

Patient Care Report Documentation

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Overview

The Patient Care Report (PCR) is the fundamental tool for documenting the care and services we provide to our patients. The PCR is an important medical record that must document available information regarding the incident, patient assessment, and care provided to the patient in a clear, concise, accurate, and complete manner.

The PCR also forms the basis for determining the amount that each patient is to be billed. Therefore, the PCR must accurately provide a picture of the response, assessment and treatment provided to each patient so that billing personnel may accurately determine the level of service that is to be billed along with an accurate summation of that service on the billing claim form. It is essential that Boston EMS maintain a strict quality assurance procedure to ensure that the accuracy and clarity of our patient care documentation is at the highest possible level at all times.

Boston EMS uses an electronic patient care reporting and information management system. The system allows users to collect and document call and patient information on mobile Android tablet throughout the course of the EMS call. PCRs are prepared contemporaneously with, or as soon as practicable, after each response, and are then available for review by the hospital staff immediately after upload to the server in accordance with 105 CMR 170.345 (B). The system is HIPAA compliant and allows hospital personnel to review reports on patients transported only to their facility, while providing EMS managers and physicians with valuable QA, statistical, billing, and demographic information.

Minimum Documentation Requirements

Unless cancelled prior to arrival on scene, responding ambulance crews are required to complete a Patient Care Report (PCR) for each response. The PCR should include all applicable information about the EMS response it documents. In cases where there are multiple patients involved in the same incident, a PCR must be completed for each patient.

The Commonwealth of Massachusetts, Office of Emergency Medical Services has established the Massachusetts Ambulance Trip Information System (MATRIS), a minimum EMS data set based on the National EMS Information System Dataset (NEMESIS), as set out in the 2006 National Highway Traffic Safety Administration Uniform Prehospital Dataset Document.^[1]

Patient Assessment and Treatment Information

The PCR should document the history of the patient's present illness or injury and the present condition of the patient. Include all associated symptoms that the patient is experiencing and other pertinent medical information that is obtained during the patient assessment. Pertinent negatives should be documented on all assessment questions asked. The completed PCR should include a description of all procedures, interventions, or medications provided as well as the time they were performed, by whom, and any resulting changes in the patient's status.

ALS Assessment / Refer to BLS

Advanced Life Support (ALS) personnel who have established direct patient contact must complete an appropriate assessment in accordance with the standards of their certification and training. If ALS personnel determine that an ALS intervention is not needed or anticipated, the patient may be referred to BLS for transport to an appropriate health care facility. Paramedics should note the assessment in SafetyPAD by selecting "ALS Assessment" from the treatment dropdown list, and clear the incident with the RBLIS (Refer to BLS) disposition. The Department is entitled to submit for reimbursement of this assessment, so it is important that it be properly documented for medical, legal, and financial purposes.

ALS Schedule II, III, IV, and VI Drug Documentation

Department Paramedics who treat a patient with a Schedule II, III, IV, and VI drug must document both the amount of drug given and the amount of the drug wasted in the ePCR and complete the signature Form (controlled Substance, Waste).

Financial Responsibility and Assignment of Benefits

Personnel shall attempt to obtain the signature of the responsible party for all patient transports. Signatures of responsibility and authority to release medical records may be obtained from an adult family member present at the time of transport (identify their relationship to the patient). When a patient is unable to sign, a reasonable explanation must be provided stating why the patient's signature was unobtainable and the attending EMT/Paramedic must sign in the space provided. Acceptable reasons for not obtaining a signature are: patient is unresponsive, combative, refuses, or is contaminated and a family member is not present to sign.

Patient Refusal

A patient refusal shall be thoroughly documented whenever a competent patient refuses to be treated and transported to the hospital. The patient, parent, or legal guardian should sign the designated refusal section located in the "Outcomes" portion of the SafetyPAD software. In cases where the SafetyPAD device is not readily available, the patient refusal may be documented on an approved (paper) Boston EMS Patient Refusal form.

Submission of the Patient Care Report

After the Patient Care Report is complete, use the CLOSE and SEND Icon to submit the report. Once successfully submitted, a copy will be automatically faxed to the receiving hospital and an electronic version will be available to authorized personnel via Webviewer. If the network connection is down, ePCRs can still be completed on the handheld device and closed and queued to be uploaded to the server once cellular connectivity is reestablished uploaded to the server at a later time.

