



Glatfelter
Commercial
AmbulanceSM
A Division of Glatfelter Insurance Group

PATIENT CARE DOCUMENTATION

PARTICIPANT MANUAL

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Introduction

This program is designed to openly discuss the importance of proper documentation of all patient care contacts. This manual is not all inclusive. It is intended to establish a baseline for good documentation. To use this manual effectively, it is important to understand the requirements and expectations of the **authority having jurisdiction (AHJ)**.

Learning Objectives

Participants who successfully complete the Patient Care Documentation program will be able to:

- Understand the purpose of patient care documentation
- List the components of a patient care report (PCR)
- Differentiate subjective and objective patient assessments
- Identify the role of medical direction
- Define relevant legal terms
- Understand the concept of consent, including as it relates to the patient refusal of treatment/transport and end-of-life care
- Understand the role of a pre-hospital provider in quality management and continuous quality improvement (CQI).
- Define the terms incident and near miss
- Discuss the impact of technology on PCR documentation, including privacy and security

Purpose of Patient Care Documentation

Patient care documentation should be all-inclusive. What does it mean? Is it complete for the circumstance? Is it legible? Does the report support the billing function? Is it defensible? Proper patient care documentation is the responsibility of each pre-hospital provider.

A professional pre-hospital provider should understand that patient care documentation is a critical task. In the field, a pre-hospital provider can do everything “by the book”, but complacency and habits can deteriorate the skill of patient care documentation over time. The documentation of the event becomes a permanent part of a patient’s history. A **patient care report (PCR)** should serve as a record of events and patient care actions taken by a pre-hospital provider.

It is the intention of this program to describe the essential points of effective documentation. A lack of documentation can be harmful and misrepresent the actual details of patient care. In addition, documentation can be used as a risk management tool within an organization.

Patient Care Documentation

Pre-Quiz

Name: _____ Date: _____

1. Which of the following describes how a patient care report (PCR) can be used:
 - a. Legal
 - b. Billing/Reimbursement
 - c. Continuous Quality Improvement (CQI)
 - d. All of the above
2. Identify the acronym OPQRST which is used for patient assessment:
O _____
P _____
Q _____
R _____
S _____
T _____
3. Off-line (indirect) medical direction is used by a pre-hospital provider on nearly every patient encounter.
 - a. True
 - b. False
4. A patient care report (PCR) is subject to discovery in court in either a criminal or civil case.
 - a. True
 - b. False
5. Implied consent applies to a patient who:
 - a. Is alert
 - b. Is unresponsive
 - c. Does not wish to be treated/transported
 - d. None of the above
6. A pre-hospital provider has a role in quality management within their organization.
 - a. True
 - b. False
7. An incident can be described as:
 - a. A medication administration error
 - b. A stretcher tip resulting in a patient drop
 - c. Both A and B
 - d. None of the above

8. Electronic protected health information (ePHI) should be just as protected as any other form of protected health information (PHI).
 - a. True
 - b. False
9. Only a device owned by your organization and approved by the authority having jurisdiction (AHJ) should be used to collect clinical media (photography, video, or other audio/visual media).
 - a. True
 - b. False
10. Your patient care report (PCR) is reported to the National EMS Information System (NEMESIS) database.
 - a. True
 - b. False

What is Documentation?

Each patient who accesses the healthcare system begins their journey with a relationship with a healthcare provider. A patient-provider relationship may be as short as a few minutes or as long as a lifetime. Neither the patient nor the provider can predict the outcome of the relationship.

Good documentation *COMMUNICATES*

When contact is made, treatment is started, and the initial healthcare provider transfers the care to another healthcare team member, the only bridge that permanently connects the provider and the patient is the documentation of the event. The PCR is the most critical item a pre-hospital provider can rely on to reflect upon the details of the event. The PCR is one of the only items that follow the patient through their journey, becoming a part of the patient's permanent medical record. Documentation is the one thing the patient can use to connect a healthcare provider to an action or period during their care.

Communication between healthcare providers is another essential component in developing consistent patient outcomes. Documentation is the formal way of recording thoughts, so that another person can understand what was seen, what was felt, what was heard, and what actions (or inactions) were taken to improve the condition of the patient.

Good documentation *STIMULATES THE MEMORY*

Another purpose of documentation is to aid in the recall of important facts and findings. It helps stimulate the memory of the author years after an event. A healthcare provider cannot recall every detail about every encounter over the course of time—especially if the relationship was relatively short in duration. A healthcare provider, who takes the time to properly document the event, not only helps the patient and other healthcare professionals, but gives him/herself a permanent record that can be used as a substitute for memory in the future.

Good documentation is *DEFENSIBLE*

Legal action generally occurs when someone (patient and/or family member) feels that they have been wronged. A PCR could be used to determine if a healthcare provider is professional or credible. The intent of a legal action is often not to punish, but make things right or whole. Good documentation may protect against or lessen the consequences of legal action.

Good documentation improves *RISK MANAGEMENT*

Risk management is the art and science of reducing losses. Documentation can be an effective tool to determine weaknesses in individual skills and to determine trends throughout an organization. Through risk management techniques, educational programs can be developed to improve the quality of documentation and further enhance patient care. An effective risk management program promotes the development of quality management programs.

Effective Patient Care Documentation

The intent of this manual is to provide an effective baseline for pre-hospital providers and demonstrate why documentation is an essential part of the profession. It should also be stressed that poor documentation may be used against the provider and organization during legal proceedings. The goal of this program is to identify best practices for patient care documentation.



Chapter 1

Patient Care Report

All healthcare professionals have the responsibility to evaluate and treat patients. Along with this responsibility comes the notion of accountability. All levels of healthcare providers must maintain an accurate record of care provided and the patient's response or outcome(s) related to that care. Documentation is a record of the facts. The documentation provides proof and support to what had occurred during an encounter. A patient care report (PCR) serves the record of patient assessments, interventions and other related events related to patient care.

Use of the PCR

Healthcare professionals are educated in different aspects and degrees of patient care. The physical therapist evaluates a patient differently than a trauma surgeon does. Each professional will use their training and experiences to guide them in their evaluation. The documentation may contain different scopes of information; however there is consistency in the use of information throughout the medical profession. It is this consistency that helps build the format for assessing patients and documenting the findings.



For pre-hospital providers, it is this consistency that enhances the ability to become proficient at writing a PCR. Currently there are few standard methods for writing a PCR.

The PCR is documentation is an accounting of the interaction of the patient with the provider. From beginning to end of a patient encounter, documentation must occur. It is necessary to include detailed information from the perspective of the healthcare professional. All treatments or actions should be rooted in accepted standards of care or medical direction, including treatment protocols.

Documentation must include a **disposition**, which includes the improvement, stabilization, and/or deterioration of the patient's condition. In any case a patient decides to refuse treatment or transport; a refusal form should be obtained with the patient's signature.

Lack of consistent and standardized documentation practices may cause other healthcare professionals to avoid or fail to value a pre-hospital provider's observations and assessments. The credibility of each provider can be diminished with each inadequate report.

Developing Documentation Skills

Pre-hospital providers spend many hours learning how to respond to, treat, and transport the sick and injured. Working as a pre-hospital provider is an admirable profession that commands respect and appreciation and is a source of pride. All pre-hospital providers should possess responsibility, accountability and an understanding of the established best practices and standards for patient care documentation.

The PCR becomes part of a patient's permanent record. Therefore, a separate PCR should be completed for each patient. Though the information needs to be protected for privacy and security, it will be viewed by several medical professionals at various times during treatment. Note that everyone who views the PCR may not be medically trained.

Professionals who may have an interest in the PCR include:

- Nurses
- Physicians
- Case Managers
- Coroners
- Therapists
- Billing & Insurance Professionals
- Law Enforcement (detectives, investigators)
- Attorneys
- Judges
- Jurors

Each person is looking for information that will lead them to understand what happened to the patient, what, if anything, went wrong and, more importantly, who may have caused harm to a patient.

Can your PCR stand up to the scrutiny of these people?

In many emergency medical services (EMS) initial education programs, insufficient time is devoted to patient care documentation compared to other aspects of the curriculum. Every patient encounter requires patient care documentation to some extent. The skill of effective patient care documentation often requires intensive on-the-job training for new pre-hospital providers.

"If the EMS training institutions have failed to adequately teach EMT students to document, they likely have also failed to establish standards for the profession of pre-hospital care.

The American College of Emergency Physicians¹

Some pre-hospital providers may possess limited reading, writing or computer skills. An individual or **authority having jurisdiction (AHJ)** may consider additional education and training to help improve reading, writing or computer skills.

The Blueprint

All healthcare professionals must demonstrate an understanding that documentation is an essential component of quality patient care.

The level of professionalism of a pre-hospital provider may be determined by the quality their PCR narrative. Each AHJ should establish a clear “blueprint” for patient care documentation:

- How did we get there? Who called for assistance?
- What did we see?
- What did we do?
- What were the results of what we did?
- How was the patient moved? Using what device(s)?
- Was medical direction consulted and followed?
- To whom was patient care transferred?
- Any special circumstances?

In summary, best practices for patient care documentation demand the need for a complete and accurate PCR. The pre-hospital provider should include answers to the above questions in the narrative of the PCR to thoroughly describe the patient encounter for the potentially diverse group external readers. In many cases, the narrative is the only information available for review by medical professionals, billing and insurance professionals, attorneys and jurors

Chapter 2

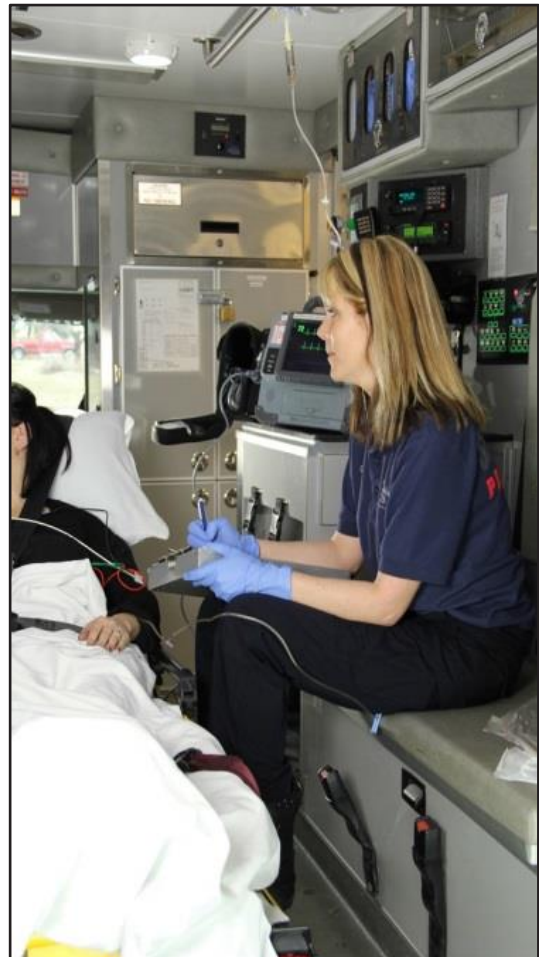
Patient Assessment and Care

There have been many books written on patient assessment. Though differences occur such as adult vs. pediatric and medical vs. trauma scenarios, the underlying reasoning remains the same. Programs such as Basic Trauma Life Support (BTLS), Pre-Hospital Trauma Life Support (PHTLS), and Advanced Cardiac Life Support (ACLS), among others, train the pre-hospital provider toward rapid assessment and treatment regimens. These patient assessment processes, clearly show patient care providers what to do and when to do it by establishing standards for professional care.

Some states require organizations to collect specific patient data while others leave the process up to individual organizations. Various states also require the organization to provide documentation on a specific PCR format. Every pre-hospital provider must thoroughly understand and follow state or local documentation requirements. Regardless of the process, patient care documentation records should track the incident from dispatch until the patient has been turned over to an equal or higher level of care provider. Dispatch information, patient information, patient condition, vital signs, on-line (direct) medical direction, treatment, and results of treatment should all be documented on the PCR.

