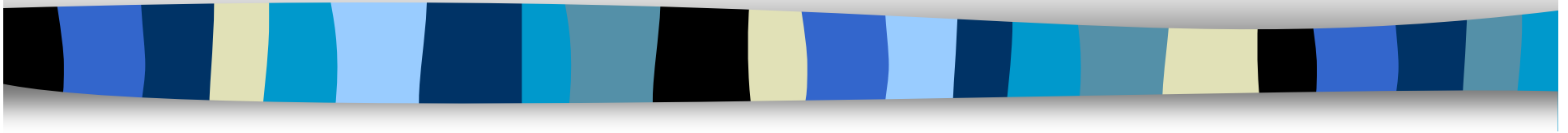


# WRITE IT DOWN!



## DOCUMENTATION STRATEGIES

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EMS Medical Director



# Objectives

- The purpose
- Why is it so important
- Strategies for good documentation
- The Narrative
- CHART format
- HIPAA
- Refusals
- Paperless



# The Purpose

- Legal document recording the event
- Part of the patient's medical record
- A record for financial reimbursement



# Why is it so important

- Helps to ensure the continuity of care for the patient
- It may prevent a lawsuit from being filed. In the event a lawsuit is filed, it provides the best defense of the EMTs actions



# Why is it so important

- It provides documentation of the event should the EMT be exposed to infection or violence.
- Reflects our credibility as health-care professionals
- Document that the Insurance company bases their decisions on for reimbursement.



# Why is it so important

- Provides an avenue of review for patient care and allows for quality improvement and educational opportunities
- Provides data for changes in public health programs



# Good Documentation Strategies

- “Good documentation is accurate, precise, comprehensive, legible, objective, timely and unaltered.”
- Developing your documentation skills is as important as any other patient care skill.
  - Roger Munger, PHD On the Write Track



# Good Documentation Strategies

## ■ Have a Plan

- Take notes
- Use the CHART format
- Remember your audiences

## ■ Readability

- Legibility
- Approved terminology and abbreviations
- Spelling, sentence structure and phrasing



# Good Documentation Strategies

- Complete information
  - Fill in all fields
  - Assure and record accurate data and times
  - Attach any supporting documents or attachments
    - (ECG rhythm strips, photographs, patient medication lists etc...)



# The Narrative

- You are creating a detailed picture of the patient and event *with your words*.
- Include a description of:
  - The scene, MOI and events leading up to the emergency
  - The patient's condition, HPI and PMH
  - Your assessment findings



# Describe

- All treatment rendered and the patient's response to that treatment
- Specifically where and when events occurred including a *where, when and who* for each intervention performed
- Any changes in the patient's condition



# Describe

- Any extenuating circumstances
  - extrication, combative patients, need for restraints and infectious/hazardous exposures etc...
- Use the persons own words to convey stated information. Use quotation marks when quoting.
- Utilize and document mnemonics such as AMPLE, PQRST, AEIOUTIPS, AVPU, ABCDE.



# The Narrative

- Make any changes in the appropriate manner
- The patient narrative is not the place to document your personal opinions about individuals or interaction problems.
  - Document only the objective facts and your presumptive diagnosis based on those facts in the narrative
  - Document interaction problems on a separate form



# CHART

- C- Chief complaint
  - What the patient/family member/caregiver tells you is the current problem. Why they called 911. If there is no information available then your best guess as to why the patient needs evaluation.



# CHART

## ■ H- History

- Include both the HPI (history of present illness/injury) and PMH (past medical history)
- This includes such mnemonics as PQRST, AMPLE, MOI, AEIOUTIPS (include pertinent positives and negatives)
- Any statements the patient or spokesperson makes about the current event and past pertinent events.



# CHART

## ■ A-Assessment

- Include a statement about how and where you find the patient upon your arrival.
- Include and specify ( who and when) for any information that first responders relay to you about their assessment.
- The primary survey (ABCDE)
- The secondary survey(head to toe exam)



# A-Assessment

- Include both negative and positive findings and responses the patient has to your assessment such as the presence or lack of pain and/or the presence or lack of sensation.
- Include the results of any assessment/diagnostic equipment used such as the ECG, pulse oximetry, capnography, blood glucose monitoring etc...



