

EI Dorado County EMS Agency Accreditation Required Reading: Article 2

If You Didn't Write It, You Didn't Do It

By Drew Fried

EMS professionals—both paid and volunteer—will agree that the hardest part of their job is the paperwork. What most of them do not understand is that proper documentation is for their protection. EMS documentation is a vital part of being a prehospital care provider. Good documentation is one of the best tools to protect you from successful lawsuits. You might be the best EMT in the world, but it means nothing if you cannot prepare the required documentation.

A Patient Care Report (PCR) is a legal document. It serves as the record of care you and your crew provide to the patient. The PCR becomes part of the patient's hospital record, describing your assessment of the patient and the care you or any bystander may have provided.

PCR formats differ throughout the country. Most states require the use of a standard format. Others leave the monitoring of documentation to the local department of health or even the local agency. With the growing use of computer technology, some PCRs are entered directly into laptop computers or PDAs, and others are prepared using a Number 2 pencil on a Scantron-type report. The pitfall of electronic PCRs is that they are not prepared in your own handwriting and therefore do not provide you a sense of ownership. Also, a Scantron-type report does not give you as the care provider an opportunity to write in your own factual comments. You must rely on the check boxes on the PCR to cover all of your assessment and treatment.

The most commonly used PCR is a written report that combines the check-off boxes and an area where you can add your assessment findings and record of treatment. This type of report gives you the most protection.

Who Will Read Your Report?

In the course of business, your PCR will be reviewed by a number of people. The first will be the hospital staff, which might review the PCR to check your patient's status at the scene and during transport. The staff will also need to see what treatment you provided. If your supervisor responds to the scene, he might need to see the report to determine if the proper care was provided.

Depending on your state's regulations, your squad might be required to conduct quality assurance (QA) reviews of members' PCRs. To conduct the review, the QA coordinator needs to read your PCRs to make sure that there are no errors.

If necessary, your agency's lawyer might need to review the PCR. This could be in preparation to defend you in a court or as evidence related to a crime. During the course of the trial, the plaintiff's lawyer will have access to your PCR, too.

PCR Preparation

The most common error on a PCR is one of omission. It is important that PCRs are filled out clearly, completely, and carefully. Take your time preparing the report. Make sure you have completed all of it before you submit it to the hospital staff. Remember: The run is not done until the paperwork is complete.

In preparing your report, make sure to include only the facts. In the narrative sections, include any significant findings and important observations about the patient and the scene. Remember that objective information is information that is verifiable and supported by fact. When you do record subjective information, be careful to record only pertinent information about the medical circumstances of the call.

Your opinions or feelings should not be included in the report at any time. Your PCR is not the place to present your own conclusions about the incident. Your report should include normal everyday language and should not include radio codes. Since lay people could read your report, use only standard abbreviations. Spell words correctly, especially medical terms. Above all, fill in the form completely.

Falsification Issues

Prehospital care providers frequently make grave mistakes when filling out PCRs. Some of these errors could cost you your job, your certification, and even your freedom.

The first thing to remember is that if you forget to write something down, the procedure to add it after you submit the report can be somewhat involved. The additions on the agency's copy should be in different color ink and in the same person's handwriting. You then must make sure that a copy of the revised report makes it into the patient's hospital record.

It's a good idea to send a notarized letter along with the revised report, requesting that the revised report be placed in the hospital record. Advise the hospital not to discard the original record; you want to establish that there was an omission you corrected.

Should you realize that you made a mistake before you submit the report, the procedure is a lot easier. First, do not try to cover up the error with correction fluid or by erasing it. Put one line through the error, so your mistake can still be seen. Write the corrections next to the error, along with your initials, so it looks like this:

The patient was complaining of pain in his ~~left~~^{DF} right hand.

The worst thing you can do on a PCR is lie. All of your entries must be truthful, including vital signs. Record only vital signs you actually take. Never indicate any treatment that did not take place or untruthful assessment findings.

Refusal of Care

Many times, EMTs arrive at the scene only to find that the patient does not want to be treated or transported to the hospital. Before leaving the scene, try to persuade the patient to go to the hospital. You will need to inform the patient why he should go to the hospital and what may happen if he chooses not to go. Make sure to document any assessment findings and all emergency care you provided. Document that you have explained the consequences of failing to go to the hospital and exactly what you told the patient. If appropriate, offer alternative methods of getting care. Make sure the patient reads and signs the medical release (RMA), and have a family member, police officer, or bystander as a witness. Remember, your partner cannot be the only witness.

When To Use a PCR

A PCR should be used for every patient on every call to which an EMT or paramedic responds. It will be the EMT's only record of care given at the scene. The PCR not only protects the prehospital care provider but also gives the hospital access to information about the patient at the scene and during transportation. The information recorded by the prehospital care provider documents whether the provided treatment helped the patient and what additional assessment findings were made during transport. A PCR also provides a standard format for documenting the care given.

Special Documentation

When assisting with the administration of both prescribed or agency-carrying medications, the prehospital care provider should note the name of the medication and the dose taken by the patient prior to the arrival of EMS. It is important to note the time and dosage of medications administered to or taken by the patient. Any time a patient receives medication, any changes in the patient's condition should be documented.

Treatment Documentation

One of the most important things to document clearly is the treatment of the patient. When documenting treatment, include all of the treatments provided. Some PCR forms do not leave enough room for treatment documentation but provide check boxes next to standard treatments. EMTs need to document treatment in greater detail than these check-off boxes allow. By checking "airway maintenance," EMTs are not released from having to document the response to the airway management. It is important for EMTs to get into the habit of writing a narrative describing the care given.

Good PCR Is a Tool

Remember that your PCR is your only proof of the patient's condition or the treatment you gave. It sometimes takes years for a civil case to go to court, so your PCR will be the only thing that will refresh your memory. A good PCR is a tool for you; an improperly completed one is a weapon against you. Your PCR is a reflection of you, so remember that spelling, grammar, and penmanship count. Write a clear, complete, and careful report.

References:

Emergency Care 9th Ed.; O'Keefe, Limmer, Grant, Murray, and Begeron: Prentice Hall: 2001.

New York State Pre-hospital Care Report Manual

Prehospital Emergency Care; Joseph J. Mistovich, Brent Q. Hafen, Keith J. Karen, Prentice Hall, 2000..

MVA sample narrative

"On arrival at the scene of an MVA, manual stabilization of the neck was held from the front of the patient. A second crew member entered the vehicle and positioned himself directly behind the patient and took over stabilization of the head and neck. Pulse, motion, and sensitivity (PMS) checked in all four extremities. A stiff neck collar, size regular, was applied. KED applied to the patient. Pulse, motor, and sensitivity checked in all four extremities. Removed from the vehicle on a long trauma board."

If you were only to check off the box indicating "spinal immobilization," you would not have indicated anywhere that you applied a cervical collar, checked for PMS, or removed the patient on a long trauma board. You could try to defend that you applied the collar, but the ground rule is, "If you didn't write it down, you did not do it."

Documentation includes all significant positive and negative assessment findings. If the patient's condition changes, write it down. The hospital needs this information. This would include the patient's denying pain, difficulty in breathing, or a loss of consciousness.

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