A systematic approach to documenting patient care will provide consistency, reduce errors, and establish professionalism. Each area in the PCR requires completion. Pre-hospital providers must complete all the boxes or circles as appropriate for the PCR. With technological advances, many of these functions are incorporated into computer programs. Understanding the “why?” of documentation will help providers audit their own reports for accuracy.

The systemic approach to patient care documentation can follow a variety of formats. All PCRs should be factual and without opinion, accurate in description and without bias. The documentation should be concise, organized, grammatically and mechanically correct, and legible. In the end, a group of peers should be able to read the PCR and understand how the patient appeared, why the treatment was needed, and agree or be able to provide actionable feedback on the outcome. Learning and using a consistent format will save time for the provider, increase their proficiency, cover all pertinent patient assessment areas, and effectively communicate the proper information to all members of the healthcare team, and reduce the opportunity for error. Pre-hospital



providers that are focused on patient care will see that a standardized format will improve their assessment skills, enhance their interaction with the patient or family, and enhance their level of professionalism.

To emphasize an often-missed point, the purpose of authoring a PCR is to document to others what was observed, what was assessed, how the patient was treated and how the patient responded. These concepts are ALL patient care issues, not legal issues. Pre-hospital providers should not view the

PCR as a means of staying out of legal trouble or maximize reimbursement, but as a means to improve patient care. The legal defensibility and reimbursement will take care of themselves if the documentation is correct each and every time. When pre-hospital providers focus on what is right for the patient and document in a standardized, acceptable medical format, the chance of negative repercussion is reduced and the appropriate level of reimbursement will follow.

Before describing the details of the formats, pre-hospital providers should document concepts that are unique to pre-hospital providers. These include dispatch and response times, arrival times to the scene and patient, observations about the scene, initial and ongoing assessment of resources that may or may not be needed, time leaving the scene and arrival at the hospital. Often these points are omitted and believed to be unimportant.

Respond Promptly

Patients or family members often perceive that they have a situation that they cannot control. When calling for help, they are seeking assistance from someone who has a higher level of training. A prompt response will minimize the anxiety that accompanies the situation. Pre-hospital providers should focus on responding safety and promptly. On the PCR, dispatch time and response time should always be recorded accurately.



Arrive Safely

The level of response (emergent vs. non-emergent) is often decided based on the dispatch information. In many cases, medical protocols indicate the response mode. If a lights and sirens response is warranted, safety is of the utmost importance. If deviation from the response protocol is warranted this must be documented so as to show why the deviation occurred.

If the responding unit is involved in a collision with or without a patient onboard, the collision and resulting actions must be documented thoroughly. The circumstances surrounding the response should be detailed to describe the collision. The actions taken by pre-hospital provider and other personnel following the collision, including notification to dispatch and care rendered, should also be documented. Litigation can be brought against personnel, not only for the collision and potential damage, but also, by the patient or family member(s) for a delayed response. Documentation should include actions to ensure a timely response to the original emergency; including any known details about substitute units dispatched to respond to the original incident.

Delayed Response

In order to provide patient care, you must first arrive in a timely manner. Any situation that interferes with the safe arrival of the EMS vehicle and its personnel detracts from the primary purpose of the response. This may include:

- Staging at the scene
- Public demonstrations
- Closest unit utilization
- Weather
- Road closures
- Traffic congestion

Any delay should be documented appropriately.

Scene Size-Up

One of the first things pre-hospital providers are taught is scene safety. This primarily involves determining whether the scene is safe to enter. Rarely, does the instruction include observations about position of objects at the scene, people present, bystander behavior, or many other nuances of the immediate environment. As a result, the scene size-up is often overlooked in documentation. At times a pertinent description of the scene can help paint the picture for hospital personnel, insurance adjusters, other investigators, and even the patients themselves. Only the facts should be documented. Observations can illustrate potential forces the patient may have experienced or what may have contributed to the emergency.

Number of Resources

Another concept taught to pre-hospital providers is the consideration of additional resources necessary for proper handling of the situation. Intuitively, most pre-hospital providers make these decisions while gathering information from the patient, family members, or others at the scene. Based on the information obtained, the pre-hospital provider may or may not call for additional help. Documenting the need for additional help, the time contacted and when help arrived will help alleviate any questions of any delays in transportation. A simple note that “no additional help was necessary” may help the provider remember what he/she was thinking at the time, if questioned.



Medical Assessment	Trauma Assessment
Is the scene safe?	Is the scene safe?
Do we have enough help? <ul style="list-style-type: none"> • Vehicles • Personnel • Special needs/equipment 	Do we have enough help? <ul style="list-style-type: none"> • Vehicles • Personnel • Special needs/equipment
Number of Patients? (Triage)	Number of Patients? (Triage)
Introduction to Patient Airway, Breathing, Circulation	Introduction to Patient Airway, Breathing, Circulation
What concerned you that you called the ambulance?	Mechanism of Injury, MVC fall, GSW, assault, seat belt +/-, Helmet +/-
CC: Chief complaint (two or three words) potential life threats or the presenting problem	CC: Major injuries, complaints
Hx Present Illness: Who, what, when, why, how? <ul style="list-style-type: none"> • Open-ended v. Close-ended questions • Sick patients look sick • Pertinent negatives 	Hx Presents Illness: Do you remember the accident, what happened? <ul style="list-style-type: none"> • Pertinent negatives • Pertinent positives
Hx: Pertinent to the chief complaint(CC) a. Relates CC to previous history	Hx: Only if pertinent to the CC (i.e. diabetic, bee sting, heart)
MED: Could be very important to the discovery of other conditions	MED: Only if readily available, accessible and pertinent
Allergies: To medicines, food, insect (i.e. Sulfa, Novocain, xylocaine, codeine, seafood, nuts, chocolate, bees, wasps)	Allergies: Only if readily available, accessible and pertinent
Primary Care: Family medical doctor	Primary Care: If available, but not pertinent
Physical Exam: Initial, focused, detailed, on-going assessment with further assessment enroute	Physical Exam: Initial, focused, detailed, on-going assessments with repeat vs 5 minutes (critical), 15 minutes non-critical or more as time and pertinent condition allows (no detailed assess on scene with presence of life threatening injury, load and go)
TX: Do what is necessary on scene. The goal is to treat life threats and proceed to appropriate facility!	TX: Rapid assessment and evaluation immobilization, oxygen, baseline breath sounds, treat enroute, appropriate facility considering injuries and receiving facility's ability to handle patient needs
Response to treatment: How did the patient's condition change?	Response to treatment: How did the patient's condition change?
Medical Direction: Report after treating per protocol and allow them to prepare for your arrival. Plan for potential aggressive resuscitation such as intubation or other aggressive therapies for a patient.	Medical Direction: As soon as appropriate, allow receiving facility time to prepare for your arrival and receive further treatment orders not permitted by protocol. Update receiving facility as time and patient condition allows. Patient care is your priority.

Additional Information

Listed are additional memory joggers. These acronyms assist pre-hospital providers in decision making and developing patient questions. They are not used as specific documentation tools.

Patient Status	Load and Go Situations
C - Critical U - Unstable P - Potentially Unstable S – Stable	C - CPR A - Altered Level of Consciousness R - Respiratory Distress S - Shock
Level of Consciousness	Pain Evaluation
A - Alert V - Responds to Verbal Stimuli P - Responds to Painful Stimuli U –Unresponsive	O – Onset P – Provocation/Palliation Q – Quality R – Radiation S – Severity T – Time
Secondary	
B - Bilateral Leg Fractures U - Unstable Pelvis T - Tender or Rigid Abdomen	

Subjective and Objective

Subjective assessments may include statements provided by the patient, family member(s) and/or bystanders. It is best to document subjective statements with quotes and cite the source. Depending on the style of documentation, the symptoms could be included in the objective portion when assessing a specific body part or organ system.

Objective assessments may include what is observed, felt or measured. Pre- hospital provider success in assessing and documenting patient conditions can be tied to the ability to perform a detailed objective assessment. The objective assessment uses qualifiers to describe what is found and observed.

Using a chief complaint of “abdominal pain” as an example:

The subjective assessment includes: quality of pain scale, location, etc. The objective assessment includes feeling rigidity, observation of ecchymosis, auscultating for bowel sounds, and palpation of the area in question. Documenting objective findings does not stop with the notation of pain in lower right quadrant, but is further qualified by terms such as increase of pain in lower right quadrant upon light palpation, exhibited by grimacing and guarding.

By objectively quantifying the findings, providers are better prepared to address the events of a specific patient encounter months or years later. An accurate depiction, however, may be accomplished using a standardized approach to assessment. Listed are a few acceptable methods for assessing patients.

SOAPIER Format

S	Subjective
O	Objective
A	Analysis of Assessment
P	Plan of Action
I	Implementation of Treatment
E	Evaluation of Treatment & Response
R	Report to Receiving Facility

CHART Format

C	Chief Complaint
H	History
A	Assessment
R	Record Treatment & Response
T	Transport & Transfer of Care

Assessment Tips

1. Document what the patient states is the symptom. If the patient describes chest discomfort as a pressure, avoid generic complaints.
2. When determining the severity, use of medically accepted scales is important for consistency and credibility. Medically accepted scales include the 0 to 10 scale, with zero describing non-existent and 10 as severe. For children the 5-level facial expression scale could be used.
3. In order to conduct a thorough assessment, ask questions that are appropriate to the area that is being assessed. For example, palpating the head and asking if there is any chest pain or nausea may cause confusion.
4. Pre-hospital providers should document normal and abnormal findings. This can be accomplished by comparing one side of the body with the other or by observing movement (symmetry), auscultation (lung, bowel sounds and/or heart tones), palpating (rigidity, crepitus). It is important to remember that observation, auscultation, and palpation is the order of priority.
5. A pre-hospital provider can develop a patient care plan through a differential diagnosis. By determining what may or may not be wrong, the provider can choose which treatment protocol or intervention is appropriate.
6. Pertinent negatives are just as important as positive findings. Pre-hospital providers should make decisions based on assessment findings. If a provider determines that a specific treatment is not necessary, the documentation should reflect this decision.

It is essential that pre-hospital providers have a thorough knowledge and comfort level when performing an assessment. Proper documentation should include a detailed account of the assessment. If an abnormality was not found during the assessment or an assessment was not completed, it cannot be recorded. A pre-hospital provider should be detail-oriented in both the completion and documentation of patient assessments.

Lifting & Moving

In conjunction with providing medical assessment and care to a patient, pre-hospital providers are responsible for safely lifting, moving, and transporting a patient to the medical facility. An ambulance carries a number of pieces of equipment to assist in lifting and moving patients in a variety of circumstances. The PCR should detail the way the patient was lifted, moved, and transported, including:

- Number of personnel used to assist/lift
- Lifting technique
- Equipment used
- Seatbelts or other means of securing the patient
- Position of the patient
- Detailed description of the transfer to and from a stretcher or other device
- Reassessment of the patient after the lift or move

A patient handling incident or near miss should be documented in an incident report and investigated. Specific information on incident investigation can be found in the *VFIS Risk Management for EMS* textbook.³¹

Specific information on proper patient handling techniques can be found in the *VFIS Patient Handling* program.

Transport

During transport, a pre-hospital provider continues the initial care provided on-scene. Every patient is monitored with an ongoing assessment enroute to the medical facility. Findings of the ongoing assessment, changes in condition, additional treatments, and response to all treatments should be detailed in the PCR.

Medical Facility Notification

Following on-line (direct) medical direction the medical control physician should notify the receiving facility and provide pertinent patient care information to either the receiving nurse or physician (refer to *Chapter 3: Medical Oversight*). In instances when this does not occur, the pre-hospital provider should provide ample notification to the receiving medical facility. Knowing the conditions and acuity of the emergency department is essential for appropriate and aggressive patient care. Keep the radio report brief and to the point. Additional information can be transferred to the receiving healthcare provider during the transfer of patient care.

