

**SECTION: G-10**

**TITLE: EMS Incident Documentation**

**REVISED: November 1, 2017**

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**GENERAL COMMENTS:**

This document establishes minimum Ada County-City Emergency Medical Services System (ACCESS) charting requirements, and is intended to establish a uniform system-wide standard for documenting patient encounters. Not only is the data used for the System's planning efforts, but as a recipient of various federal grants we are required to participate in the National Incident Fire Reporting System (NIFRS) and the National Emergency Medical Services Information System (NEMESIS) and to stay current with monthly State Incident Reporting requirements.

**Patient Care Charting (EMS)**

Charting every patient contact fulfills many important requirements. This document is not intended to define one charting style as better than another. This document is not intended to eliminate existing charting styles that already satisfy minimum department requirements.

This policy is to ensure:

- that new employees have direction concerning acceptable documentation
- that all employees understand the components that must be included in every chart
- that the department and the provider's liability is greatly reduced when charting is consistent, accurate and thorough.

Patient care reports (PCRs) are completed for four reasons:

- 1) to provide a legally defensible account of the call, the assessment and the treatment
- 2) to provide a route of communication between providers for educational purposes
- 3) to provide the basis for billing
- 4) to provide continuity of care between pre-hospital providers and ED/hospital staff

A PCR (and associated paperwork) should be the only representation of the call that is generated. No other material (e.g. written, electronic, photographic) should be generated or personally kept (e.g. 12-leads that have the patient's name and DOB).

A well written chart will allow the provider (author) to easily recall all medical and non-medical details. A well-written chart should anticipate questions possibly posed by a variety of readers. A complete chart will answer all questions about the situation, assessment, treatment and disposition of the patient and provides an accurate account of all details.

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### **SOAP Charting**

ACCESS uses a modified SOAP charting format and currently employs software by ESO in both a web-based and a mobile version. The mobile version of this software is available on the MDT tablet in the apparatus and it allows crews to chart at any location. Charts can be uploaded (sync'd) with the cloud and opened in the web-based

version for updating and completion. The tablet also provides the ability to upload information directly from a cardiac monitor. This file becomes part of the PCR, and allows for review of rhythm strips, 12- leads, defibrillations, cardioversions, and vital signs. The web-based version is almost identical. The web version also provides the ability to scan and attach pertinent paperwork to a chart.

- Subjective is the narrative section in ESO
- Objective is the assessment and vitals section in ESO
- Assessment (field diagnosis) is in the narrative section in ESO
- Plan is the procedures and narrative sections in ESO

### **Narrative**

The narrative is a free text field in ESO that should be reserved for information told or given to a provider, or information not covered in sufficient detail elsewhere in the chart. It should include several basic elements that may enable a provider to produce an easily understood story with minimal effort.

Those elements could include:

- Reason the crew(s) was dispatched to the door/scene (history of present illness/injury).
- Chief complaint
- How the patient was found – environment, body position, etc.
- An improved limb-lead description (if desired)
- Discussion about compliance with medications
- Recent trauma/illness
- Patient safety
- Hospital destination
- Patient changes during course of call
- Anything not otherwise documented that is pertinent
- Procedures or treatment plan that were not initiated due to resistance by the patient, situational conditions, scene factors, etc.
- Treatments and outcomes or responses that are not detailed in the drop-down menus of ESO

### **Charting by Exception**

By using ESO, providers may elect to employ a method called “Charting by Exception” (CBE). CBE is the practice of only documenting unusual or unexpected findings. This type of documentation assumes that all findings are normal unless an abnormal finding is observed.

In the case of ACCESS, CBE will ONLY be used in the “Assessment” portion of the PCR to document physical exam finding and NOT for responses to interventions. Strict adherence to use of a comprehensive physical exam, minimizing use of the “Not Assessed” selection in the “Assessment” portion of an ESO chart, and generous use of the “Comments” fields found on the “Assessment” pages is recommended.

In the “Assessment” section of ESO, the provider is offered four (4) choices:

- Not Assessed (default) - the body location was not observed, palpated, or examined in any way. It seems apparent that, by using at least these three criteria, use of “Not Assessed” would be extremely limited.
- No Abnormalities\* - the body location has been either observed, palpated, and/or directly examined, and no abnormal findings have come from that exam
- Selection of fixed check boxes - a selection of any one of these precludes use of either “Not Assessed” or “No Abnormalities”, and should be followed with a description in the text field of the body location
- Use of the “Comments” field in combination with “Not assessed” or “No abnormalities” to explain assessments not explained adequately in the checkboxes.

*\* The definition of “no abnormality” is patient dependent. You may note that your patient has bilateral below-the-knee amputations. While this is not normal, it is normal for this patient. This type of finding should be documented in the notes section or the narrative and noted as normal for that particular patient.*

When using the “Comments” field in the Assessment tabs, accuracy and descriptive language will help color a descriptive picture for those reviewing the chart. Provide adequate descriptive language so those that did not see the patient, but are reviewing the chart, have an accurate picture of the assessment findings.

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### **Mandatory Charting Elements**

Mandatory charting elements are defined due to a variety of needs. These elements are dictated by:

- Administrators of ACCESS
- Billing office
- Medical Directors
- Idaho State Bureau of EMS

When charting, please include all the following in every PCR (where applicable):

- Every chart must be signed by the provider(s).
- Every patient should have an applicable head to toe exam charted (some exceptions apply).
- Every patient should have at least one complete set of vitals. This includes blood pressure, heart rate, and respiratory rate.
- Transported patients should have a minimum of two sets of vitals.
- Interventions performed prior to the arrival of ACCESS providers are to be documented in the flowchart.
- Complete the appropriate specialty tabs.

### **Treat and Release/Refusal Charting**

These types of charts present some of the greatest liability in EMS. In the case of most refusals or treat and release charts, it is not the care rendered that produces a problem, it is poor documentation. A Refusal or Treat and Release PCR should be written with greater attention to details and an understanding that each appropriate portion of the chart must be completed with great detail.

Elements that should be included:

- Pertinent denials
- Offer of transport must also be documented
- Outline of the discussion about the patient's refusal
  - Was the decision mutual or against medical advice (AMA)?
  - Was Medical Direction contacted?
    - Any Medical Control contact should include the name of the MD, the facility contacted, and a summary of the discussion
  - Was the patient offered other transportation/assistance options?
  - What were the circumstances of the refusal?
  - What were the risks of refusal that were discussed?
  - Was the patient offered further assistance if they recalled EMS?
- Document mental status of the patient prior to accepting a patient's refusal
- Signature of the patient and an appropriate witness on the refusal paperwork

### **Tips for Charting**

This is a brief list of charting suggestions.

- Consider concise, potent sentences that are complete and provide for easy, smooth reading.
- Avoid excessive use of the word “patient” as in “patient said”, “patient did”, “patient this”, and “patient that”.
- Reread the narrative portion of the chart to pick up errors in spelling or grammar and ensure that the chart’s meaning is clear. Attempt to read the document as would a reviewer not on the scene.
- Accept feedback gracefully. Feedback is useful and necessary in maintaining a very high performance level.
- Remember, questions about your care usually have nothing to do with the care itself, but the manner in which it was charted.

### **PHYSICIAN PEARLS:**

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