APPENDIX H: DOCUMENTATION PEARLS

- EMS Clinicians must follow all SHCGB and CT OEMS policies with regards to documentation. EMS Agencies might have additional documentation policies that their clinicians must follow. This document is a resource to assist clinicians when documenting their patient encounters.

- All charts must be completed as soon as possible after the call, and no later than 8 hours of arrival at the hospital. If the ePCR cannot be completed within 8 hours due to high call volume, it must be completed as soon as possible, always before the end of the crew's shift.

- All the following information is required to be documented on an ePCR:
  - Incident Number
  - Unit Number and Level of Care
  - Incident Location
  - Incident Disposition
  - Incident Times* (*must include dispatched, enroute, on scene, at patient/patient contact, depart scene, arrival at receiving and patient care transferred)
  - Unit Crew and Level of Care (Must include crew names; ID numbers are NOT sufficient)
  - Patient's chief complaint (and secondary complaint, if applicable) along with complete history of present condition/complaint.
  - Detailed assessment of chief complaint (and secondary complaint, if applicable).
  - Interventions performed/administered to the patient.
  - Must also include post administration reassessment.

- Document at least **<u>two</u>** full and complete set of vital signs, consisting of the following:
  - Blood Pressure* (at least one manual preferred)
  - Palpated Heart Rate* with Quality
  - Respiratory Rate* with Quality of Respirations
  - Pulse Oximetry*
  - Glasgow Coma Scale* (defined in State of Connecticut Protocol)
  - Pupillary Response and Measurement
  - Lung Sounds in all fields
  - Pain Scale*
  - Skin*
  - Temperature

  (*) Included in Full and Complete Set of Vital Signs

- Critical Ill, High Acuity or Unstable Patient:
  - Vitals will be obtained approximately every 5 minutes
- Low Acuity or Stable Patient :
  - Vitals will be obtained approximately every 15 minutes (In the event of short transport times, one set of vital signs at patient contact and one set enroute or upon arrival, should be documented.)

- It is the paramedic's responsibility to upload and transmit all cardiac monitor data obtained on an incident to their PCR. This includes, but is not limited to:

    - ECG Monitoring (both 3 and 12 Lead) Provider must document their rhythm interpretation, ectopy, ST changes and any other pertinent findings
    - Cardioversion, Defibrillation, Pacing Events
    - ETCO2 Waveform and Readings
    - Pulse Oximetry Waveform and Readings
    - Blood Pressures

- Any other data that has been stamped by provider or monitor Any data that is deemed to be inaccurate by the Paramedic, shall be documented as such. This data can also be removed. Any changes to imported data that are made due to inaccuracies will have a comment stating that data was changed due to inaccuracy.

- Medication administration must include:

    - Medication Name
    - Route Administered
    - Dose Administered
    - Time of Administration
    - Response
    - Patient Weight (in KG)

- All information, including but not limited to all successful and unsuccessful intervention attempts (12-Lead ECG, Intubation, DMO Consult, Vascular Access, Field Presumption Time of Death, Stroke Alert, etc.) and assessment findings shall be documented in the appropriate data field. Solely documenting information in the narrative is not sufficient. as to why it was not performed.

- All vascular access attempts must be documented. Including (type, size, location, and outcome (successful/unsuccessful).

- Patients with complaints of any type of pain will have at least two pain scales documented along with any (and all) treatments administered. Pain scale will be reassessed after treatment and documented appropriately.

- Patient signatures are required to be obtained by the patient on all patient contacts. If a patient signature is unable to be obtained, a responsible party, hospital staff member or witness signature can be obtained in place of the patient signature. If a patient signature is unable to be obtained, the reason for not being able to obtain the signature must be documented in the PCR.

- In the event a patient refuses medical assessment, treatment, intervention, or transport, every effort must be made to have patient sign stating that they are refusing and what they are refusing. There must also be clear and detailed explanations documented on the PCR citing that patients were informed of any risks, consequences, and/or benefits to what they are refusing.

- Physician signatures are encouraged for any medical control consultation, for termination of cardiac arrest, all advanced airway confirmations and any order outside of the current Connecticut EMS Protocol.

- ePCR software shall be capable of including all trend data, events, and ECGs uploaded from the cardiac monitor in the PDF version of the ePCR and shall be transmitted to the YNHH ESO HDE.

