Documentation of Patient Care

- All patients will have their assessment and management fully and accurately documented in a timely manner using the documentation tools provided by their agency. The patient care report will be completed no later than the end of the provider's shift in which that care occurred (established by previously existing Medical Control Board policy). Vital information will be communicated to the hospital verbally and in writing at the time of patient turnover. This should include initial, significant, and final vital signs, ECG tracings, pertinent history and physical exam findings, and treatments provided.
- To facilitate quality patient care, CQI and accurate billings if applicable, specific points are outlined below to be included in relevant patient care reports.
- If a physical exam item is/was not assessed, either delete that element so it does not become part of the auto-generated narrative, or if that is not possible in your patient care reporting mechanism, note "not assessed". Do not write "n/a" which means "not applicable".

A written patient care report includes the following minimal elements.

1. Chief Complaint including pertinent dispatch information, as well as info received from other sources (bystanders, police—which should be attributed or quoted as appropriate).
2. History of Present Illness: including OPQRST (Onset Type, Provocation, Quality, Radiation, Severity, Time of Onset). Include pertinent positives and negatives. This should also include description of unusual circumstances that are pertinent.
3. SAMPLE History: Symptoms, Allergies, Medications, Past Medical History, Last oral intake, Events leading up to 911 call
4. Physical Exam appropriate to patient complaint. This should also include your observations of other pertinent things on scene. Be as specific as possible in your description. HEENT, Neck, Chest, Abdomen, Pelvis, Posterior, Extremities, Neuro/Mental Status.
5. Vital Signs: In almost every patient should include LOC, BP, P, R, perfusion, oxygen saturation (prior to oxygen supplementation if possible).
    a. For Fire Department agencies, there should be at least one set of vital signs if they arrive sufficiently prior to transport EMS.
    b. For EMSA, there should be at least 2 full sets of vital signs for every patient, or an explanation why that was not possible.
    c. Stable patients should receive vitals at least every 15 minutes or with significant status changes / interventions, critical patients should have their critical vitals monitored at least every 5 minutes or with significant status changes / interventions. Vital signs should be recorded within 5 minutes of patient turnover at hospital. If an invasive airway is placed, capnography waveform should be recorded with each patient movement, including prior to patient movement from ambulance at hospital and once patient is physically on the hospital/helicopter stretcher at time of turnover.
    d. A significant status change may be a change in mentation, increase in pain, development of new symptoms (seizure). Which vitals are critical depend on the complaint—respiratory patients the pulse (changes with meds and distress), respiratory rate, breath sounds, oxygen saturation, waveform capnography readings.
    e. Downloaded vital signs (including BP, P, EtCO2, SaO2) from monitors should be checked and corrected if they are wrong, or conflicts explained in your narrative. For example, in a cardiac arrest, if the pulse reads "110" due to CPR, it must be corrected to "0" because the patient was pulseless.
6. Additional assessment findings as appropriate may include:
    a. 12-lead ECG if indicated (syncope, suspected cardiac chest pain, dysrhythmia or suspected ischemic equivalent)

b. Glucometry (altered mental status, symptoms of hypoglycemia or hyperglycemia)
c. Capnography, Los Angeles Prehospital Stroke Scale, Pain scale (1-10) if indicated

7. Provider assessment: what you thought was wrong with the patient and what protocol(s) you followed. Include triage level here if appropriate.
8. Interventions performed. Document medications, procedures, alerts (STEMI, Stroke, or Trauma), and most importantly, why these were indicated.
9. Reassessment following interventions--(e.g. decreased dyspnea, increased O2 sat, decreased pain scale, improved blood glucose)
10. Turnover: note that verbal (or written) report was given, to whom patient was turned over to and when.
11. Review the written record to assure it paints an accurate and objective picture of the events of the call, and that there are no conflicts between the downloaded information from the monitor and the narrative.