Transfer of Care

In a recent position statement, the American College of Emergency Physicians (ACEP), Emergency Nurses Association (ENA), National Association of EMS Physicians (NAEMSP), National Association of Emergency Medical Technicians (NAEMT), and National Association of State EMS Officials (NASEMSO)²⁰ collaboratively identified the importance of effective transfer of care procedures between pre-hospital providers and the receiving facility. The position statement asserted “all members of the healthcare team, including pre-hospital providers, nurses, and physicians, must communicate with mutual respect for each other and respect the verbal and written communication from any healthcare provider as an important part of the patient’s history”. With each organization independently adopting the position statement, the group acknowledged a deficiency in the transfer of care between pre-hospital providers and the receiving facility. From a risk control and patient safety standpoint, an emphasis should be placed on a combination of accurate verbal and written³⁰ communications when transferring care to another provider.

Patient Follow-Up

Patient follow-up is an excellent public relations tool and allows a professional approach to include the patient in quality management. If the patients (the customer) are not satisfied with the service, whether perceived or real, the service cannot be successful. If they were unhappy, an opportunity is presented to correct problems. The process may include a phone call, a form letter asking for responses to pre-selected questions, or a questionnaire placed in the patient’s invoice for service.

Documentation of Response Mode & Times

Time of Dispatch

Recording the time of dispatch and the time responding demonstrates a prompt response by the emergency vehicle and its personnel. If available, the call processing time should be included in a PCR. The call processing time is the total time from when a caller reached the dispatch center to when the emergency vehicle was dispatched. By involving dispatch centers and providers, the response process can ensure prompt handling of incidents.

Time Arrived on the Scene

Documenting arrival times is valuable for determining routes of travel and methods of response. Through tracking of response times and arrival times, an organization can plan response routes. Traffic patterns and times of the day can be studied to further minimize delays in reaching the scene.

Time Arrived at Patient

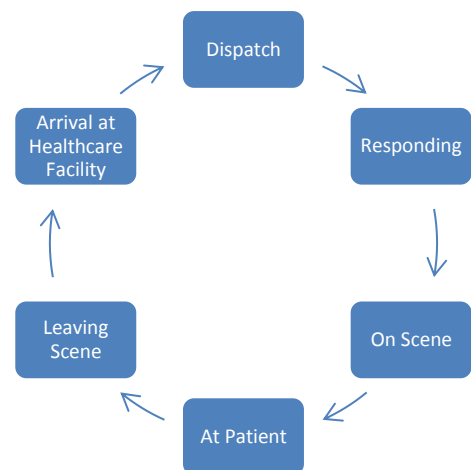
There are many situations when an emergency vehicle will arrive on scene and a pre-hospital provider will not be able to access the patient. Locked doors, uncontrolled pets, and natural or man-made barriers are a few examples. Pre-hospital providers should not only document the time of arrival, but also the time pre-hospital providers reach the patient. In the narrative, if the time is protracted, written observations should be added.

Time Leaving the Scene

The time enroute to the medical facility must be documented for quality purposes. Tracking on scene times can help determine if resources were available and used, provide factual information for pre-hospital provider education of special circumstances, and support PCR documentation for difficult medical situations. The use of lights and sirens²⁹ must be documented. The PCR should describe any delays encountered during the response and if the response mode was upgraded or downgraded for any reason.

Time Arrived at Health Care Facility

The completion of the call ends with the arrival at the facility and transfer of information to the next level of the health care team. Releasing the patient, physically transferring from ambulance litter to bed, and discussing pertinent information requires documentation of the time performed as well as to whom the patient was released. The value of this documentation is obvious when looking at how patients impact bed usage or flow in the emergency room, extended care facility, or doctors' offices. The arrival time completes the circle of documentation regarding the length of involvement with the patient. It is this endpoint that provides for the beginning of a good quality assessment program.



Exercise 1

Medical Case Study

You have been dispatched for an elderly male with shortness of breath. Response is approximately 11 minutes from your location. You arrive to find a 53 y/o male sitting in a high-Fowlers position gasping for breath. A relative is trying to comfort the victim. The closest appropriate medical facility is 22 minutes from the scene.

Complete your assessment using the vital signs and statistics provided by the instructor. This should be done from initial victim contact to transfer of information and care to the next level of medical intervention.

Note: Assess the victim based on your level of training and treatment protocols.

Upon call completion, complete your Patient Care Report.

Chapter 3

Medical Oversight

Medical direction is not only a necessity but an asset to any organization. Every pre-hospital system needs input and involvement from physicians. All related patient care functions, dispatch, scene response, to hospital response, assessment and quality management deserve physician involvement. Both on-line and off-line medical direction issues should be addressed.

On-line (direct) medical direction is communication that takes place with a **medical control physician** either in person or via two-way radio, telephone or cellular phone. Medical direction is generally provided by a physician through the receiving medical facility or a contracted free-standing facility.

Off-line (indirect) medical direction is provided via written protocols that establish policy and provide step-by-step procedures for the provision of patient care at both the ALS and BLS levels. Off-line medical direction is typically provided by a state, regional, or organization **medical director**. Some systems grant pre-hospital providers certain patient care privileges through **treatment protocols**, prior to contacting medical direction. Treatment outside of medical direction should be avoided and only utilized when all other communication efforts have been exhausted.



Off-line medical direction is utilized in communication centers to dispatch medical incidents simply by following pre-established written treatment protocols. This is exemplified in a position paper of the National Association of EMS Physicians and the National Association of State EMS Officials. The paper, *Use of Warning Lights and Sirens in Emergency Medical Vehicle Response and Patient Transport*¹⁹, makes eleven statements which identify the need for the involvement of medical direction. One statement suggests, “Emergency Medical Services (EMS) medical directors should participate directly in the development of policies governing emergency medical vehicle response, patient transport, and the use of warning lights and sirens.”

All states require medical direction with varying levels of involvement. In some states, a medical director may be responsible for providing medical guidance and advice to the ambulance service. Medical directors may authorize personnel to provide care within the scope of practice, establish treatment or other protocols, and review cases for quality or disciplinary action.

Regardless of state or local requirements, involving medical direction in all clinical functions is the ticket to a safe and harmonious system.

Telecommunications for Medical Direction

The pre-hospital provider operates as an extension of the medical director. The medical director may be legally responsible for the pre-hospital provider's clinical related actions. The medical director is the authority for pre-hospital care provided by the pre-hospital provider, and is typically responsible for patient care when it falls under the guidelines of the state laws, treatment protocols or the rules and regulations of the AHJ.

There may be different levels of communication with a receiving facility. Pre-hospital providers frequently contact a receiving facility with the intent to notify of their arrival, patient condition and clinical care provided. Under some circumstances, medical consultation is sought or medical orders are requested from the medical control physician.

Electronic communication equipment is one of several tools available to the medical control physician to supervise and direct the pre-hospital provider. Since this equipment is susceptible to failure, the pre-hospital provider must be prepared to provide quality patient care without the resource of on-line medical direction.

The installation of the **First Responder Network Authority (FirstNet)**¹¹ high-speed wireless broadband network now allows responders using the network to securely transmit patient information to a receiving facility or to the medical control physician. This network allows secure live streaming of video which will permit the physician to engage in pre-hospital care by not only hearing but also by seeing the patient in his/ her current environment, giving medical direction and observing effectiveness of treatments.

Every AHJ should have a policy, standard operating guideline or procedure (SOG/SOP) for medical direction. The SOG/SOP or policy may contain:

1. A reasonable attempt should be made by the pre-hospital provider to establish a telecommunications link via radio, secure video, streaming or telephone for medical direction prior to the initiation of clinical procedures requiring on-line medical direction.
2. When reasonable attempts to seek medical direction are not successful, appropriate care should be provided to emergent patients, in accordance with pre-established protocols.
3. "Reasonable attempts" could be defined in terms of proximity to an appropriate receiving facility, the seriousness of the patient's status, and available communications capability.
4. When on-line medical direction is not immediately available, pre-hospital care provided prior to establishing contact with medical control physician must be thoroughly documented and reported to the appropriate medical director or management of the organization for review.
5. Inappropriate care provided without medical direction will result in the loss of provider privileges, at the discretion of the medical director.

Chapter 4

Legal Considerations

In recent years, pre-hospital providers and organizations have realized an increased level of scrutiny, especially in legal proceedings. In addition to being a permanent medical record, a PCR may also serve as a legal document. Those that accept the responsibility of the medical profession must also accept the accountability that comes with documentation.

Would you remember?

Try to recall details from a randomly selected response written over a year ago?

Would the PCR enable a detailed recollection scene conditions, complaints, assessment and/ or treatment?

Could you defend your actions in court?

Legal Terms

The following legal terms are explained using the definition listed in *Black's Legal Dictionary*.²

A **criminal action** is a legal action brought by society (State/Federal) to punish a person. A criminal action does not monetarily compensate the injured party. Any fine collected goes to the government. These laws make certain behaviors illegal and punishable by fines and/or imprisonment. In order for the defendant to be found guilty, the state must show the defendant intended to act as he/she did and acted illegally.

A **civil action** is a lawsuit between parties in a private capacity. A civil action's main purpose is to compensate for an injury sustained through negligence or the violation of an individual's legal rights. Civil actions do not result in imprisonment. The laws make the guilty party financially responsible for an action that was not intended.

A PCR may be utilized for purposes of **discovery** or **deposition** in a legal proceeding. Either the PCR or the pre-hospital provider may be reviewed and scrutinized by the court.

Damages are compensation in money imposed by law for a loss or injury. If damages are awarded, the following terms describe the intent and amount of compensation received by the party the damages were awarded to:

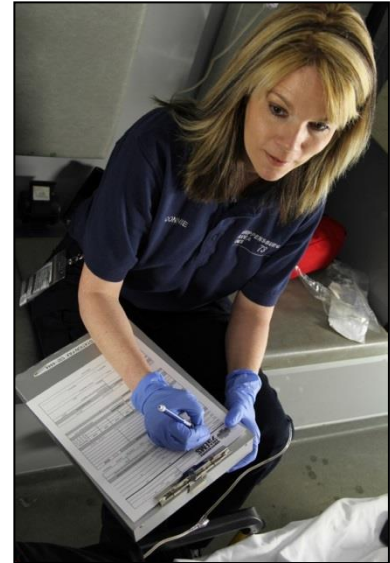
<p>Compensatory</p>	<p>Cover the actual injury or economic loss. Intended to put the injured party in a position he was in prior to the injury</p> <p>Includes: Medical expenses, lost wages and the repair or replacement of property. Compensatory damages are also called actual damages.</p>
<p>General</p>	<p>Cover injuries for which an exact dollar amount cannot be calculated. Usually composed of pain and suffering, but can also include compensation for shortened life expectancy, a loss of companionship of a loved one and in defamation cases.</p>
<p>Punitive or Exemplary</p>	<p>Awarded over and above special and general damages. Punish the party at fault for willful or malicious misconduct.</p>
<p>Special</p>	<p>Covers out-of-pocket costs of the winning party.</p>

Chapter 5

Patient Refusal

The refusal of patient care should be a concern for all health care providers. Many issues arise when patients want to refuse the services of pre-hospital providers. The very fact that someone does not want treatment brings challenges that make most pre-hospital providers uncomfortable. Nevertheless, the **patient refusal** of treatment and/or transport against the advice of medical professional occurs frequently. So what do you do?

First, pre-hospital providers must understand that as healthcare providers they must receive **consent** from the patient to treat them. Many pre-hospital providers mistakenly believe that by virtue of the patient or family calling 911 that consent is automatic. The doctrine of consent requires that all healthcare providers obtain a patient's consent before initiating any examination or treatment. This requires that the providers explain the benefits, risks, alternatives as well as the potential consequences of any healthcare decision. A patient may choose to accept, refuse, or refuse any portion of treatment; as well as, accept or refuse transport by ambulance. Pre-hospital providers should then offer the patient a choice of accepting or refusing the treatment. In any case where a patient refusal occurs, thorough documentation is imperative.



In patient refusal situations, it is the pre-hospital provider's challenge to first determine the mental competency of the patient. Is the patient mentally and/ or legally competent enough? Is the patient capable of understanding the severity or potential severity of the situation? Is the patient free from the influence of drugs and alcohol?

