed and submitted electronically.
- b. EMS personnel shall complete patient care records (ePCR) on all EMS incident and patient contact responses.
- c. All available and relevant information shall be accurately documented on the ePCR.
- d. Intentional failure to complete an ePCR when required or fraudulent or false documentation on an ePCR may result in formal investigative action under the California Health and Safety Code, 1798.200.
- e. Patient care documentation management is to be compliant with HIPAA and medical record retention requirements.

COMPLETION OF PATIENT CARE RECORDS **DRAFT**

POLICY NO: **6001**

Last Revised:

Page 2 of 3

- f. The LEMSA may request specific documentation elements related to CQI, field study or trials and other emergency management data collection requirements.

6001.03 ePCR AVAILABILITY

- a. A completed PATIENT ePCR, available to the receiving facility is a high priority for each patient prior to clearing the receiving hospital, when unable due to system demands or technical hindrance, completed patient ePCR shall be made available within 2 hours of providing patient care. (Exception: EOA Contract Compliance standards)
- b. A partially completed or preliminary ePCR, marked as such, shall be left with the patient if a complete ePCR cannot be completed prior to clearing the receiving facility.
- c. Non-transporting agencies that have turned over care to transporting personnel shall send a partially completed or preliminary ePCR(or acceptable paper form), marked as such, with the patient.
- d. All INCIDENT ePCR's must be fully completed and submitted within 24 hours

6001.04 ePCR PROCEDURES

- a. Personnel providing patient care are responsible for accurately documenting all available and relevant patient information on the ePCR. Provider agencies may set documentation standards which are more specific than required by regulation.
- b. Care given prior to arrival, by bystanders or first responder personnel, shall be documented on an ePCR.
- c. Use of usual and customary abbreviations is permitted in the narrative section of the record or as defined in automated ePCR pre-designated pick lists.
- d. The PCR shall contain the following Basic Data Elements, when available:
 - 1) Initial Response Information
 - a) EMS unit number
 - b) Date and estimated time of incident
 - c) Time of receipt of call
 - d) Time of dispatch to the scene
 - e) Time responding
 - f) Time of arrival at the scene
 - g) Incident location
 - 2) Patient Information
 - a) Name
 - b) Age and date of birth
 - c) Gender
 - d) Weight, if necessary for treatment
 - e) Address
 - f) Chief complaint
 - g) Patient history
 - h) Vital signs
 - i) Appropriate physical assessment
 - j) Emergency care rendered, and patient's response to such treatment

COMPLETION OF PATIENT CARE RECORDS **DRAFT**

POLICY NO: **6001**

Last Revised:

Page 3 of 3

- k) Documentation of care rendered using Agency defined/ required electronic data element fields
 - l) Electronic data fields of patient response to treatment and use of the narrative field
 - m) Patient disposition
 - n) Time of departure from scene (if transported)
 - o) Time of arrival at receiving facility (if transported)
 - p) Name of receiving facility (if transported)
 - q) Name and unique identifier number(s) of EMS personnel on the call
 - r) Signature of EMS personnel on the call
- e. The ePCR shall be completed and distributed in accordance with this policy.
 - f. A completed ePCR shall not be altered or changed except by the individual who completed the ePCR. Exceptions are permitted to add or change billing information, or add a name or other pertinent demographics unknown at the time of the call.
 - g. If a paper interim PCR is used, or a change is made on a hard copy of an automated ePCR, documentation errors shall be lined through (e.g. ~~Like this~~), and the correction shall have the patient attendant's initials beside it.
 - h. Any changes made to an electronic PCR shall have documentation of those changes retained in the computer database.
 - i. In situations where the patient, or their legal representative, declines medical care or transport when care is recommended and felt to be necessary by the prehospital personnel attending that patient, documentation should include all available basic data elements. *Refer to Treatment Guideline 7005 Patient Refusal of Treatment or Transport.*

6001.05 CORE MEASURES DATA ELEMENTS

- a. California Emergency Medical Services Authority has developed outcome based Core Measures. Data elements for these core measures should be addressed in any provider agency documentation standards. (REFERENCE EMSA Document #166)
 - 1. Trauma - Times, Destination decisions
 - 2. Acute Coronary Syndrome (ACS) - ASA, 12 lead destination decisions
 - 3. Cardiac Arrest - AED use, bystander involvement
 - 4. Stroke- use stroke screening, destination decisions, times, FSBG use
 - 5. Respiratory - CPAP use, Beta2 use
 - 6. Pediatric - Bronchodilator use and Trauma Center Diversion
 - 7. Pain - Measured
 - 8. Endotracheal Intubation - Success and ETCO2
 - 9. Response and Transport - Times

6001.06 HOSPITAL RESPONSIBILITIES

- a. Hospitals should implement mechanisms to assure that prehospital documentation arriving with the patient is readily available to ED staffs and is incorporated into the hospital medical record system.