Airway Management

1. Any invasive airway placement should have the following elements documented:
    a. Indication for invasive airway placement
    b. Airway placement procedure:
        i. Supraglottic placement
            1. Any difficulties with placement
            2. Waveform capnography to confirm (if used)
                a. Initial EtCO2 and EtCO2 on hospital/helicopter stretcher
            3. Breath sounds present, gastric sounds absent
        ii. Endotracheal intubation
            1. Medications (e.g. etomidate) if used
            2. Blade used/Tube size used
            3. Visualization of glottis if orotracheal
            4. Time of intubation
            5. Waveform capnography to confirm
                a. Initial EtCO2 at minimum
            6. Breath sounds present, gastric sounds absent
            7. Depth (at teeth or lips)
            8. Tube secured (e.g. tube holder)
        iii. If applicable, note that CPR was not interrupted
        iv. Any complications encountered (e.g. vomitus, foreign body airway obstruction

Respiratory Distress

1. History:
    a. Time course of onset
    b. Potential aspiration?
        i. If foreign body obstruction: Patient able to speak, move air? Inspiratory stridor? Cause?
    c. Respiratory past medical history:
        i. COPD? Asthma? Frequency of use of home meds? Tobacco use or exposure? Any triggers of respiratory distress? Home oxygen (what baseline amount), CPAP (how often used)? Prior intubation?
        ii. CHF? Medication or dietary noncompliance?
        iii. Prior response to therapy?
    d. Assessment of severity:
        i. Severe: significant retractions, tripoding, # of words able to speak between breaths, sharkfin capnography waveforms

ii. Lung exam: wheezes, rales, rhonchi
iii. JVD? Peripheral edema (difference from baseline)?

e. Presence, duration and character of any chest pain or known anginal equivalent?

2. Reassessments including respiratory rate, oxygen saturation and EtCO2 trending
3. If inhalation injury: Type of gas, duration of exposure, area of exposure (enclosed room?), associated burns / singing (oral, nasal, facial area)

Cardiac Arrest

1. Events prior to collapse
2. Description / location of patient on arrival
3. Last time seen alive, estimated down time
4. Presence of DNR documentation (note whether valid or not, date executed, and physician name/witness names/power of attorney names if legible
5. Bystander CPR prior to EMS system arrival or not
6. Medical history including any recent hospitalization or illness. Name of primary care physician if known.
7. All care events during the resuscitation (starting chest compressions, electrical, airway/capnography, vascular access, meds)
8. Any cardiac rhythm changes during resuscitation

Post Resuscitation

1. Time of ROSC and initial ROSC rhythm
2. Oxygenation/ventilation care (e.g. use of ventilator? Ventilator settings?)
3. Perfusion care (e.g. use of IV fluids, cardiac meds, vasopressor)
4. Post-resuscitation vital signs and 12-lead ECG acquisition, interpretation, transmission
5. Mental status
6. Use of therapeutic hypothermia – indication/contraindication? How much fluid if used?

Acute Coronary Syndrome

1. OPQRST and SAMPLE
    a. Cardiac risks: hypertension, diabetes, smoking, obesity, family history (< age 55 family with MI)
    b. Prior cardiac history? Are symptoms the same or different? Any recent cardiac evaluation (stress test, cath) and results if known
    c. Name of cardiologist if applicable
    d. Nitro: If prescribed nitro, when was the last time it was taken? If given by EMS, did it help?
    e. Exertional (what level?) vs. pain at rest?
    f. Radiation or pain and to where?
    g. Associated symptoms: dyspnea, diaphoresis, nausea?
2. Aspirin given since 911 called (Y / N)? Contraindication if any? Note “PTA” if appropriate.
3. Treatments:
    a. 12-lead ECG acquisition and interpretation time (within 10 minutes of patient contact) and transmission
    b. Medications – aspirin? nitroglycerin? fentanyl/morphine?
    c. If STEMI, ED alert time?
4. Reassessments: Pain scale, repeat vital signs, any cardiac rhythm changes

Cardiac dysrhythmias:

1. What criteria made patient unstable / symptomatic (or not) and needing intervention

   a. what signs of inadequate perfusion due to bradycardia—hypotension/shock, altered mental status,
   b. why bradycardia felt to be primarily cardiac in origin
2. Medication list (meds such as beta blockers, calcium channel blockers, anti-dysrhythmics?)
3. 12-lead ECG acquisition, interpretation, and transmission
4. If electrical therapy required, document any sedation if administered

Acute Stroke

1. Time last seen normal
2. Los Angeles Prehospital Stroke Scale assessment
3. Blood glucose
4. Contact information for witness/family if not transported with patient
5. Stroke alert activation time
6. Any change in neuro status during scene/transport care
7. Cell phone number(s) obtained for family (hospital pt treatment authorization purposes)