Does the patient understand the potential consequences of refusing treatment, up to and including death? The pre-hospital provider must respect the rights of patients and determine the patient's ability to decide. These are only a few of the common questions which need addressed. Failure to determine mental/legal competency could result in legal consequences for a pre-hospital provider.

Most often pre-hospital providers will begin to determine competency using the initial assessment tool of orientation. A person may adequately demonstrate awareness of self (person), their surroundings (place), the current time and the events. Thus the pre-hospital provider may judge the person competent to refuse when in fact the person may not comprehend what is happening. It is comprehension that pre-hospital providers may need to focus on when determining competency. The patient should demonstrate a capability of understanding the nature of their condition and the risks or benefits of treatments or the refusal of treatment and/or transport.

When dealing with consent issues, a means of consent needs to be identified and understood by the pre-hospital provider. **Informed (expressed) consent**, as defined by *Black's Legal Dictionary*², is consent that is "directly given, either verbally or in writing." Informed (expressed) consent is established when the patient understands the risks and alternatives. **Implied consent**, as defined by *Black's Legal Dictionary*², is consent that is "manifested by signs, actions, or facts, or by inaction or silence, which raise a presumption that the consent has been given." Pre-hospital providers may presume that, if able, the patient would consent to treatment.

Wolfberg³⁶, an attorney with expertise in EMS legal matters, defined consent as "authorization by a patient who is both legally and mentally capable of making decisions, or, in the alternative, by a legally authorized decision maker on the patient's behalf." The definition is clear and the factors which play a role in determining consent will be examined in more detail. A patient must be recognized in the law as having the legal capacity to enter into an agreement for medical treatment. Several classifications exist regarding those that may not have legal capacity.

Minors are those individuals under the age of 18 that require the consent, with few exceptions, from a parent or legal guardian. Parental consent may be witnessed or taken over the phone, if included in treatment protocol. An emancipated minor is one who has graduated from school, is married, is under court order of emancipation (i.e. a minor who has 'divorced' his parents), and, in some states, minors with children. The mature minor may be another exception, where it has been determined by the courts (generally in terminal medical situations) that the minor is competent to make life or death decisions. Wards of the Court (Adjudicated Incompetents) require that consent must come from a court-appointed guardian.

To determine mental capacity, pre-hospital providers need to realize that a patient must be capable of understanding what has happened to them for their consent to be valid. Generally, a patient must be alert and oriented as to person, place, time, and event. Mentally disabled, intoxicated, and seriously injured individuals are common patients encountered by pre-hospital providers who raise the question of mental capacity. The pre-hospital provider's challenge is to distinguish incompetence from bad decision-making. A legally competent patient has the right to make a bad decision even if the pre-hospital provider disagrees with that decision.

The next factor deals with knowledge. A patient otherwise capable of giving consent must also be given enough information upon which to make a reasoned, intelligent decision about emergency medical care and transportation.

May Consent	When
Patient	If competent
Parent	If patient is a minor
Other relatives	If statute permits
Guardian	When court appointed
Healthcare Proxy	When patient appointed
Friends, caretakers, and others	In varying situations

Pre-hospital providers must note that the legally and mentally competent patient can put limitations on treatment and/or transportation. The patient may also withdraw consent at any time after it is given, but before the procedure is done.

Guidelines for refusal situations include:

- Assess the patient’s mental status and legal capacity
- Advise the patient of his medical condition and proposed treatment
- Avoid the use of confusing medical terminology. Be clear and concise
- Ensure that the patient’s refusal is knowing and voluntary
- Exploit uncertainty—if the patient is hesitant, try to talk him into care
- Persist in your efforts—don’t give up after one try
- Protect yourself by thoroughly documenting the situation, the advice given, and the witnesses present (with addresses and phone numbers)
- Medical Direction: Follow applicable protocols; consult a medical control physician and request the physician speak with the patient
- In any situation a patient decides to refuse any aspect of treatment and/or transport, complete a refusal form with a patient signature

To test for competency, pre-hospital providers should perform a cognitive evaluation. This process tests the mental capacity of the patient by evaluating the cognitive or thinking areas of the brain.

A refusal initiated by a pre-hospital provider should be limited to true non-emergency situations. In addition to the above criteria, the pre-hospital provider should conduct a complete patient assessment. The assessment is based on the level of training and available equipment but should include and not be limited to, the vital signs, cardiac monitoring, pulse oximetry, and, if applicable—a blood glucose test. Since abandonment should always be a concern, patients must be given follow-up care instructions. Pre-hospital providers should always include the option that the patient can call for help if necessary.

The pre-hospital provider must always keep the best interests of the patient at the forefront. If your genuine concern for the patient’s well-being is not successful, consider family persuasion. Depending on the situation, law enforcement may already be, or need to be involved. Law enforcement officials carry a certain demeanor, which can be persuasive. No matter what avenue is being used, assure the

involvement of a medical control physician. The medical control physician provides an unbiased opinion and is capable of asking questions not previously considered. The physician can make a distant rational decision of direction which in itself can persuade the patient. The physician can even speak directly to the patient in many situations.

After being informed of the risks, if a competent patient decides to refuse any portion of treatment or transport, require the patient to sign a refusal form. In addition, have a witness, preferably not another pre-hospital provider sign the refusal form. A patient refusal form documents the patient acknowledges the risks of refusing treatment and/or transport against the advice of a pre-hospital provider. If the patient refuses to sign, have the witnesses sign, acknowledging that the patient refuses to sign the refusal form.

If an organization does not have specific forms for patient refusals, the forms are one way to decrease the likelihood of litigation brought against the pre-hospital provider for alleged negligence and failure to provide patient care. The patient refusal form acknowledgement signatures are intended to be in addition to, and not in place of, the PCR.

Public Service Responses

Public service responses are often frequent in the industry and present an opportunity for medical negligence if they are not handled appropriately. These may result from a person calling 911 because of an inability to get up after a fall. Complicating matters more, a significant number of these responses tend to involve elderly or handicapped persons who may not be able to identify if they are truly injured.

Discuss the protocol, policy, or procedure surrounding a “public service” response in your area.

To assist organizations, VFIS recommends considering the following best practices to help reduce the risk of medical liability during a public service response: Be aware of specific state or regional protocols for handling public service or lift assistance responses. These protocols vary from state to state. It is important organizations adhere to the protocols under which they operate.

Resource: VFIS Public Service Response Practices Risk Communique²⁹

POLST: A Medical Order

A nationwide standardization effort has provided opportunity for clarifying documentation of end-of-life care orders. **Physician Orders for Life- Sustaining Treatment (POLST)** may also be referred to as State Orders for Life-Sustaining Treatment (SOLST) or Medical Orders for Life- Sustaining Treatment (MOLST). Forms may differ by state, but generally include similar information. A three-section structure has been widely implemented across the United States through the efforts of **The National POLST Paradigm**.²² The following example references the Oregon POLST²⁵ form.

Note: Identify specific information on POLST and advanced directives applicable within your state or local jurisdiction.

The POLST is intended for only terminal or seriously-ill patients, not the general population. A guideline used by healthcare professionals in determining candidacy for a POLST form includes a reasonable anticipation of the patient dying within the next year.

Section A: Cardiopulmonary Resuscitation (CPR)

Section A is used only if the patient is unresponsive, pulseless, and not breathing. If the “Attempt Resuscitation/CPR” is marked or none of the options in this section are selected, pre-hospital providers are obligated to provide CPR in accordance with local protocols. For specific procedures, reference local protocols for guidance.

A Check One	CARDIOPULMONARY RESUSCITATION (CPR): <i>Unresponsive, pulseless, & not breathing.</i>
	<input type="checkbox"/> Attempt Resuscitation/CPR If patient is not in cardiopulmonary arrest, <input type="checkbox"/> Do Not Attempt Resuscitation/DNR follow orders in B and C .

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While this section is similar to a **Do-Not- Resuscitate (DNR) Order**, the POLST does not replace the need for a DNR Order. DNR orders only apply when a person does not have a pulse, is not breathing and is unresponsive. The POLST and DNR Orders are complementary, but independent documents.

Section B: Medical Interventions

Section B is used when CPR is not required, but the patient experiences a medical emergency that challenges their ability to communicate. This section is divided into three categories that outline the extent of treatment desired and an area where their healthcare professional can indicate specific orders aligned with the patient’s wishes.

For pre-hospital providers, this section provides two key pieces of information. First, information regarding the extent of treatment desired by the patient and any specific medical orders is detailed. Second, this section of the form indicates if the patient wishes to be transported to the hospital or remain at home.

Pre-Hospital Treatment Protocol

If the patient only has a DNR order, pre-hospital provider may be required by protocol to transport the patient to the hospital. Protocols may require medical command physician consultation or other procedures. For specific procedures, reference applicable protocols for guidance.

Transport Determination

If the patient is transported to the hospital, this section will also indicate to healthcare providers at the hospital if the patient desires to be admitted to the intensive care unit (ICU).

B Check One	MEDICAL INTERVENTIONS: <i>If patient has pulse and is breathing.</i>
	<input type="checkbox"/> Comfort Measures Only. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.</i> Treatment Plan: Provide treatments for comfort through symptom management.
	<input type="checkbox"/> Limited Treatment. In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). <i>Transfer to hospital if indicated. Generally avoid the intensive care unit.</i> Treatment Plan: Provide basic medical treatments.
	<input type="checkbox"/> Full Treatment. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. <i>Transfer to hospital and/or intensive care unit if indicated.</i> Treatment Plan: All treatments including breathing machine. Additional Orders: _____

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The POLST Paradigm Treatment Category Explanation:

Full Treatment

The goal of this option is to provide all treatments necessary (and medically appropriate) to keep the patient alive. In a medical emergency patients want to go to the hospital and, if necessary, be put in the intensive care unit (ICU) and on a breathing machine.

Limited Treatment/Select Treatment

The goal of this option is to provide basic medical treatments. Patients want to go to the hospital but do not want to be put in the intensive care unit (ICU) or on a breathing machine. They are okay with antibiotics and IV fluids.

Comfort Measures Only

The goal of this option is to focus on making the patient as comfortable as possible where they are. Patients do not want to go to the hospital. If the patient's comfort cannot be taken care of where they are, transfer to the hospital may be necessary.

Section C: Artificially Administered Nutrition

Section C provides medical orders regarding artificial nutrition if the patient would become unable to consume food normally. In some states, artificial hydration is also covered in this section. This section generally outlines that nutrition should be offered naturally by mouth whenever possible, using the least assistive means.

C Check One	ARTIFICIALLY ADMINISTERED NUTRITION:	<i>Offer food by mouth if feasible.</i>
	<input type="checkbox"/> Long-term artificial nutrition by tube.	<i>Additional Orders (e.g., defining the length</i>
	<input type="checkbox"/> Defined trial period of artificial nutrition by tube.	<i>of a trial period):</i> _____
	<input type="checkbox"/> No artificial nutrition by tube.	_____

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POLST Signatures

The signatures which are required to validate POLST differ by state. These signatures may include: an appropriately credentialed healthcare professional and the patient or their healthcare proxy. Other states may require notarization or consultation with an attorney.

Healthcare professional: Because the POLST is a medical order, an appropriately credentialed healthcare professional is required to sign the form. The credentialing requirements for healthcare providers qualified to sign the order differ by state. The form states the healthcare professional acknowledges with their signature that the orders detail the patient's wishes based upon their medical condition at the time the form was completed and signed.

Patient or Healthcare Proxy: The process to identify a healthcare proxy is a legal process which differs in each state. Likewise, the authorities granted to healthcare proxy may also be unique in each state. While it is not a requirement in every state, the patient or their healthcare proxy may be required to sign the POLST form for it to be recognized as valid. This signature serves as a verification that the patient or their healthcare proxy understands and agrees with the orders contained within the POLST form. Healthcare providers should become familiar with the regulations in their state.