Handwritten / Paper Documentation

In the event a handheld device is not available, all required information shall be documented on a standard Boston EMS paper PCR and (if applicable) Patient Refusal form (available from Field Supervisors and/or Material Management). A copy of the paper PCR report shall be left at the receiving facility. Any paper generated 51-A reports, patient refusals, PCRs, or other patient care related documentation should be sealed in an envelope. Arrangements should be made for a

Supervisor to collect the paperwork and deliver it to the EMS Administrative Headquarters where it will be scanned and attached to the accompanying PCR record as soon as possible.

Amendment of Patient Care Reports

PCRs create a legal record of an ambulance call. It is the responsibility of all personnel to ensure that their PCRs accurately reflect patient information, care given and the medical condition of the patient. To that end, Supervisory personnel or management of Boston EMS may request that staff members modify, amend or fully complete PCRs for a given call when PCR reviews suggest that the information documented may be incorrect or incomplete. Information for each patient call must be complete, accurate, honest and wholly based on the patient's condition. It is legally permissible for staff members to amend PCRs for reasons of completeness, correction, and clarity, and in compliance with the procedures outlined below. Boston EMS does not endorse nor will it tolerate any staff member who embellishes or falsifies medical necessity, mileage, services rendered, supplies used or any other information for the purpose of obtaining or enhancing reimbursement.

Proper reasons for modifying a patient care report may include correcting erroneous information, such as the patient's name, address, insurance numbers, incident number, dispatched information or patient care-related information. Medical information on PCRs should only be modified by the original author. When an amendment of medical information is required, arrangements shall be made for the original author to come to the EMS Administrative Headquarters where the ePCR will be "reopened" by a system administrator, and any necessary modifications or additions may be made. Any modification will automatically be time stamped by the computer system to clearly show the amendment and when the changes were made. Other personnel (billing, QA, etc.) may amend patient demographic information (name, address, insurance numbers, mileage, etc.), correct spelling errors and make other changes not related to patient care documentation. In all cases, any change to a previously submitted PCR (either electronic or hand written) shall include the name of the person making the change, as well as the date and time the change was made.

Mileage Reporting

Mileage reporting has been automated and is auto populated by the system

Abbreviations / Standard Terminology

To help reduce the numbers of errors related to incorrect use of terminology, only standardized, commonly accepted abbreviations should be used. One of the major causes of medication errors is the use of potentially dangerous abbreviations and dose expressions. Underlying factors contributing to many of these errors are illegible or confusing handwriting by clinicians and the failure of health care providers to communicate clearly with one another.

Examples of especially problematic abbreviations include the use of trailing zeros (e.g., 2.0 vs. 2) or use of a leading decimal point without a leading zero (e.g. .2 instead of 0.2). The decimal point is sometimes not seen when dosages are handwritten using trailing zeros or no leading zeros. To help reduce the numbers of medical errors related to incorrect use of terminology, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a list of abbreviations, acronyms, and symbols that should no longer be used^[2]. While the initiative was

intended for in-hospital use, the same safety concepts are applicable to the prehospital setting as well because patient medication information and field treatment notes are often initially written down on index cards and can be misinterpreted when passed among prehospital providers.

<i>Abbreviation</i>	<i>Potential Problem</i>	<i>Preferred Term</i>
U (for unit)	Mistaken as zero, four or cc.	Write "unit"
IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten)	Write "international unit"
Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I"	Write "daily" and "every other day"
Trailing zero (X.0 mg), Lack of leading zero (.X mg)	Decimal point is missed	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)
MS MSO ₄ MgSO ₄	Confused for one another Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"
>(greater than) <(less than)	Misinterpreted as the number "7" or the letter "L"	Write "greater than" or "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write full drug name
@	Mistaken for the number "2"	Write "at"
Cc	Mistaken for U (units) when poorly written	Write "ml" or "milliliters"
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "microgram"

^[1] OEMS Administrative Requirement, A/R 5-403 <http://www.mass.gov/eohhs/docs/dph/emergency-services/ar/5-403.pdf>

^[2] <http://www.jointcommission.org/patientsafety/donotuselist/> In addition, the Institute for Safe Medication Practices (ISMP) has published a list of dangerous abbreviations relating to medication use that it recommends should not be used. The list is available on the ISMP Website at: <http://www.ismp.org/Tools/errorproneabbreviations.pdf>