- Time of prehospital alert notification must be documented on all patients meeting alert criteria. If patients meet alert criteria, and no alert notification is made, the reason for this must be documented.

- Medications are to be administered as outlined in the most current version of the statewide EMS protocols. Any deviation from protocol must include a rationale for administering a different dose and must be done through direct medical oversight. An EXCEPTION FORM must be completed in these instances.
- Expletives are NOT TO be included in the run form. This is, in a word, unprofessional and lends nothing to the description of the patient encounter. If, in the opinion of the documenting provider, such language must be included, statements such as “expletive deleted” or something to a similar effect are an acceptable replacement for the actual word.
- Medical abbreviations should be limited to those accepted by a reliable source. Two examples include Taber’s Online (https://www.tabers.com/tabersonline/view/Tabers-Dictionary/767492/all/Medical_Abbreviations) and OpenMD. (https://openmd.com/dictionary/medical-abbreviations). Each agency should consider identifying such a source for its own use.

CHIEF COMPLAINT SPECIFIC GUIDANCE

ACS/NON-TRAUMATIC CHEST PAIN

- Time of first medical contact
- 12 lead acquisition, interpretation, and time acquired (attach to PCR electronically)
    - Photographs of EKGs may be attached provided the ENTIRE EKG printout can be seen.
- Was a PAMI alert notification made and the notification time?
- Aspirin administration for appropriate patients and dose (or "catch-up" dose.)
    - Document if the patient has taken aspirin and what dosage prior to arrival
- Use of nitroglycerin prior to EMS arrival, how many tablets/sprays, and time taken
- Use of erectile dysfunction drugs within the last 48 hours and type

STROKE/CVA

- The time the patient was last known well
    - The LKW time is defined as the last time the patient can be confirmed to be at their baseline.
- Performance of and the time a Cincinnati Pre-Hospital Stroke Scale (CSS) was assessed
- Documentation of each component of CSS score
    - For example, document facial droop, slurred speech and pronator drift rather than CSS of 3.
- Blood glucose level via finger stick
- Was stroke alert notification made and the notification time?
- Contact information of a reliable family member/ witness

SEPSIS

- Documentation of temperature, either subjective/tactile or through the use of a thermometer
- A complete set of vital signs as defined in this document
- End-tidal CO2 with attached values and waveforms
- Administration of a fluid bolus and total volume infused
- Was a sepsis alert notification made and the notification time?

TRAUMA

- Mechanism of injury and description
- Documentation of each component of the Glasgow Coma Score
    - For example, document E4, V5, M6, rather than GCS 15.
- Application of SMR.
    - If SMR was not applied/ performed documentation of c-spine clearance and the assessment used to clear the cervical spine according to protocol 4.5
- IV access if attempted.
    - If IV access was not attempted or deferred, a rationale must be documented.
- Steps taken to preserve body temperature of patient suffering from major trauma
    - Major trauma is defined using a validated scale during the PCR review process. For the purposes of this document, major trauma include, but not limited to
        - Penetrating to the head, neck, torso, proximal extremities
        - High speed MVA w/wo ejection
        - Fall from a substantial height
        - Hemodynamically unstable patients due to a traumatic cause
- Accurate location(s) of any injuries using the specific medical terminology
- Start and end times of extrication when applicable
- Was a trauma alert notification made and the notification time?

AIRWAY

For BLS providers, assess the potential difficulty of ventilating a patient with a BVM using the ROMAN mnemonic:

- Radiation/Restrictions
- Obese/Obstruction/OSA
- Male/Mallampati/Mask Seal
- Age
- Neck stiffness

DIFFICULT INTUBATION:

The LEMON assessment may be used and documented when considering endotracheal intubation with or without the use of rapid sequence intubation.