Education

The POLST is intended to provide a basis of communication between the patient and healthcare provider.¹⁷ Through a discussion of end-of-life care, the patient is educated on their healthcare treatment options.²⁷ The POLST form documents this discussion and "provides actionable medical orders" that may be used, if necessary, in the future.^{3,17,22}

In addition to the patient being educated, pre-hospital providers should receive training on POLST and advanced directives. In a survey of pre-hospital providers, POLST forms are reaffirmed as "actionable medical orders" providing a change to the treatment provided in 44% of cases.^{17,26} In 26% of cases, the decision altered transport to the hospital.²⁶ For this purpose, it is important that pre-hospital providers understand and recognize the role of POLST forms in laws, regulations, and protocols pertaining to their

local jurisdiction. It is through education and communication that pre-hospital providers can abide by the wishes of their patients and the standard of care pertaining to end-of-life care.

Advanced Directive: A Legal Document

Advanced Directives fall into two separate types: living-wills and healthcare proxies. These two directives can be completed independently or combined into one document. Differing from POLST, every competent adult can and are encouraged to have an advanced directive.

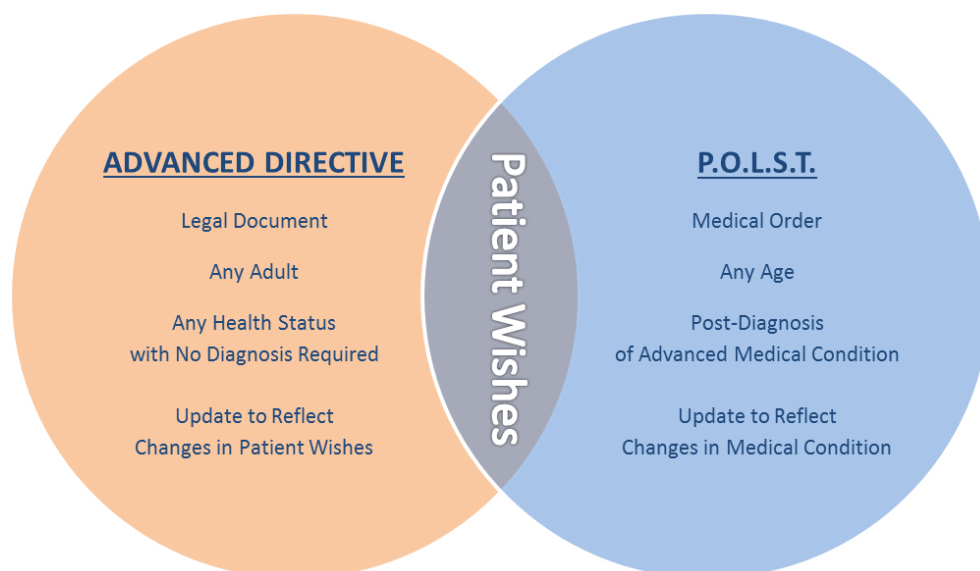
Advanced Directive Signatures

The signatures which are required to validate an advanced directive differ by state. These signatures may include: an attorney or notary, the patient or their healthcare proxy, with or without a healthcare provider.

A **healthcare proxy** is a surrogate, sometimes referred to as a healthcare power of attorney, identified to make healthcare decisions on the patient's behalf when the patient is no longer capable of making healthcare decisions on their own.

A **living will** generally will indicate what an individual wants or does not want if they become terminally ill, incapacitated, or are otherwise no longer capable of making healthcare decisions on their own. This document provides the appointed healthcare proxy and healthcare provider with guidance to make decisions on the behalf of the patient. The authority of an appointed healthcare proxy may differ by state. It is important that pre-hospital providers are familiar with this authority within their state.

The completion of an advanced directive does not necessarily require consultation or approval by a healthcare professional. If the patient only has a DNR order, pre-hospital providers may be required by protocol to transport the patient to the hospital. Protocols may still require medical control physician consultation or detail other procedures honor an advanced directive without a POLST. As mentioned previously, the relationship between POLST and advanced directive are complementary.



Summary

In summary, calls for service not resulting in a patient transport, pose significant risk to the pre-hospital provider. Patient refusals for any reason, or patients, who are treated and not transported, should have special attention given to the detail of the PCR. If the pre-hospital provider has questions, seek on-line (direct) medical direction is highly recommended.

Chapter 6

Documentation Quality

Quality Management in pre-hospital care has come a long way since the 1973 EMS Systems (EMSS) Act¹⁰, which called for the development and implementation of EMS systems across the United States. The EMSS Act identified fifteen components that each state was to meet to have a quality pre-hospital care system. The thirteenth component was “System Review and Evaluation.” Though significantly different than what is known today, it was the predecessor of modern day quality assurance. In this section we will take a look at quality management as it pertains to patient care documentation.

Many times inappropriate situations and errors occur that could have been prevented. **Quality Management** is best defined as a process to determine whether a practice, such as medical technique or system modification, are being used properly, comparing their use with some predetermined standard. The quality process is designed to reduce the chance of error through both a prospective and retrospective process.

Quality management is essential to verify proper patient care, protocol, and standing order compliance and subsequent documentation. When variations occur, they should be evaluated and corrective action should be taken immediately. Medical director involvement is essential when evaluating issues of protocol violation or deviation. With aggressive involvement by organizational leadership, the **quality manager** and the medical director; weaknesses identified in the evaluation process should trigger continuing education programs which address system and healthcare provider needs.

Continuous Quality Improvement

An ongoing process of evaluation, training, and continuing education are the driving forces behind **Continuous Quality Improvement (CQI)**. The goal of CQI is to maximize the performance within an organization, sometimes referred to as performance improvement. Pre-hospital providers should consider the CQI process as an integral part of their everyday function. Quality management is driving force toward the improvement of the profession. The CQI process can easily be measured with patient outcomes and operational efficiencies. Presented in a positive, constructive format, this process will help providers visualize the benefits of CQI and accept its rewards with open arms.

The **Malcolm Baldrige Quality Program**²³ is an excellent model to assist your organization’s quality management efforts. The Baldrige program identifies seven key action areas or categories.

Malcolm Baldrige Quality Program

- **Leadership** involves the efforts of senior leaders and management leading by example to:
 1. Integrate quality improvement into the strategic planning process and throughout the entire organization, and
 2. Promote quality values and CQI techniques in work practices.
- **Information and Analysis** concerns managing and using the data needed for effective CQI. Since quality improvement is based on managing by fact, information and analysis are critical to CQI success.
- **Strategic Quality Planning** involves three major components:
 1. Developing long and short-term organizational objectives for structural, performance, and outcome quality standards
 2. Identifying ways to achieve those objectives
 3. Measuring the effectiveness of the system in achieving quality standards.
- **Human Resource Development and Management** involves working to develop the full potential of the pre-hospital workforce. This effort is guided by the principle that the entire pre-hospital workforce is motivated to achieve new levels of service and value.
- **Process Management** concerns the creation and maintenance of high-quality services. Within the context of quality improvement, process management refers to the improvement of work activities and workflow across functional or department boundaries.
- **System Results** entail assessing the quality results achieved and examining the organization's success at achieving quality improvement.
- **Satisfaction of Patients and Other Stakeholders** involves ensuring ongoing satisfaction by those internal and external to the pre-hospital system with the services provided.

In essence, data from the properly completed PCR should be used to determine system performance and excellence. Questions such as the following should all be addressed:

- Are services timely?
- Do pre-hospital providers adhere to treatment protocols?
- How does performance compare to similar organizations?
- What is the level of patient and stakeholder satisfaction?
- Have quality management efforts been successful at improving performance?
- Do pre-hospital providers understand and “buy in” to the quality management program?

The PCR provides important data for operations of the organization. Areas such as response times, extenuating circumstances, treatment, and transport time intervals, patient condition upon arrival, adherence to established treatment protocols, response to patient treatment, and provider impression of patient condition are some of the pertinent information available to ensure quality reporting.

Pre-hospital providers must accept the principle that a complete, well-documented, PCR must be done routinely, not just when extenuating circumstances occur, such as a problem or question. Pre-hospital providers should also expect that evaluation of the treatment and subsequent documentation will not only improve their ability to develop as a professional, but, also the delivery of emergency care will improve.

Benchmarking is a comparison between actual performance and a standard. The National Emergency Medical Services Information System (NEMSIS)²¹ is an EMS data reporting effort aimed at providing accurate EMS data nationwide. State or local databases may provide additional opportunities to benchmark an organization's performance to other similar organizations. For more information on NEMSIS and EMS data collection, refer to *Chapter 9: Technology*.

Documentation Errors

After gathering all the information that is pertinent to the event, pre-hospital providers are encouraged to put the findings in writing. The success of the PCR will require that a thorough description of the event is transferred from any notes to a hard copy. This step takes forethought and planning. By using a standardized approach to the assessment, the recording of the findings should follow the same flow. This flow can reduce the amount of time and energy it would otherwise take to complete a PCR. When pre-hospital providers do not think about what is written, mistakes occur. The following are actual examples of these mistakes.

- *Patient was alert and unresponsive*
- *The skin was moist and dry*
- *Lab test indicated abnormal liver function*

These errors, by themselves, do not prove the incompetence of a pre-hospital provider, but there is a belief in patient care that documentation follows treatment. In other words, poor documentation is indicative of poor treatment and good documentation is preceded by thorough, complete assessment and treatment.

Pre-hospital providers should devote time to learning how to write and continue to enhance their skill of writing through practice, critique and peer feedback. Careful documentation not only demonstrates professionalism, but increases the organization's ability to receive financial reimbursement for the services provided. An organization should develop a comprehensive quality management program to support evidence-based improvement initiatives.

Correction & Supplemental PCRs

Many agencies request that providers use blue or black ink when completing a PCR. For certain copying purposes, black ink should be used for PCR and ancillary documents.

Correction of documentation errors should follow a distinct format. Simply strike a line through the misspelled word or phrase, and then write error above or alongside the strike-over word or phrase.

Follow the error with the correct word or verbiage—initial and date the error. Do not scribble out the error and never use correction products on these documents. Any attempt to remove the original record could be perceived as hiding information.

Once you have separated or saved and filed the completed PCR, attempts to make corrections must not be made on the original document. A **supplemental PCR** may need to be completed to correct or make an addition to a PCR once the document has been submitted. The need for supplemental PCRs may be required when unusual circumstances arise. For example: if a pre-hospital provider realizes or is made aware of a documentation error, such as omitting oxygen administration as an intervention, a supplemental PCR should be completed. The supplemental form should be completed with all pertinent information; including the date, time and reason for the supplement. Be sure to forward copies to the appropriate agencies.

For an **electronic PCR (ePCR)**, corrections should not be made to the original document after completion. A supplemental PCR is composed after PCR has been filed, electronically “locked”, or otherwise completed. A supplemental PCR should indicate the date and time of completion.



Misspelled words, illegible handwriting, and poor writing skills lead to questioning the credibility of the care provider. Pre-hospital providers should consider these factors before completing the PCR.

Conduct a self-evaluation of your writing and documentation skills to decide whether to write, print, or type the PCR. All healthcare providers should remember that dictionaries and spell check are wonderful tools, however, verifying work selection and proofreading is still needed.

Frequently Misspelled Words		
<i>anaphylaxis</i>	<i>Crepitus</i>	<i>epistaxis</i>
<i>aneurysm</i>	<i>Cyanosis</i>	<i>hiatal</i>
<i>anxiety</i>	<i>Diaphoresis</i>	<i>nauseous</i>
<i>arrhythmia</i>	<i>Diaphragm</i>	<i>xiphoid</i>
<i>asphyxia</i>	<i>Dyspnea</i>	
<i>consciousness</i>	<i>Ecchymosis</i>	

Abbreviations

Many healthcare professionals choose to utilize abbreviations and acronyms. In the absence of a national standard for abbreviations and acronyms, regional variances exist within the field.

