

PATIENT CARE RECORD (PCR)

I. PURPOSE

To establish requirements for completion, reporting, and submission of Marin County approved Patient Care Records.

II. RELATED POLICIES

ALS to BLS Transfer of Care, ATG 4
Against Medical Advice (AMA), GPC 2
Release at Scene (RAS), GPC 3
Trauma Re-Triage, 4606 A & B

III. DEFINITIONS

- A. Patient – someone who meets any one of the following criteria:
 - 1. Has a chief complaint or has made a request for medical assistance
 - 2. Has obvious symptoms or signs of injury or illness
 - 3. Has been involved in an event when mechanism of injury would cause the responder to reasonably believe that an injury may be present
 - 4. Appears to be disoriented or to have impaired psychiatric function
 - 5. Has evidence of suicidal intent
 - 6. Is dead
- B. Emergency Medical (EM) Number – a number assigned by the Marin County Communication Center to identify each 9-1-1 call dispatched for medical assistance.
- C. Incident Number – The “F” number assigned to an incident.
- D. Electronic Patient Care Record (ePCR) - the permanent record of prehospital patient evaluation, care, and treatment.
- E. Field Transfer Form (FTF) – a temporary, paper record of patient care used only when ePCR is unavailable
- F. Quicksheet – A single section within Elite Field that streamlines data entry.
- G. Short Form – A printed report, typically received via fax at the ED containing a minimum set of data elements from the ePCR.
- H. Posting – the process of uploading the ePCR from Elite Field to the ImageTrend server. The first time a record is posted, a fax will be sent to the ED. Each post to an out of county facility will result in a fax.
- I. Completed PCR – the PCR is considered complete when it has been posted and locked.
- J. Triage Tag – a paper record for multi-casualty incidents involving 6 or more patients

IV. POLICY

- A. An ePCR shall be completed for every call for which an EM is issued.
- B. For all transported patients:
 - 1. To ensure an informed continuum of care for all patients transported to the hospital, field personnel will post the ePCR no later than 10 minutes prior to ED arrival. If short ETAs preclude posting before arrival, the ePCR must be posted as soon as possible upon arrival. Immediate patient care needs shall take precedence over posting.
 - 2. Once posted, hospital personnel can retrieve ePCR information from the ImageTrend Elite Viewer or secure the short form that is automatically faxed to their facility. If this patient information is not available, hospital personnel will notify

field personnel. In no event shall field personnel leave the ED if the short form or posted patient information or similar document (e.g. FTF or locally printed short form) is not available. The transfer of care will include a verbal report to hospital clinical staff.

3. When available, posted information shall contain at a minimum:
 - patient name
 - patient address
 - patient telephone number
 - date of birth
 - chief complaint
 - contact information of the best medical historian
 - medical decision maker (when not the patient)
 - pertinent findings on physical exam
 - last known well (if applicable)
 - vital signs
 - medications
 - allergies
 - presence of advanced directive/DNR
 - medications administered
 - procedures performed
 - Kaiser / insurance number
 4. A paper FTF shall only be used as a backup during system downtime, equipment failures, loss of internet connectivity, while on a fire line assignment, or any incident/situation where personnel do not have the ability to capture and post data via ImageTrend.
 5. If the ePCR system precludes the transfer of information to the hospital and a compatible printer is available, the ePCR should be printed locally.
 6. Data gathering and documentation responsibilities should never take precedence over hands-on rescue and patient care and therefore may not always be possible to compete during an incident. Nevertheless, prehospital information, particularly for critical patients, is essential for the emergency department and hospital course of care and every effort to obtain the information should be made.
 7. A completed ePCR must be available to the receiving facility within 20 minutes of transferring care. If this is not possible (e.g. unit must leave for another call), then a complete and legible short form or posted ePCR must be available to hospital staff prior to leaving the ED. When this occurs, an ePCR must be completed and available to the facility as soon as possible and no later than 3 hours after the transfer of care.
 8. Notification patients (e.g. sepsis, stroke, STEMI, trauma) or critical patients (e.g. cardiac arrest and/or airway emergency) require a completed ePCR before field personnel leave the hospital with the exception being for a rapid re-triage patient that utilizes the same transport unit.
 9. For all patients transported, the ePCR will be completed by the personnel assigned to the transport unit.
- C. For non-transported patients (e.g. AMA, RAS, Dead on Scene), the ePCR will be completed as soon as possible and no later than three hours by the paramedic or EMT most involved in patient care and responsible for the patient's disposition.

