 EMS Standard Operating Procedures

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<th>Policy Title:</th>
<th>Patient Care Documentation Guidelines</th>
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<td>Section:</td>
<td>Operations</td>
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<tr>
<td>Adoption Date:</td>
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Purpose:
Establish standards of quality for documentation of patient care.

Policy:
All indicated statistical data required on individual forms should be completed, and should include, at a minimum:

1. Date of service

2. Times:
   - Time call was received
   - Time of dispatch
   - Time en route
   - Time of on scene arrival
   - Time of patient contact
   - Time of departure from scene
   - Time of arrival at destination
   - Time unit becomes available

3. Identification of patient to include:
   - Name
   - Age
   - Sex
- Date of birth
- Address when available
- Phone number when available
- Social security number when available

4. Location of incident

5. Vehicle and crew identification

6. Disposition of patient

7. Other agencies on scene, i.e. other EMS providers, law enforcement.

8. Name of transporting agency.

9. Receiving facility to which patient was transported.

10. Impression of patient condition

11. Patient assessment findings shall include the following:
   - Chief complaint per statement of patient.
   - History of presenting illness or mechanism of injury.
   - Past medical history, medications, allergies, patient's physician if known.
   - Complete vital signs to include:
     - Blood pressure
     - Pulse rate and quality
     - Relative skin temperature, color, and diaphoresis if any
     - Respiratory rate and quality
     - Lung sounds

   If complete vital signs are not obtained, the reason is to be documented. Frequency of reassessment should be dependent on the patient's condition with a minimum of vitals once every ten minutes.

   - ECG interpretation if indicated
   - Blood glucose level is indicated
   - Capillary refill status
   - Pupil responsiveness
   - Level of Consciousness by GCS
   - Oxygen saturation levels if indicated
   - End tidal CO2 monitoring data

12. Complete secondary and physical assessment related to findings of primary survey:
• Mental status or neurological exam
• Evaluation of motor and sensory function.
• System specific exam as indicated (i.e. cardiac, GI/GU)

13. Document of patient interventions and response to treatment, including type of intervention, times, identification of who administered medications or initiated invasive procedures and equipment utilized and the degree of response to treatment given.

14. Additional documentation required for specific interventions, i.e.:

• ALS Assessment.
• Oxygen therapy: liter flow, type of delivery device.
• Peripheral IV and intraosseous access: location, catheter size, fluid rates, staff initiating, amount infused, time and number of attempts
• Intubation: Route, size of tube, verification of tube placement by auscultation and end tidal CO2 detection, securement of tube, and number of unsuccessful attempts.
• Suction: route, description of fluid, amount suctioned.
• Needle thoracotomy: tracheal position before and after procedure, site, size of needle, presence of free air or fluid, auscultation of breath sounds bilaterally before and after, time and number of unsuccessful attempts.
• CPR: Time started and discontinued, whether CPR in progress on arrival, continuation of CPR.
• Defibrillation/Cardioversion: EKG rhythm interpretation, joules used for each attempt
• External transcutaneous pacing: milliamps and rate at start and at capture.
• Cardiac monitoring: rhythm interpretation on patient encounter form and EKG strip, strip attached to patient record and base hospital copy with notation of patient's name, date, time, lead used.
• Medications: drug name, dosage, route, method: bolus, push, drip infusion
• Pulse oximetry: oxygen saturation percentage at room air or at specific liter flow rate.
• Restraints: include documentation required in "Use of Restraints" policy.
• Spinal immobilization: equipment used, motor and sensory function assessment before and after application.
• NG/OG Tube: Confirmation of placement and indication of gastric return
• Waveform Capnography/ETC02 Monitoring: Time of application, initial ETC02 levels and subsequent changes following administered treatments.

15. Required signatures:
16. Refusal of Care or Transportation

In addition to the above guidelines, documentation should be performed in compliance with the “Refusal of Care or Transport” policy.

17. Completion Deadlines

- Reports are to be completed prior to the end of a scheduled shift unless approved by the Divisional Chief on duty or his acting.
- Reports are never to be taken home

18. Handling of reports

- All unwritten and written reports will be kept out of plain view.
- Unwritten report should be stored in a drawer, or other location, where the report will be secure and confidential while not being written.
- Reports being transported in the ambulance whether complete or incomplete will be kept in an enclosed folder to protect confidentiality.
- Reports or pt. paperwork should not be transported in employee’s private vehicle or taken home for privacy reasons.

19. Student Writing of Reports

- Only employees of WDM EMS who may be riding in a student capacity will be allowed to complete reports using the computerized reporting software.
- All reports written by WDM students will be signed by the student and the primary attendant after the review is complete.

20. Review of Completed Reports

- The on duty Divisional Chief, or his acting, will be responsible for the review of reports written during a shift.
- Reports will be reviewed in the pre bill stage for completeness and statistical accuracy and routed for corrections when applicable.
• Reports will be coded using the appropriate form and secured to the report.
• All completed reports will be turned in to the Billing Department following review and coding.

21. Reports Needing Corrections

• An email will be sent to the employee responsible for writing the report, as well as to the Divisional Chief responsible for that employee, notifying him/her that the correction is needed.
• Reports needing corrections will be unlocked through the documentation software and rerouted back to the employee.
• The crew member needing to make a correction should make every effort to get the correction(s) made as soon as feasible, but no later than the end of their next shift.