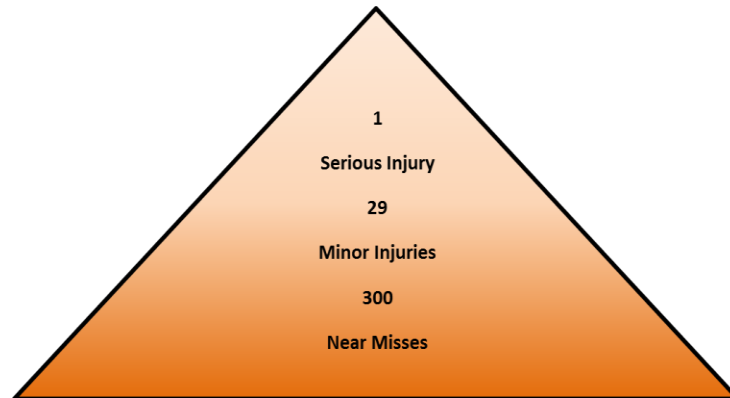
Consequently, abbreviations and acronyms have the potential to impact the effectiveness of PCR documentation. Clear and concise documentation can be negatively impacted by the use of uncommon or undefined abbreviations and acronyms. Use of uncommon or undefined abbreviations and acronyms can be viewed as unprofessional, calling into the accuracy of the PCR. This is very apparent when unprofessional slang is integrated into a PCR such as: “DRT” meaning “dead right there” or “WNL” meaning “we never looked”.

Many states and colleges may publish a list of acceptable abbreviations and acronyms to be used by healthcare providers under their jurisdiction. An organization may elect to adopt an existing list, such as the *Taber Medical Dictionary* or another source. It is necessary to provide guidance to healthcare providers on acceptable abbreviation or acronym use within the organization. Consultation with the organization’s medical director, quality manager, billing specialist, and legal counsel is beneficial.

Chapter 7

Near Miss/Incident Report

Every **incident** or **near miss** offers a potential lesson to be learned. If an incident or near miss was not reported, a lesson has gone unlearned. Recurrence of a minor incident or near miss left uncorrected may cause a serious injury or fatality. All incidents must be investigated to determine the cause of the incident and to ensure that actions to prevent recurrence are implemented. Thorough documentation of incidents and near misses involving patients, pre-hospital providers, or other personnel is essential. For more information on incident reporting and investigation, see *Risk Management for EMS*.³¹



One area of concern for pre-hospital providers is how to document abnormal events that occur during treatment. This would include patient care issues vs. incident reports. Situations that arise during patient care that fall outside of normal or routine care should be evaluated for the necessity of reporting the incident on the PCR or separately on an incident report. Obviously, if a situation occurs that directly impacts or compromises the current status of the patient, it must be documented. Judgment on the detail of documentation is important. All objective findings and assessments must be included on the PCR. Subjective findings or comments that may implicate others or find fault should be reserved for the incident report.

Often, when a bad outcome occurs and the patient or patient's family is seeking a remedy for the wrong all they have to look to is the PCR. Often the author will document what they believe or their perception of the cause of the occurrence. The perceptions of the pre-hospital provider may be influenced by on limited knowledge, anger, conjecture, or bias. Any information documented on the PCR should be factual in nature, while the incident report is the form used to document problems associated with the situation. The documentation on the incident report must be done without bias.

Chapter 8

Privacy & Protecting Health Information

Privacy: A Shared Responsibility

Every healthcare provider, regardless of the number of employees that possess or transmit health information, is a covered entity under **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.⁶ Pre-hospital organizations and personnel carry a responsibility to protect the health information of their patients.

Information that identifies the patient or could reasonably be used to identify the patient is considered **protected health information (PHI)**.

Examples of PHI include:

- Patient name
- Pictures or video of patient
- Patient mailing or physical address
- Patient date of birth
- Patient social security number
- Physical or mental health condition of an individual patient
- Assessment, treatment, or other provision of healthcare of an individual patient
- Payment for the provision of healthcare by an individual patient

HIPAA established national standards to protect patients' medical records and other health information used by health plans, healthcare facilities and healthcare providers in the United States.

The Privacy Rule⁷ established standards for the protection of individually identifiable health information handled by health plans, healthcare clearinghouses, and healthcare providers conducting healthcare transactions in an electronic form. Privacy Rule compliance was required on April 14, 2003 and a year later for small health plans.

The Security Rule⁸ established standards for the protection of confidentiality, integrity, and the availability of **electronic protected health information (ePHI)** for patients. Compliance with the Security Rule was required as of April 20, 2005, and a year later for small health plans.

For more additional information on protecting ePHI, refer to *Chapter 9: Technology*.

Protecting PHI

An array of safeguards must be established to be in compliance with HIPAA. Organizations should establish policies to govern compliance with the provisions within HIPAA. All pre-hospital personnel must be trained and maintain appropriate safeguards for PHI at their organization.

PHI is used and disclosed routinely as an integral part of healthcare operations and treatment. Permitted use and disclosures should be on an as-needed basis to professionals responsible for these functions. Access to PHI should be limited in scope to adequately fulfill their professional responsibilities.

PHI is frequently stored or shared in a variety of forms. Whether in verbal, written, or electronic form, it remains the responsibility of the individual possessing the privileged information to ensure confidentiality is maintained. Safeguards should be put in place, regardless of the PHI form, to combat against unauthorized disclosures. Unauthorized disclosures (unintentional or malicious) extinguish the integrity of the healthcare system entrusted with PHI. Some examples of safeguards include, but are not limited to, shredding of paper notes, securing paper copies of PCR's in a locked box or locked filing cabinet and password protecting an electronic device on which PHI data and information is being entered.

Patient information is critical to quality healthcare systems. HIPAA allows sharing of information for specific permitted uses and disclosures in healthcare operations and treatment. For further information on permitted uses and disclosures, reference the fact sheets published by the U.S. Department of Health and Human Services.

Healthcare professionals cannot disclose PHI in casual conversation around the station, in a public place, on social media, or at home. A patient's right to privacy must be respected.

Resources:

Healthcare Operations Fact Sheet (PDF)

Treatment Fact Sheet (PDF)

HIPAA Enforcement

Pre-hospital providers must do their part to protect the PHI of their patients. The consequences of mishandling PHI can impact both organizations and individuals. While criminal or civil penalties may be imposed by state or federal authorities, the emphasis on the investigation remains to better protect patient information.

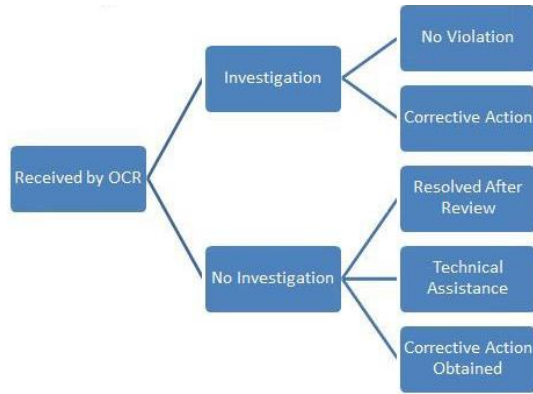
The Enforcement Rule: Health Information Technology for Clinical and Economic Health Act

The Health Information Technology for Clinical and Economic Health (HITECH) Act, a federal law, grants the authority to the Office of the Attorney General in each state to enforce HIPAA violations. The State Attorney General is permitted, under the HITECH Act, to bring about civil charges on the behalf of citizenry under its jurisdiction.

Office for Civil Rights

The Office for Civil Rights (OCR)²⁴ is responsible for investigating complaints, conducting compliance reviews, and educating covered entities in support of compliance. The OCR has the ability to impose fines up to \$100 per violation and up to \$25,000 per year for civil violations. Additionally, OCR works collaboratively with the United States Department of Justice in cases where criminal violations are discovered. Criminal cases may lead to fines of up to \$250,000 and include up to 10 years of incarceration.

Office for Civil Rights Actions



Resolved After Intake or Review	Cases are closed if the complaint, referral, breach report, news report, or other event does not meet specific criteria or is not within the jurisdiction of the office.
No Violation	Cases are closed if no violations are identified.
Technical Assistance	Cases are closed if technical assistance by investigators may serve as an early intervention to reach compliance.
Investigation Completed	Cases are closed if the investigation is completed and no violations have been identified.
Corrective Action Obtained	Cases are closed if corrective action is taken. OCR requires corrective action be taken by the covered entity or business associate to meet minimum compliance expectations outlined in HIPAA. Corrective actions may include specific changes to policy, procedure, training, or safeguards. Technical assistance may be provided if corrective actions were made within a prescribed period of the incident or investigation. Additionally, corrective action closures include settlement agreements between OCR and the entity or business associate.
No Investigation Completed	Other circumstances prevent an investigation from being completed.

Other circumstances where OCR may close a case may include when the office:

- Receives a referral from the Department of Justice for prosecution
- Encounters a surrounding natural disaster situation
- Receives a resolution from state authorities
- Notes steps taken toward compliance
- Deems ineffective use of enforcement resources

Exercise 2

HIPAA Case Studies

Discuss the case studies below:

- Discuss the scenario
- Identify the HIPAA compliance issue the scenario presents
- Describe the steps to reach a resolution of the identified issue

Scenario #1: Voicemail Communications

An Emergency Medical Technician left a voicemail message at the phone number provided by the patient. The voicemail included detailed information concerning the patient's medical condition and specific treatment information. The voicemail was received by the patient's nephew at the patient's residence.

Issue: *Minimum Necessary; Confidential Communications*

Resolution: The organization may implement a new SOP regarding the use of minimum necessary information in voicemail messages. In conjunction with the implementation of SOP, the organization should provide adequate training and integrate the subject into annual refresher training.

Scenario #2: Patient Access to Medical Records

A patient requested a copy of his/her medical record following a transport by ambulance. The organization provided a copy and billed the patient \$100.00 in documentation review and other administrative fees.

Issue: *Access*

Resolution: The organization is permitted, under the Privacy Rule, to charge "a reasonable cost-based fee" to cover the costs associated with copying and postage. The organization should prepare an itemized summary of applicable copying and postage fees, refunding the unreasonable "documentation review" fee to the patient.

Scenario #3: Transfer of Written PHI

A paramedic placed a patient's insurance card on a medication cart outside of the patient's room.

Issue: *Impermissible Uses and Disclosures; Safeguards*

Resolution: OCR clarified in previous investigations that a health insurance card meets the statutory definition of PHI, requiring the appropriate safeguards. The hospital and organization may revise their SOP's regarding the transfer of written PHI, including health insurance cards. In conjunction with the implementation of the new SOP, the hospital and organization should provide adequate training and integrate the subject into annual refresher training.

Scenario #4: Fax Communications

A patient care report was mistakenly faxed to the patient's place of employment instead of the receiving hospital.

Issue: *Safeguards*

Resolution: In a similar case, OCR required a revision be made to the fax cover page to underscore a confidential communication for the intended recipient. In conjunction with the implementation of a new fax cover page, the organization should provide adequate training and integrate the subject into annual refresher training.

Scenario #5: Patient Access to Medical Records

An organization denied access to a patient who had requested to view his/her medical record until the remaining balance was paid for the inter-facility transport six months prior.

Issue: *Access*

Resolution: The Privacy Rule requires that patients have access to their medical record within 30 days of a request, regardless of whether the services have an outstanding balance or have been paid in full. The organization should ensure access to the medical record.

Scenario #6: Disclosures to Law Enforcement

A law enforcement officer verbally requests access to a PCR containing PHI of a patient transported by an organization. The patient was not a suspect, witness, or victim of a crime. The law enforcement officer did not provide a written request and no order of the court was tendered.

Issue: *Impermissible Uses and Disclosures*

Resolution: The Privacy Rule specifies conditions in which law enforcement may obtain PHI. This may or may not require judicial involvement with a subpoena, warrant, or other court order. Unless state law states otherwise, disclosures to law enforcement must be made in response to written requests and when ordered by the court.

