DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT, PARAMEDIC, MICN)

SUBJECT: **DOCUMENTATION OF PREHOSPITAL CARE** REFERENCE NO. 606

PURPOSE: To identify the base hospital and Emergency Medical Services (EMS) provider procedures for documentation of prehospital care.

AUTHORITY: California Code of Regulations, Title 22, Sections 100128, 100129, 100170, 100171

DEFINITIONS:

Patient: A person who seeks or appears to require medical assessment and/or medical treatment.

Patient Contact: An EMS response that results in an actual patient or patients.

EMS Response: The physical response of an EMS provider due to activation of the EMS system with a request for medical evaluation.

Patient Response: An EMS Response that results in an actual patient or patients.

Multiple Casualty Incident (MCI): The combination of numbers of ill/injured patients and the type of injuries going beyond the capability of an entity's normal first response.

PRINCIPLES:

1. The EMS Report Form and the Base Hospital Form are:

   a. Patient care records
   b. Legal documents
   c. Quality improvement instruments
   d. Billing resources
   e. Records of canceled calls, false alarms, and no patient found (EMS Report Form only)

2. Any assessment or treatment provided to, and medical history obtained from, the patient shall be accurately and thoroughly documented on the EMS Report Form.

3. Any person who alters or modifies the medical record of any person, with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor (section 471.5 of the California Penal Code).

4. An EMS Report Form must be completed for every EMS response if a provider agency is unable to submit an annual volume report to the EMS Agency for the following types of calls:

   a. Canceled calls
   b. No patient(s) found
   c. False alarms

APPROVED: Director, EMS Agency Medical Director, EMS Agency

POLICY:

I. EMS Report Form Completion – Paramedic/EMT Personnel

A. EMS providers shall document prehospital care according to procedures identified in the EMS Report Form Training Manual.

B. Paper-Based EMS Report Form Completion

1. Paramedic/EMT personnel from the first responding agency shall complete one local EMS Agency approved EMS Report Form (one for each patient) for every 9-1-1 patient contact which includes the following:

a. Regular runs
b. DOA (dead on arrival; patients determined or pronounced dead per Reference No. 814, Determination/Pronouncement of Death in the Field)
c. ALS interfacility transfer patients

C. Electronic EMS Report Form Completion

1. Paramedic/EMT personnel may document and submit prehospital care data electronically in lieu of the standard EMS Report Form if their department has received prior authorization from the EMS Agency.

2. Paramedic/EMT personnel shall complete one EMS Agency approved electronic EMS Report Form (one for each patient) for every patient contact and one for each ALS interfacility transferred patient.

D. Multiple Providers

1. In the event of an automatic or mutual aid incident when two first responding providers have each completed an EMS Report Form, or patient care is transferred from one ALS provider agency to another, , each provider agency shall document the Sequence Number from the other provider's patient care record in the space designated for Second Sequence Number. DO NOT cross out or line through the imprinted Sequence Number if utilizing a paper EMS Report Form.

2. The provider agency transferring patient care must have a mechanism in place to provide immediate transfer of patient information to the transporting agency.

E. Multiple Casualty Incidents (MCI)

1. One standard EMS Report Form must be initiated for each patient transported in an MCI. Provider agencies may use alternate means of documenting MCIs if the EMS Agency is notified prior to implementation and agrees with the proposed process.

2. Documentation should include the following, at minimum:

a. Name
b. Chief Complaint
c. Mechanism of Injury
d. Age and units of age
e. Gender
f. Brief patient assessment
g. Brief description of treatment provided
h. Transporting provider (provider code and unit number) and level of service (ALS, BLS or Helicopter)
i. Receiving facility

3. Non-transported patients should be documented on a standard EMS Report Form, an EMS Agency-approved MCI Report Form, or a patient log.

4. Each provider agency should submit copies of all records and logs pertaining to an MCI of greater than 5 victims to the EMS Agency within 10 business days of the incident. MCI documents should be hand carried or delivered to the EMS Agency in an envelope clearly marked with the incident date and location.

F. Completion of the EMS Report Form Prior to Distribution

1. EMTs and paramedics responsible for documenting prehospital care shall ensure that EMS Report Forms are completed in their entirety prior to dissemination of copies. In most instances, this means that the form is completed at the scene or upon arrival at the receiving facility.

2. An exception to this is when a first responding agency is giving the receiving hospital (red) copy to a transporting agency. In the interest of expediting the transfer of care, it is recognized that information such as the unit times may not be documented on the receiving hospital (red) copy of the EMS Report Form.

G. Field Transfer of Care

1. When patient care has been transferred from the first responding ALS or BLS provider agency to a BLS provider agency for transport to a receiving facility, the provider agency receiving the patient should **NOT** complete a standard EMS Report Form with an imprinted Sequence Number (will result in the same patient being entered into TEMIS with two different numbers).

2. The provider agency that receives the BLS patient for transport to a receiving facility should complete their agency's PCR/invoice and document the Sequence Number imprinted on the first responding agency's PCR on their PCR.