Altered Mental Status

1. Baseline mental status for patient (per whom?)
2. ETOH / Substance use history?
3. Traumatic injuries?
4. Blood glucose level. If low/high, history of diabetes? If diabetic:
   a. Use of insulin and/or oral meds? Last dose of meds?
   b. Etiology of hypoglycemia: missed meal? Increased exercise? Vomiting / nausea / recent illness?
   c. Post-treatment reassessment of mental status and verification of baseline
5. Other potential causes, EtCO2 in patient with COPD hx

Seizure

1. Any injuries (mouth, head, tongue) due to seizure, or evidence of head trauma that may have caused seizure in patient with no history of seizure
2. Duration and number of seizures, whether patient fully regained consciousness between seizures (does pt meet criteria for status epilepticus?)
3. Time to return to baseline LOC
4. Prior history of seizures—same type? Any medications / drug use? Last time pt had breakthrough seizure?
5. Etiology of seizure: Medication noncompliance? Alcohol withdrawal?

Syncope / Dizziness

1. Symptoms leading up to event:
   a. Activity preceding syncope or onset
   b. Recent illness (e.g. vomiting/diarrhea, GI bleeding)
2. Associated symptoms:
   a. Chest pain, dyspnea, nausea
   b. Neurologic: headache, focal weakness, slurred speech, visual or sensory changes
   c. Vertigo (room spinning)? vs. dizzy (feeling lightheaded)?
3. Medications: any new meds?
4. Last meal
5. Blood glucose level
6. 12-lead ECG
7. In females of childbearing age: possibility of pregnancy? Last menstrual period?

Behavioral Emergencies

1. Documentation is to follow the specifications in Section 7 of the MCB Treatment Protocols.
2. Any patient statements regarding intent for harm to self or others (preferably in quotes)

Toxic Ingestion / Exposure/ Burns

1. Name of substance (note MSDS # if applicable to hazmat)
2. Ingestion:
    a. Amount taken, route, and approximate time ingested
    b. Vomiting since ingestion? Pills noted in vomitus?
    c. Intentional vs. accidental ingestion? Prior attempts if intentional?
    d. Oral or nasal mucosa burns?
3. Exposure (toxic gas / smoke / liquid / solid):
    a. Enclosed space?
    b. Estimated length of exposure time?
    c. Associated signs / symptoms (i.e., singed hairs, burns)
4. Systemic symptoms? Toxidrome?
5. Documentation of contact with poison control (time) and their recommendations.
6. Any patient statements regarding intent for harm to self or others (preferably in quotes)

Allergy / Anaphylaxis

1. Possible/probably cause of reaction, time from exposure to onset
2. Prior similar reactions?
3. Presence / absence of specific signs of allergic reaction or anaphylaxis
    a. Dyspnea, stridor, altered voice
    b. Facial / airway (tongue, lips) edema
    c. Urticaria and/or pruritis
    d. GI symptoms of nausea, vomiting, and/or diarrhea
    e. Hemodynamic changes – hypotension, tachycardia

Pain Management

1. Indication for pain management
2. Which comfort measures provided (positioning, splinting)
3. Objective evidence for pain noted (e.g. trauma findings, tachycardia, hypertension)
4. Patient able to follow commands / hemodynamically stable
5. Initial pain scale, pain scale following treatment

Spinal Motion Restriction

1. Documentation is to follow the specifications in Protocol 10O of the MCB Treatment Protocols.

Environmental Emergencies

1. Circumstances of exposure:
    a. Suspected etiology
    b. Symptoms
2. Any decontamination that was performed

Active Labor and Childbirth: Separate documentation report required for mother and each neonate delivered

1. Obstetric SAMPLE history
2. Nondelivery:
    a. Estimated weeks gestation / due date, last menstrual period?
    b. Known intrauterine pregnancy?
    c. Gravida - Para
    d. Any complications of prior or current pregnancy
    e. High risk (why? e.g. multiple gestation pregnancy)
    f. Abdominal pain (where)? Trauma?
    g. Sensation of fetal movement?
    h. S/S preeclampsia: peripheral edema, headache, visual disturbance, hypertension?
3. Possible labor, add:
    a. Time of onset of contractions
    b. Frequency of contractions (duration & frequency and whether palpable)
    c. Vaginal discharge / bleeding?
    d. Rupture of membranes, discoloration of amniotic fluid?
    e. Vaginal exam: crowning?
4. Delivery, add:
    a. Presenting part
    b. Birth info:
        i. Time of birth
        ii. Male / female
        iii. Newborn resuscitation care events & APGAR scores

Informed Patient Consent/Refusal

1. Documentation is to follow the specifications in Section 14 of the MCB Treatment Protocols.