Adapted from US Department of Health and Human Resources.²⁴

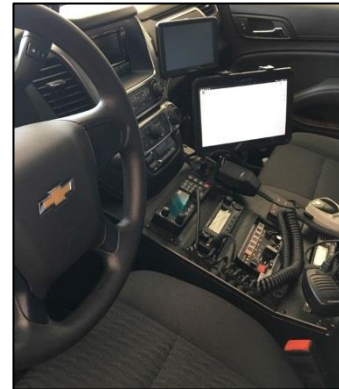
Chapter 9 Technology

Technology innovations will continue to revolutionize the way we live and work. Many organizations now complete their patient care reports electronically using software or web-based program. While it can be expected that the capabilities and functions of **electronic patient care report (ePCR) programs** will differ, many of the same principles for quality documentation in this text apply for ePCR documentation.

Many ePCR programs feature checkbox selections and other types of categorization for the purpose of data collection. While these features provide valuable data for quality improvement initiatives, they do not replace the need for a well-written narrative and may pose a unique set of risks that differ from paper documentation.

Data Collection

The **National Emergency Medical Services Information System (NEMSIS)**²¹ is an EMS data reporting project aimed at providing accurate EMS data nationwide. Many entities have independently recognized the need for EMS data collection, designing databases and systems to fit their needs at the local and state levels. NEMSIS provides “standardized elements and eventually submit the data to a national EMS database,” which can be used to study and further the industry nationwide.²¹



Resource:

www.nemsis.org

HIPAA & Technology

The U.S. Department of Health and Human Services published two regulations under the Health Insurance Portability and Accountability Act (HIPAA)⁶ of 1996, the HIPAA Privacy Rule⁷ and the HIPAA Security Rule⁸.

The Privacy Rule

Standards for Privacy of Individually Identifiable Health Information established national standards for safeguarding PHI.

The Security Rule

Security Standards for the Protection of Electronic Protected Health Information established a national set of security standards for electronically protected health information (ePHI).

In an effort to assist covered entities in complying with the HIPAA Security Rule, the U.S. Department of Health and Human Services has provided a number of tools on the HHS website, including:



Resource:

NIST HIPAA Security Toolkit Application HIPAA Security Risk Assessment (SRA) Tool

Types of Safeguards

Administrative Safeguards

Administrative Safeguards address the assessments, plans, documentation, SOGs/ SOPs, training, and other administrative actions to protect ePHI, such as:

- Policy/SOG/SOP development and enforcement
- Personnel training
- Business Associate Agreements (BAAs)
- Continuity and disaster recovery plans
- Security and risk assessments

As PHI is migrated to electronic formats, it is imperative the information is secured in compliance with HIPAA. Protection of PHI, including ePHI, should be engrained into the practices of personnel through the adoption of SOGs/ SOP's. Technology implementation brings a potential for user error, susceptible to unauthorized disclosure of PHI. To prevent unauthorized disclosure and emphasize the importance of the SOG/SOP, all personnel (pre-hospital providers and other ePCR users) should receive data security awareness training as well as training specific to the ePCR program utilized by the organization. The training should explain the HIPAA legal requirements and established SOGs/SOPs. Leaders must instill patient privacy practices as a priority for the service, enforcing violation of SOGs/SOPs that occur and mitigating any security risks that may exist.

In cases where third-party services are utilized, it is the responsibility of the service to ensure the appropriate **Business Associate Agreements (BAA)** is obtained.⁵ A continuity and disaster recovery plan

should address the security of ePHI in the event of a disaster involving the system or facility (natural or man-made). If “back-up” file storage is used, these redundant files must also be secured.

The assurance of ePHI data security is a continuous improvement effort as technology and threats sophisticate. Regular security and **cyber risk assessments**⁹ will assist in mitigating any vulnerabilities or deficiencies that may exist. A regular security assessment and cyber risk assessment should comprise a review of SOGs/SOPs, effectiveness of established safeguards, and the observed practices of all personnel. The cyber risk assessment provides a “flexible approach” to “reasonably and appropriately” safeguarding ePHI based upon the organization⁵. While there are provisions for flexibility, any steps deemed unreasonable or inappropriate must be documented in the cyber risk analysis.

Physical Safeguards

Physical Safeguards address the security of the physical location or data storage location containing ePHI, as well as the security of transferring electronic data including:

- Facility Access Security
- Workstation Security Hardware

Facility Access Security

Steps must be taken to limit physical access to PHI and systems containing ePHI. The specific steps to be taken are identified following a detailed risk analysis. Possible facility access controls may include: Door locks, security alarms, video surveillance, security guard, or a combination of multiple controls. Established facility access security mechanisms must be in working order and utilized as intended.

Workstation Security

Access to systems or workstations (servers, desktops, laptops, or mobile devices) containing ePHI should be physically secured. The method of securement may vary by device or intended use. Possible workstation security methods may include device docking station locks, cable locks, etc. Hardware such as fingerprint readers, facial recognition, or other technologies may also contribute to workstation security. Workstation use procedures should include a practice to mandate that users log off or otherwise “lock” a workstation before leaving the physical location. ePCR users should be mindful of screens being within the “line of sight” of the public eye. If permitted, the use and handling of removable hardware (CD, USB, etc.) should be addressed with a comprehensive set administrative, physical, and technical safeguard. Likewise, the use and handling of software, network drives, or cloud- based interfaces should be addressed with a comprehensive set of safeguards, which may be part of a Business Associate Agreement (BAA) with a third party.



Technical Safeguards

Technical Safeguards address the configuration and monitoring of hardware, software, or other technologies to limit access to ePHI such as:

- Access control permissions
- Systems monitoring and audit controls
- Integrity controls
- Transmission and network security

Regardless of the size or complexity of the IT infrastructure, it must be understood that “confidentiality is threatened not only by the risk of improper access to electronically stored information, but also by the risk of interception during electronic transmission of the information”.⁸ The risk of a security incident due to lack of understanding or compliance by ePCR users should be mitigated with a few components, such as:

- Access controls, commonly referred to as “permissions”, should be in place to limit access to ePHI to entitled privileged users.
- Integrity controls that track or limit the unauthorized alteration, destruction, or duplication of PHI are necessary, which are commonly complementary to established access controls.

Access Controls

Passwords should carry complexity requirements that prevent password compromise. Passwords should be at least eight characters in length. Passwords should also include a blend of numbers, symbols, capital letters, and lowercase letters. Passwords should not consist of recognizable names or words, such as “password”. If used, symbols should not be used as letter replacements, such as “passw0rd”. Passwords are private and should be kept confidential. Additionally, passwords should not be re-used for multiple systems or used for a variety of personal or business uses, and should be changed frequently.

Workstations should be “locked”, requiring a password to access, any time the user leaves the workstation. Technical controls should be considered to automatically lock after a period of inactivity. Users should not allow anyone to gain access to the system, unless specifically permitted for authorized IT support.

Many organizations with mobile technology have been afforded the ability to collect electronic signatures (e-signatures). A supply of hard copies of all forms where signatures are collected electronically should remain available in the event of technical issues.

Integrity Controls

Appropriately assigning user permissions (user, quality manager, supervisor, administrator, etc.) is a key component of establishing integrity controls. Periodically, through a security assessment, these permissions should be audited. Most ePCR programs have functionality designed to track or limit alteration, destruction, or duplication of PCRs. These functions should also be audited through a security assessment.

Transmission Security

The practice of encryption is the safeguard to assure that ePHI is not compromised when being transmitted from one point to another. Regardless of the means of transmission, a service should ensure the transmission is secure and encrypted.⁸ Proper transmission procedures should be indicated in the SOGs/SOPs and covered in the personnel data security training.

File retention requirements are not included under the HIPAA Privacy Rule, but state laws may establish a specific time period files must be retained. Organizations should establish and/or follow their digital record retention policy. Regardless of the period of time files are retained, the HIPAA Privacy Rule requires that appropriate safeguards be implemented to protect the ePHI. These safeguards must be sustained throughout the life of the file, from creation to destruction.

Security Incident

In the event of a security incident, procedures should be established to govern the appropriate response. A **security incident**⁸ is defined as “the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system”. All aspects of HIPAA compliance aim to reduce the likelihood of a security incident resulting in the compromise of patient privacy. All ePCR users should receive training on data security and security incident response procedures.

Mobile Technology

With mobile technology gaining in popularity and affordability, digital tools may be leveraged in various aspects of patient care and documentation. It is the responsibility of the service to establish SOG/SOP's that outline appropriate use of these tools, ensuring no impedance of the care being provided. Both the pro's and con's should be evaluated when considering new technologies while ensuring access, transmission and integrity controls are in place.

Clinical Media

With the advent of telemedicine or other forms of remote access to clinical care, patient care will improve in both efficiency and effectiveness. **Clinical media** is photography, audio/video recording or streaming, or other multimedia of a patient which is collected by medical professionals.

1. Professional educational use would be media used in academic programs or medical training.
2. Medical publication is clinical media supporting clinical research in medical journals.
3. Documentation is the collection of clinical media to be included in the patient's medical record

Clinical media may be used for the purposes of professional education, medical publication, or documentation. The American Health Information Management Association³³ recommends for patient consent to be obtained, regardless of its intended use, prior to capturing or utilizing clinical media. In addition, a policy should be established in consultation of legal counsel.

Photography

Documentation is intended to “paint a picture” of patient encounters. With cameras being standard features on cellular phones, the ability to take a photograph has never been more readily available. For healthcare providers at a receiving facility, “a picture is worth a thousand words,” especially when accompanied by a pre-hospital provider’s testimony describing on-scene conditions. Furthermore, photographs have the potential to supplement the documentation of physical exam findings. As a component of the patient’s health record, “...images should be provided the same privacy, security, and confidentiality requirements as any other document within the record”.³³ Access controls, transmission controls and integrity controls must be in place. The capabilities and limitations to ePCR program and information technology systems should be considered in determining the proper handling of clinical photography.

Audio/Video (AV) Recording/Streaming

Access to high-quality and affordable AV recording devices present opportunities for use in pre-hospital care. Expanded application the field, in some areas, includes the practice of **telemedicine**. Telemedicine provides the ability to connect physicians at a receiving facility or another remote location with pre-hospital providers in the field using AV teleconferencing. This transmission must be conducted over a secure network, such as the *FirstNet* broadband network. Telemedicine continues to shape the delivery of healthcare and its anticipated growth can be presumed with **Community Paramedicine (CP) or Mobile Integrated Health (MIH)** initiatives.

AV recording, either with a body-worn camera or mounted cameras within the patient compartment, have also been implemented by services for the protection of pre-hospital providers, organizations and the patient. Just as clinical photography becomes part of the patient’s medical record, video does as well. Secure file storage and retention of video files should be considered before implementing AV recording solutions. Specific requirements and restrictions vary by state.

Caution:

Depicting or recording a patient poses a concern for patient privacy. Legal counsel should be consulted prior to implementing any type of video/audio recording/transmission or photography to ensure the practice complies with all applicable laws and regulations. Laws and regulations may require permission to be obtained by the patient, restrict recording in specific circumstances or locations, or prohibit the practice. If video/audio recording/ transmission or photography is permitted and a service elects to leverage the technology, SOP/SOG’s should be established and pre-hospital providers should receive training on the proper procedures and use of the technology. Some organizations may choose to refuse to allow video/audio recording/ transmission or photography altogether.

Electronic Recording Devices

The use of organization-owned and -operated recording devices can be more easily managed to ensure privacy and prevent a security incident. A secured broadband network should be accessible only to authorized agencies, such as an emergency service organization and hospitals. The use of a pre-hospital provider's personal device to capture clinical media should be avoided, as these types of transmissions are not over a secure network. If permitted to be used for recording, a provider's personal device (cell phone) is subject to the same legal requirements and safeguard controls as an organization-owned device.

Summary

This manual has discussed many topics pertinent to patient care documentation. It is important to put what was observed and performed on paper or some form of electronic media. A detailed patient assessment is the foundation for the delivery of quality patient care. Medical direction guides almost every aspect of pre-hospital care and the medical director and medical control physician are resources often forgotten and under-utilized. For many pre-hospital providers, writing a PCR is taken for granted. The legal and ethical implications raise thought provoking realizations—compounded by the progression of technology in the industry.

Patient Care Documentation

Post-Quiz

Name: _____ Date: _____

1. List at least three (3) purposes of a patient care report (PCR).
 - a. _____
 - b. _____
 - c. _____
2. Provide an example of a subjective and an objective patient assessment.

