SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 6050
Effective Date: 10/01/2020

Documentation of Prehospital Care

I. PURPOSE

To establish documentation standards for the purposes of medical record keeping and quality improvement practices.

II. POLICY

A. Patient Care Documentation Standards
   1. An agency-approved Patient Care Report (PCR) shall be completed for all patient contacts.
   2. PCR's should be completed as soon as operationally possible but no later than end-of-shift, or within 24 hours, whichever comes first.
      a) A copy (paper or electronic) will be provided to the receiving facility.
      b) For patients transported Code 3, providers should attempt to complete and transfer the PCR prior to departing the hospital, unless prevented due to technical issues or EMS system demand.

III. NON-TRANSPORTING EMS PROVIDERS

A. Non-transporting providers working in either an ALS or BLS capacity shall document findings, interventions, times, and other relevant patient care activity on an agency-approved first responder form (paper or electronic).
   1. The form shall be made accessible to transporting providers and receiving facilities as soon as feasibly possibly, or by end of shift, whichever comes first.
   2. Provider agencies shall retain a copy of the form in accordance with medical record regulations.
   3. Patient refusals completed by non-transporting providers shall be documented on a PCR, in accordance with Policy 4040.

IV. DOCUMENTATION REQUIREMENTS

A. Providers shall make all effort to obtain, at minimum, the following information:
   1. <u>Initial Response Fields</u>
      - Dispatch-generated Incident Response Number
      - The date and estimated time of incident
      - The time of receipt of the call
      - The time of dispatch to the scene
      - The time of arrival at the scene
      - The time of first medical contact by an EMS provider
      - The location of the incident

2. Patient Demographics and Care Fields
    - Name
    - Age
    - Self-reported gender
    - Self-reported race
    - Weight (mandatory for pediatrics, may be estimated or caregiver-reported)
    - Address
    - Primary Impression
    - Chief complaint
    - Vital signs (Intervals: 10-15 minutes if stable, 5 minutes if unstable)
    - Physical assessment
    - Any emergency care rendered and the patient's response to such treatment
    - Patient disposition
3. Transport and Transfer of Care Fields
    - The time of departure from scene
    - The time of arrival at receiving facility (if transported)
    - The time of patient care transfer to a receiving provider
    - The name of receiving facility (if transported)
    - The names of the transporting Paramedics and/or EMTs
    - Signatures of the transporting Paramedics and/or EMTs

B. If a provider is unable to obtain the minimum required documentation listed above, the circumstances shall be documented in the narrative section of the PCR.

C. The PCR should include findings, interventions, and other information related to patient care that was performed or obtained by another provider prior to arrival.

D. Providers shall document base contacts with Base Hospital Physicians in the PCR, including time of contact and physician name.

V. SPECIAL CIRCUMSTANCES

A. Refer to the following policies for special documentation requirements:
1. Policy 4040 – Procedure and Documentation for Non-Transported Patients
2. Policy 4041 – Scene Management, Physician On-Scene and Mass Gatherings
3. Policy 4043 – EMS Use of Physical Restraints
4. Policy 7010 – Emergency Medical Services at Special Events
5. Policy 8000 – EMS MCI Policy

VI. AUTHORITY

California Code of Regulations, Title 22, Sections 100170 & 100171

APPENDIX A: NOTABLE DATA ELEMENTS

The following references highlight important patient care information for specific cases to promote thorough documentation and enhance quality improvement practices and research.

1. **Cardiac Arrest**
    a) Accurate intervention and medication times
    b) Patient response to interventions
    c) ROSC or termination time
    d) AED/CPR prior to arrival, including name of provider
2. **Chest Pain/Acute Coronary Syndrome**
    a) Time of Aspirin administration
    b) Detailed EKG findings
    c) Room-air SpO2
    d) Time of symptom onset (in HH:MM format)
    e) Time of hospital notification for STEMI Alert
3. **Stroke**
    a) Cincinnati Prehospital Stroke Scale findings
    b) Blood glucose reading
    c) Time of symptom onset (in HH:MM format)
    d) Time last seen normal (in HH:MM format)
    e) Time of hospital notification for Stroke Alert
4. **Advanced Airway**
    a) Time of adjunct placement
    b) Reason for advanced airway placement
    c) Room-air SpO2
    d) End tidal CO2 (waveform and ETCO2 number)
    e) Reconfirmation of adjunct placement after all patient movement
5. **Severe Agitation and Use of Restraints**
    a) Patient behavior that necessitated restraint usage
    b) Type of restraint or adjunct used
    c) Time restraint was applied
    d) Reassessment of patient condition every 5 minutes post-restraint
    e) Respiratory monitoring using end tidal CO2 (if chemical sedation performed)
    f) Blood glucose reading
6. **Near Drowning**
    a) Description of fluid (salt or fresh water, temperature, etc.)
    b) Duration of submersion
    c) Height of fall/mechanism of injury
    d) Evidence of head/spinal trauma or other associated injuries
    e) Neurological status
    f) Respiratory findings