Documentation of Patient Care Report

Standard:

Establish the minimum documentation requirements for every patient contact.

Purpose:

To provide consistent and accurate documentation of the events of a patient encounter, the ATCEMS System Medical Director is responsible for designating the minimum data required for patient care reporting. The following is the minimum requirements for documentation on all patient encounters.

Application:

For every patient contact, the following documentation requirements apply and must:

a) Be truthful, accurate, objective, pertinent, legible, and complete with appropriate spelling, abbreviations, and grammar.
b) Use only approved medical abbreviations refer to *"Approved Medical Abbreviations" (Appendix A-01).*
c) Reflect the patient's chief complaint and a complete history or sequence of events that led to their current request or need for care.
d) Contain a detailed assessment of the nature of the patient's complaints and the rationale for that assessment.
e) Reflect the initial physical findings, a complete set of initial vital signs, all details of abnormal findings considered important to an accurate assessment and significant changes important to patient care. Reflect ongoing monitoring of abnormal findings and the patient.
f) Summarize all assessments, interventions in chronological order and the results of the interventions with appropriate detail so that the reader may fully understand and recreate the events.
g) For medication administrations include: the name, concentration, dosage administered, route, administration time, indication, patient response, and who performed the medication verification and cross check with you.
h) For patients with extremity injury, note neurovascular status before and after immobilization. For patients with spinal immobilization, document neurovascular status in all extremities before/after spinal immobilization.
i) For IV administration, document the catheter size, site, number of attempts, type of fluid, and flow rate.
j) Include a lead II strip for all patients placed on the cardiac monitor. All 12-leads should also be included. Any significant rhythm changes should be documented. For cardiac arrests, the initial strip, ending strip, pre and post defibrillation, pacing attempts, etc. should be attached. Or, electronically captured, uploaded and combined with the ePCR record.
k) Document clearly any requested orders, whether approved or denied, with physician name.
l) Document any waste of narcotics including the quantity wasted, where wasted, and must have the name of the person who witnessed the waste.
m) Include an explanation for why an indicated and appropriate assessment, intervention, or action prescribed by the Clinical Operating Guidelines did **NOT** occur.
n) Be available in an acceptable time period after the patient encounter by leaving the ePCR short form at the hospital if transported.
o) Remain confidential and be shared only with legally acceptable entities.
p) If multiple System Organizations are on the scene, at least one System Provider/Responder making patient contact from each response organization is responsible for documenting ALL interactions, assessments and treatments their response organization provided to the patient on a separate PCR for their Organization.

q) Once the PCR is completed, original document will not be modified for any reason. Any changes required to correct a documentation error or for clarification shall be recorded in an addendum.