- D. For calls where there is no medical merit, the unit that completes the ePCR will be determined according to provider agency policy.
- E. The ePCR is the permanent PCR and will be filled out in a complete manner and will include all care provided in the prehospital setting. When possible, it shall include all 12 lead ECGs and any ECG other than normal sinus rhythm. When possible, pertinent photographs from the scene should be attached to the ePCR (e.g. vehicle damage).
- F. The completed PCR includes all care rendered by the transporting providers as well as any care given prior to arrival of the transporting unit by bystanders and/or first responders. Documentation of care provided by first responders (of a different agency than the transport unit) may be required by their department policy.
- G. For air ambulance transportations, a FTF will be given to the receiving provider.
- H. Personnel assigned outside of the county to provide medical-mutual aid (e.g. fire-line EMT/Paramedic, cover engine assignment), shall complete a FTF for each patient contact. The FTF will be created on site and retained by the provider agency.
- I. Willful omission, misuse, tampering, or falsification of documentation of patient care records is a violation under Section 1978.200 of the California Health and Safety Code.

V. GENERAL INSTRUCTIONS

- A. The patient care record is part of the patient's permanent medical record and is used for, but not limited to, the following purposes:
 - 1. Transfer of information to other healthcare providers
 - 2. Medical legal documentation
 - 3. Billing for services
 - 4. Development of aggregate data reports for Continuous Quality Improvement (CQI), including specific quality indicators and identification of educational needs
 - 5. EMS Agency case investigation
- B. Reference to a Marin County EMS Event Form or similar record should not be included on the patient care record.
- C. If ALS to BLS transfer of care is determined to be appropriate, documentation of assessments and all care rendered must be completed by both the ALS and the BLS units according to policy ATG 4.
- D. Provider agencies are responsible for training their employees in the initiation, completion, distribution of patient care records, HIPAA and any accompanying forms based on the EMS Agency's currently approved training curriculum.

VI. DOCUMENTATION REQUIREMENTS

- A. When reasonably possible, complete demographic information should be included in the PCR.
- B. A clear history of the present illness with chief complaint, onset time, associated complaints, pertinent negatives, mechanism of injury, etc. The information should accurately reflect the patient's chief complaint as stated by the patient and should be sufficient to refresh the clinical situation after it has faded from memory.
- C. An appropriate physical assessment that includes all relevant portions of a head-to-toe physical exam.
- D. Check and document at least two complete set of vital signs (VS) for every patient including pulse, respirations, blood pressure and pulse oximetry. Repeat and document VS every five minutes for emergent patients and every 15 minutes for non-emergent patients (e.g. BLS patients). When required by policy, a temperature should also be documented at least once in the VS section. For children \leq three (3) years of age, blood

- pressure does not need to be documented unless the child is critically ill in whom blood pressure measurement may guide treatment decisions.
- E. A pain scale shall be documented for all patients \geq six (6) months who have a GCS of $>$ 14.
 - F. All pediatric patients being treated and transported by ALS will be measured with a color-coded resuscitation tape. The corresponding colored wrist band will be applied, and the patient will be treated according to the Pediatric Dosing Guide (P18A).
 - G. Only approved medical abbreviations may be used – see 7006b.
 - H. All pertinent medications taken by the patient prior and/or administered by a first responder (e.g. erectile dysfunction medications, aspirin, medications used for OD, Narcan, etc.) should be documented if known.
 - I. The CAD to PCR interface should be used to populate all PCR data fields it supplies. Imported data may be manually corrected as needed.
 - J. When the cardiac monitor is applied, data will be transferred to the PCR from the device. If transferred automated VS do not correlate with manually obtained values, or are not consistent with the patient's clinical condition, providers should manually check VS and record manual results.
 - K. All 12-lead ECGs must be imported. Any significant rhythm changes should be documented. For cardiac arrests the initial strip, ending strip, pre and post defibrillation, and pacing attempts, should be attached.
 - L. For drug administrations, the drug dosage, route, administration time and response shall be documented.
 - M. Treatments should be documented in chronological order. Response to treatment shall also be documented.
 - N. For patients with extremity injury, neurovascular status must be noted before and after immobilization.
 - O. For patient with spinal motion restriction, document motor function before and after motions restriction.
 - P. For IV administration, document catheter placement, catheter size, number of attempts, and flow rate if applicable.
 - Q. Any Physician Consult request and response will be documented.
 - R. All personnel information, including signatures, will be documented.
 - S. All crew members are responsible for accuracy of the content of the PCR.