Objective: _____

Subjective: _____
3. Medical direction can be sought:
 - a. By referring to treatment protocols
 - b. When consultation with a medical control physician is indicated by treatment protocols
 - c. In person or via two- way radio, telephone or cellular phone
 - d. All of the above
4. Define the term “deposition” in your own words:

5. A Do-Not-Resuscitate (DNR) is the same as a Physician Orders for Life- Sustaining Treatment (POLST).
 - a. True
 - b. False
6. Before a patient can be considered to be permitted to refuse treatment/transport, what must the pre-hospital provider do first?
 - a. Speak with a bystander
 - b. Determine mental/legal competence
 - c. Consider medical direction
 - d. Abandon the patient

7. Every pre-hospital provider can positively contribute to continuous quality improvement (CQI) of their organization by:
 - a. Leaving patient care reports (PCRs) in draft or unfinished state
 - b. Consulting with on-line (direct) medical direction, when indicated
 - c. Never submitting a supplementary PCR
 - d. All of the above
8. Define the term “near miss” in your own words:

9. What is a concern when using a personally-owned electronic device, such as a cell phone, to collect clinical media?

10. Your organization is a “covered entity” and subject to HIPAA compliance.
 - a. True
 - b. False

Appendix

Glossary

Administrative Safeguard: *a safeguard using administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information.*

Advanced Directive: *a legal document (such as a living will) signed by a competent person to provide guidance for medical and health-care decisions in the event the person becomes incompetent to make such decisions.*

Authority having jurisdiction (AHJ) *an organization, office, or individual responsible for enforcing the requirements of a code or standard, or for approving equipment, materials, an installation, or a procedure.*

Business Associate Agreement (BAA) *a person or entity, other than a member of the workforce of a [HIPAA] covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information.*

Civil action: *a lawsuit about a person's rights.*

Clinical media: *is photography, audio/video recording or streaming, or other multimedia of a patient which is collected by medical professionals.*

Community paramedicine (CP) **See:** *Mobile Integrated Healthcare (MIH)*

Consent: *to give assent, permission or approval.*

Continuous quality improvement (CQI): *a quality management philosophy used by organizations to better their processes.*

Criminal action: *relating to crime or to the prosecution of suspects in a crime.*

Cyber risk assessments: *a review of cyber security standard operating procedures (SOPs) and guidelines (SOGs), effectiveness of established safeguards, and the observed practices of all personnel.*

[Cyber] security incident: **See:** *Security Incident*

Damages: *compensation in money imposed by law for a loss or injury.*

Deposition: *testimony taken down in writing under oath.*

Discovery: *acquisition of notice or knowledge of given acts or facts.*

Disposition: *the destination of a patient after medical treatment.*

Do Not Resuscitate (DNR): *a request to withhold resuscitation attempts which may be a part of an advanced directive or complementary to a POLST.*

Electronic patient care report (ePCR) programs: a software or web-based computer program used to produce an ePCR.

Electronic PCR (ePCR): a PCR in the electronic form.

Electronic protected health information (ePHI): any PHI in the digital or electronic form. **See:** Protected health information (PHI).

First Responder Network Authority (FirstNet): a secure broadband network established for exclusive use for emergency services. (www.firstnet.com)

Health Insurance Portability and Accountability Act of 1996 (HIPAA): federal act which established national standards to protect patients' medical records and other health information used by health plans, healthcare facilities and healthcare providers in the United States.

Healthcare proxy: a surrogate, sometimes referred to as a healthcare power of attorney, identified to make healthcare decisions on the patient's behalf when the patient is no longer capable of making healthcare decisions on their own.

Implied consent: is consent manifested by signs, actions, or facts, or by inaction or silence, which raise a presumption that the consent has been given.

Incident: an event which may cause personnel injury or death, property damage, or criminal or civil liability.

Informed (expressed) consent: is consent that directly given, either verbally or in writing.

Living will: a form of advanced directive which generally will indicate what an individual wants or does not want if they become terminally ill, incapacitated, or are otherwise no longer capable of making healthcare decisions on their own.

Malcolm Baldrige Quality Program: a seven-part model for quality management.

Medical control physician: a physician who provides on-line (direct) medical direction.

Medical direction: consultation or orders provided by a physician to a pre-hospital provider.

Medical director: a physician who provides off-line (indirect) medical direction. A medical director may also function as a medical control physician.

Mobile Integrated Health (MIH): non-emergency mobile healthcare services provided by pre-hospital providers, also referred to as "Community Paramedicine" (CP).

National Emergency Medical Services Information System (NEMSIS): a national EMS database. (www.nemsis.org)

Near miss: *an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.*

Objective assessments: *assessments which are “hands on”— what is observed, felt or measured.*

Off-line (indirect) medical direction: *medical direction provided via written protocols that establish policy and provide step- by-step procedures for the provision of patient care at both the ALS and BLS levels by a medical director.*

On-line (direct) medical direction: *medical direction provided either in person or via two- way radio, telephone or cellular phone by a medical control physician.*

Patient care report (PCR): *a record of events and patient care actions taken by a pre-hospital provider.*

Patient refusal: *to decline treatment and/or transport against the advice of medical professional.*

Physical Safeguards: *a safeguard intended to address the security of the physical location or data storage location containing ePHI, as well as the security of transferring electronic data.*

Physician Orders for Life- Sustaining Treatment (POLST): *end-of-life care orders intended for only terminal or seriously-ill patients, a medical order.*

Protocols: *See: Off-line (indirect) medical direction.*

Protected health information (PHI): *information that identifies the patient or could reasonably be used to identify the patient is considered.*

Public service responses: *a request for assistance, such as a “lift assist”, from an allegedly healthy and uninjured person.*

Quality management: *a process to determine whether practices, such as a medical technique or system, are being used properly, comparing their use with some predetermined standard.*

Quality manager: *individual responsible for quality management.*

Security incident: *the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.*

Subjective assessments: *statements provided by the patient, family member(s) and/or bystanders.*

Supplemental PCR: *a method to correct or make an addition to a PCR once the document has been locked or submitted.*

Technical Safeguards: *a safeguard to address the configuration and monitoring of hardware, software, or other technologies to limit access.*

Telemedicine: *to connect physicians at a receiving facility or another remote location with pre-hospital providers in the field using AV teleconferencing.*

The National POLST Paradigm: *nationwide initiative to standardize POLST programs. (www.polst.org)*

Treatment protocols: *See: Off-line (indirect) medical direction.*

Incident Report

Reference Number: _____ Date: _____ Shift: 24-08; 08-16; 16-24

Incident Type: _____

Unit #: _____ Time of Incident: _____ Time of Report: _____

Personnel Involved: _____

Incident Description:

(continue on separate sheet if necessary)

Signature: Provider completing report

Signature: Supervisor receiving report

-Department Use Only-

Resolution: Date: _____ Time: _____

Signature: Investigating Supervisor

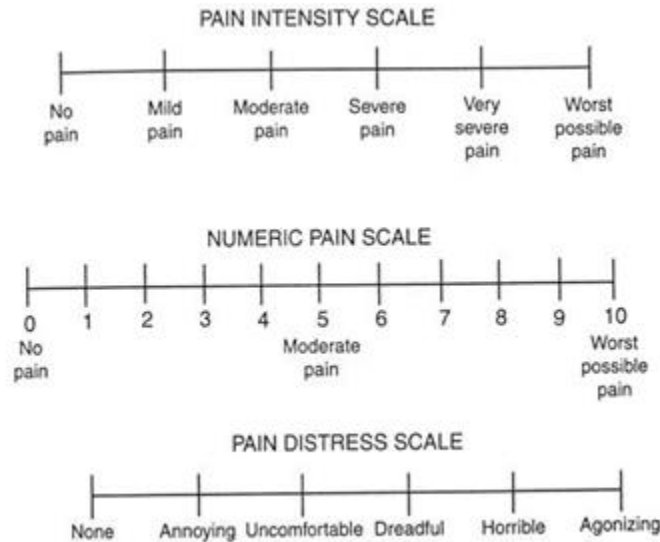
Signature: Chief of Operations

Sample SOG

Standard Operational Guidelines for Patient Care Documentation

- I. **Purpose:** To outline the appropriate means of documentation and situations that requires documentation. To outline those situations that may result in a monetary charge.
- II. **Scope:** All documentation will be done with an ePCR and must be completed within 24 hours of dispatch. The data section must be completed for all calls prior to leaving for the day.
- III. **Situations Requiring Documentation:**
 - a. All 911 dispatches, routine transfers, and inter-facility transfers where patient contact is made must be documented in accordance with organizational guidelines.
 - b. Anytime a unit is acknowledged by the communication center as “responding,” proper documentation must be completed.
 - c. If a responding unit is canceled prior to being acknowledged by the communication center as “responding,” there is no need to document the incident.
 - d. Standbys and special events also require documentation (see section 4.4.)
- IV. **Documentation:** All incidents will be documented using the following format:
 - a. Data: (All events)
 - i. Call number
 - ii. Date of call
 - iii. Service name and Service number
 - iv. Dispatch and Available times
 - v. Disposition of call
 1. ALS—Patient receiving ALS care BLS—Patient receiving only BLS care
 2. AMA—Patient refusing care and/or transport, receives no care beyond assessment
 3. DOA—Expired patients where no care is initiated
 4. Treat—No Transport
 5. No patient

Adult Pain Rating Scales



Location

- Area of the body
- Diffuse or localized
- Radiates and area involved

Quality

- Stabbing, knife-like
- Throbbing
- Cramping
- Vise-like, suffocating
- Searing, burning
- Superficial, deep

Intensity

- Rate on scale: 0-10 (0 = no pain, 10 = most pain ever experienced)

Factors Associated with Pain

- Nausea
- Vomiting
- Bradycardia, tachycardia
- Profuse perspiration
- Apprehension of anxiety

Precipitating Factors

- Motion affecting incision area (e.g., coughing, turning, deep breathing)
- Fear and emotional distress
- Inflammation or infection
- Trauma
- Disease state

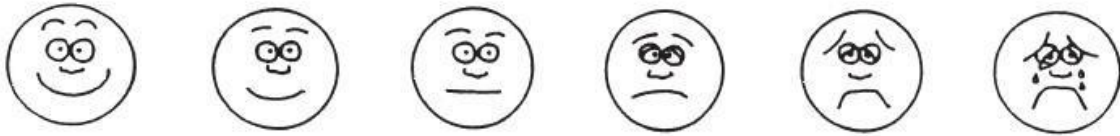
Aggravating Factors

- Position changes
- Environmental stressors
- Fatigue
- Inadequate pain relief measures

Alleviating Factors

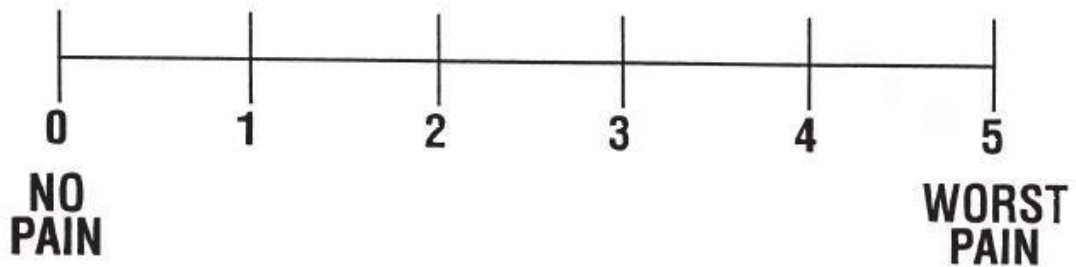
- Position change
- Medications
- Biofeedback
- Visualization
- Relation Techniques
- TENS
- Massage

Pediatric Pain (Intensity) Rating Scales



Explain to the child the facial expression scale values represent pain or discomfort they feel. Ask the child to choose the face/number that best describes how he/she feels now.

Note: Use the method most appropriate for the child's development level.



Ask the patient to point to the number which represents his/her current pain level.

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