3. The receiving hospital (red) copy of the EMS Report Form, as well as the PCR from the BLS transport provider (red copy), must accompany the patient to the receiving facility where it becomes part of the patient's medical record.

4. It is the responsibility of the EMS Provider to ensure that a completed copy of the EMS Report form is provided to the receiving facility upon transfer of care.

H. Completion of Advanced Life Support Continuation Form

1. Required for each patient on whom airway management is necessary or cardiopulmonary resuscitation is attempted or patient is pronounced dead following resuscitative efforts if the information is not documented elsewhere on the EMS Report Form.

2. Paramedics completing this form must ensure that the demographic information (patient name, date, provider code/unit) and Sequence Number are legibly and accurately transcribed from the EMS Report Form.

II. Base Hospital Form - MICN and/or Physicians

A. Base hospital personnel (MICNs and physicians) shall document prehospital care according to procedures identified in the Base Hospital Form Training Manual.

B. Base Hospital Form Completion

1. MICNs and/or physicians shall complete at least one EMS Agency approved Base Hospital Form (one for each patient in which medical direction is given) for every base hospital paramedic radio/telephone contact.

2. MICNs and/or physicians shall **NOT** complete a Base Hospital Form when another base hospital calls with notification of an incoming paramedic call.

3. MICNs and/or physicians may document and submit base hospital data electronically in lieu of the standard Base Hospital Form if the base hospital has received prior authorization from the EMS Agency.

C. Base Hospital Directed Multiple Casualty Incidents (MCI)

1. EMS Agency-approved **MCI Base Hospital** Forms may be utilized for incidents involving three or more patients.

2. Physicians and MICNs should limit requested information to **only** that which is essential to determine destination or medical management. Additional information and Sequence Numbers should be obtained after the MCI has cleared.

3. The following should be documented for MCIs involving three or more patients:

a. Date
b. Time
c. Sequence Number
d. Provider and unit
e. Chief complaint
f. Mechanism of injury

g. Age
h. Gender
i. Brief patient assessment (primary injuries and MOI)
j. Transporting provider, method of transport (ALS, BLS or Helicopter)
k. Destination

4. Upon request of the EMS Agency the base hospital should submit all records pertaining to an MCI of >5 victims to the EMS Agency within 10 business days.

5. Provider agencies may use alternate means of reporting MCIs. Base Hospitals will be notified by the EMS Agency when alternate reporting methods will be implemented by various provider agencies.

6. MCIs involving **ONLY** BLS patients: BLS patients who are transported to a receiving facility should be documented on one form (provided no medical direction is given).

7. MCIs involving ALS **and** BLS Patients:

   a. One standard Base Hospital Form or one EMS Agency-approved MCI Base Hospital Form must be completed for each ALS patient.

   b. One standard Base Hospital Form must be completed for each SFTP patient when the base hospital provides destination and/or medical direction.

   c. BLS patients on whom no medical direction has been given do not require a Base Hospital Form. The number and disposition of the BLS patients may be documented on the Base Hospital Form of an ALS patient in the Comments Section.

8. Alternate methods of documenting MCIs may be initiated by Base Hospitals with the approval of the EMS Agency.

III. Modification of the EMS Report Form

A. Modifying the EMS Report Form (additions, deletions or changes) after the form has been completed or disseminated:

1. Make corrections by drawing a single line through the incorrect item or narrative (the writing underneath the single line must remain readable).

2. Make the changes on the original, noting the date and time the changes were made, with the signature of the individual making the changes adjacent to the correction. Ideally, changes should be made by the individual who initially completed the form. Under no circumstances should changes to either patient assessment or patient treatment documentation be made by an individual who did not participate in the response.

3. An audit trail of changes made to an electronic record will be included on the EMS Report form.

B. Making substantive changes (documentation of additional medications, defibrillation attempts, pertinent comments, complaints, etc.) to the EMS Report Form:

1. Photocopy the EMS Report Form with the changes and send the copy, along with a cover letter, to all entities that received the original form (EMS Agency, receiving facility). The cover letter should explain the modifications and request that the modified copy be attached to the original copy.

2. Do not re-write the incident on a new EMS Report Form because this would result in a mismatch in Sequence Number. If the form requiring corrections has been mutilated or soiled and cannot be photocopied, then a new form may be used to re-write the incident provided the Sequence Number of the new form has been replaced with the Sequence Number from the original form.

3. For electronic documentation systems, patient care related corrections are to be made as per provider agency policy. Provider agency shall notify its' receiving hospital(s) of the mechanism by which ePCRs are updated. Notification of the updated record will be made to all entities who received the original form (receiving hospital, EMS Agency). If the receiving hospital receives a printed copy of the record, a printed copy of the revised record will be provided directly to them.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 608, **Disposition of Copies of the EMS Report Form**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 519, **Management of Multiple Casualty Incidents**

EMS Report Form Reference Manual