OPERATIONS: EMS DOCUMENTATION

1. An EMS patient care report form (PCR/ePCR) will be completed accurately and legibly to reflect the patient assessment, patient care and interactions between EMS and the patient, for each patient contact which results in some assessment component.
2. Every patient encounter by EMS will be documented. Vital signs are a key component in the evaluation of any patient and a complete set of vital signs is to be documented for any patient who receives some assessment component.

PURPOSE

To document total patient care provided including:

- Care provided prior to EMS arrival.
- Exam of the patient as required by each specific complaint based protocol.
- Past medical history, medications, allergies, living will / DNR, and personal MD.
- All times related to the event.
- All procedures / medications administered and their associated time and patient response.
- Notation of treatment authorization if any deviation from protocol / narcotic use.
- Reason for inability to complete or document any above item.
- A complete set of vital signs.

PROCEDURE

1. The patient care report should be completed as soon as possible after the time of the patient encounter.
2. All patient interactions are to be recorded on the patient care report form or the disposition form (if refusing care).
3. The patient care report form must be completed with the above information.
4. A copy of the patient care report form should be provided to the receiving medical facility within 24 hours.
5. A copy of the patient care report form is to be maintained by the EMS entity.
6. A copy of the patient care report shall be given to the Medical Director per his or her order.

OPERATIONS: EMS DOCUMENTATION – cont.

- Document the contact and any on-line medical direction that is given. If you are not able to reach Medical Control, document attempts and cause for failure. Always describe the circumstances of the call. It is very important to document the mental status of the patient who refuses transport. Any refusal call should also note the contact of Medical Control.
- The times vitals are taken must be noted. Vitals should be repeated every five minutes, or following any medical treatments. Vitals should be completely recorded. If a part of the set of vitals is omitted, the reason should be clearly given.
- Use accepted medical abbreviations and terminology. Do not make them up.
- Make an effort to spell correctly. Become familiar with the correct spelling of commonly used words.
- The name, dose, route, time and effect should be documented for all medications administered.
- When standards are followed such as in a full arrest; every step should be documented. To write "ACLS protocols followed" is **NOT SATISFACTORY**.
- When providing copies of the PCR/ePCR for the Emergency Department and the Medical Director, be sure to include all associated and appropriate patient care documentation and EKG's with patient identifiers.
- A complete set of times must be recorded on every report.

Documentation of Vital Signs:

1. An initial complete set of vital signs includes:
   - Pulse rate
   - Systolic AND diastolic blood pressure
   - Respiratory rate
   - Pain / severity (when appropriate to patient complaint)
   - Pulse Oximetry
   - 12 lead EKG printout and transmitted
2. Every attempt should be made to auscultate blood pressures, however if unable to auscultate, a palpated pressure will suffice.
3. **Medical Control should be contacted if the patients mental capacity is in question**
4. Document situations that preclude the evaluation of a complete set of vital signs.
5. Record the time vital signs were obtained.
6. Any abnormal vital sign should be repeated and monitored closely.