- Look externally for clues that may hamper the attempt
- Evaluate the 3:3:2 rule: three fingers between incisors, thyro-mental distance of three fingers, hyoid to cricoid distance of two fingers
- Mallampati score: Scores greater than 2 are at increased odds of a difficult intubation
- Obstruction: Swelling, secretions, tumors, etc.
- Neck mobility: Neck stiffness that would prevent optimal positioning

INTUBATION/ADVANCED AIRWAY MANAGEMENT

- Indications for choosing to intubate the patient?
- Patient's weight in kg
- Medication dosages
- Preoxygenation: What technique was used to preoxygenate the patient?
- Blade type and size: curved, straight, 0-4, video laryngoscopy
- Intubation attempts and successes
    - An intubation attempt is defined as the placement of the laryngoscope blade into the patient's mouth
- Size of the ETT and depth at the lip line and how secured (e.g.. commercial device)
- Verification of placement via:
    - Auscultation (e.g., breath sounds clear and equal bilaterally w/o sounds over the epigastrium)
    - Direct visualization (e.g., the ETT was seen passing through and resting between the vocal cords)
    - Bilaterally equal chest rise and fall
    - Waveform capnography (a description of the wave form and ETCO2 reading)
        - continuous waveform capnography must be included on all intubated patients,
- If cricoid pressure was applied
- A secondary airway device used if intubation was not elected or not successful.
- For alternate airways, document the size, type, and technique used to insert the device must be documented

CARDIAC ARREST

- Approximate time of collapse if it can be determined
- Was the arrest witnessed and if so, by whom (for example bystander, family member, EMS provider)
- When was last time the patient was seen awake or at their baseline?
- Presenting rhythm. This may be documented as "shockable" or "not shockable" if an AED was applied.
- Were dispatcher CPR instructions provided and/or layperson CPR performed prior to arrival.
- Use of an AED/ prior to arrival, number of shocks delivered, and time of shocks delivered if known
- Use of mechanical CPR devices such as the LUCAS device and time of application if known
- If/when CPR was terminated and why.
- Was ROSC achieved, at what time, and what physical/physiological indications?
- What was the patient's rhythm upon arrival at the ED?

- If resuscitation was not attempted in the field, why and what indications precluded the attempt.
    - Refer to protocols
- If direct medical oversight was consulted, what facility and physician was contacted.
- What time was the presumption made?
- All EKG tracings attached to the ePCR

ANALGESIA/SEDATION (PATIENT OR PROVIDER ADMINISTERED):

- Use of age-appropriate pain scale with first and last pain score, at a minimum
- Use of basic adjuncts for pain management
- Patient weight in kg
- Medications and dosages administered with times
- Documented reassessment of pain following any intervention for pain management (e.g. ice packs, splinting, positioning, padding, etc.)

CPAP

Indications for the use of CPAP include the following:

- Clinical presentation
- The patient is alert and able to follow commands
- The patient's respiratory rate is greater than 10 breaths per minute
- No evidence or suspicion of pneumothorax or other injury/procedure related to the tracheobronchial tree
- No active nausea or vomiting
- Initial PEEP setting and any changes made
- Pulse oximetry reading

IV INFUSIONS

- IV site
- The gauge of angio-catheter used
- Medication dosage and concentration, if applicable
- Fluid type and bag size
- Rate of administration (TKO or KVO is appropriate when a fluid bolus is not being administered)

MVC

- Type of vehicles involved and type of crash
- Restraints used
- Intrusion into the passenger compartment and other damage to the passenger compartment
- Position of the patients and was there any deaths within the passenger compartment
- Speed and skid marks present

OPIATE OD

- BVM ventilation prior to any naloxone administration
- Was naloxone administered prior to EMS arrival, by whom, and how much
- Naloxone only administered for patients with suspected opiate overdose exhibiting hypo-ventilation
- Lowest effective naloxone dose administered
- If the agency is participating in the naloxone leave behind program, documentation of with whom the naloxone was left with
- If the agency has selected to add buprenorphine to its formulary, documentation of the Clinical Opioid Withdrawal Score prior to administration of buprenorphine

REFUSAL

- Please refer to protocol 6.12

PHYSICAL OR CHEMICAL RESTRAINT

- Reason for restraint clearly documented and appropriate for use of restraint
- Attempt made to deescalate the patient prior to administering medications
- Documentation of the Richmond Agitation Sedation Scale prior to administering any chemical restraint. See protocol 6.16
- Assessment/reassessment of distal CMS documented after application of physical restraints
- Ventilation, oxygenation, and hemodynamics are closely monitored following any restraint.
- Patient weight in Kg for weight based medications