# CHART

- R- Treatment on scene
  - Include all treatment and interventions completed on scene.
  - Remember to document who and when for each intervention along with the patient's response to that intervention.
  - Document the time, dosage and route of administration for any medication given.



# CHART

- T- Transport Document (and transfer):
  - Where you transported the patient and whether or not you transported with lights and sirens.
  - All treatment done in route to the hospital (again document who did the intervention and the patient's response.)
  - Any changes in the patient's condition
  - To whom you released the patient
- Status at time of transfer



# CHART

- The EMSA now teaches DCHARTE in the basic curriculum
- The D stands for dispatch information received in route to the call
- The E stands for Exceptions such as the ambulance being delayed due to break down or other circumstances.



# Health Information Portability and Accountability Act (HIPAA)

- HIPAA privacy rule does not prohibit EMS providers from focusing on quality patient care during the time care is needed.
- EMS providers can use the information in the patient care record—such as for billing, clinical practice review, and training—and can share that information with other covered entities also involved in the patient's care—such as a receiving hospital or another pre-hospital provider in a tiered response system—as long as it is for legitimate treatment, payment, or health care operation purposes.



# HIPAA

## ■ ***Business Associate Relationships in EMS***

If an EMS agency contracts with or uses an outside organization or personnel to perform services in its behalf which involve the necessary sharing of PHI, the EMS agency must obtain a business associate agreement with such an organization. This written agreement contains provisions that all PHI will be appropriately protected and used by the business associate for only those purposes necessary under the arrangement. Examples include

- billing services
- legal counsel
- accounting services
- Medical Director
- Dispatchers
- outside management services, such as for critical incident stress management
- other independent consultants and contractors



# HIPAA

## ■ Remember

- Do not share PHI outside of the organization
- Do appropriate paperwork on every patient
- Use common sense
- Review the web sites
- In case reviews, sign attendance sheet and keep quiet



# The Patient Refusal

- The litigation rate for EMS has been steadily increasing.
- “According to one study,” patients evaluated by paramedics but not transported to the hospital account for 50 to 90% of EMS lawsuits”.
- “Objective and logical....documentation is your best defense.”
  - Roger Munger



# The Patient Refusal

- “Documentation must prove ON IT’S FACE, IN WRITING the patient’s then-present CAPACITY to understand and appreciate fully the nature of his condition, the choices available to him, and the possible consequences of refusal.”
  - Gene Gandy



# The Patient Refusal

- Until studies are completed and protocols for alternative means of transport/alternative destinations are in place:
  - Do not at any time attempt to talk the patient out of going to the hospital or going to the hospital by POV.



# The Patient Refusal

- If you feel strongly that the patient should be seen, make every attempt to convince them they should be seen.
- Contact an MCEP if you are uncertain or feel they may be able to help in convincing the patient to go.



# The Patient Refusal

- Assure that the patient is competent to sign a refusal and advise them about all the possible risks in refusing care or transport.
- Document what you told the patient and their response and level of understanding in the R portion of your CHART narrative.



# The Patient Refusal

- Advise them that they can call 911 back if they should change their mind or their condition deteriorates.
- Assure that they sign the approved form and get witnesses to sign as well.
- I advocate that you read the appropriate section of the liability release and document that on the chart.



# Paperless

- “ It’s not a question of *if* we will use paperless reports, but *when* we will switch to electronic documentation in some form.”
- Data collections, financial reimbursement, legibility, and consistency are the major reasons.
  - Roger Munger



# Paperless

- Many services throughout the country including New Mexico are using computerized run reporting methods
- The State of New Mexico is requiring services to provide data for the CODES project
- Though resistance is high initially, people quickly become dependent on the latest in technology



# Summary

- Complete, accurate, legible documentation is an important key to
  - Providing continuity of patient care and recording the event
  - Protection from litigation
  - Credibility as health care professionals
  - Financial reimbursement



# Summary

- Ultimately the Prehospital care report provides improved quality of patient care through quality improvement review practices, and educational programs.