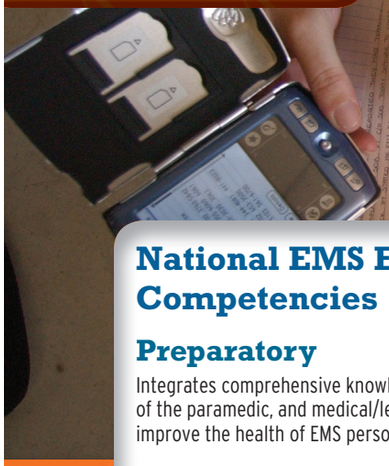
CHAPTER 6



Documentation

National EMS Education Standard Competencies

Preparatory

Integrates comprehensive knowledge of the EMS system, safety/well-being of the paramedic, and medical/legal and ethical issues, which is intended to improve the health of EMS personnel, patients, and the community.

Documentation

- Recording patient findings (p 149)
- Principles of medical documentation and report writing (p 149)

Medical Terminology

Integrates comprehensive anatomic and medical terminology and abbreviations into written and oral communication with colleagues and other health care professionals.

Knowledge Objectives

1. Describe the purpose of documentation. (pp 151-152)
2. Identify the information required in a patient care report. (PCR) (pp 153-154, 158-159, 163)
3. Explain the legal implications of the patient care report. (pp 149-150)
4. Discuss the implications of the Health Insurance Portability and Accountability Act of 1996 as they relate to documentation. (pp 150-151)
5. List standard items that must be documented for every emergency call. (pp 153, 163)
6. Discuss the process for documenting transfer of care, and special considerations surrounding documentation. (pp 154-158)
7. Discuss state and/or local special reporting requirements, including multiple-casualty incidents, exposure situations, involvement of other agencies, workplace injuries, interfacility transfers, and potential abuse or neglect. (pp 156-158)
8. Understand how to document refusal of care, including the legal implications. (pp 154-156)
9. Compare handwritten reporting with electronic reporting, and discuss the pros and cons of each. (pp 152-154)
10. Discuss various types of formats for the narrative portion of the patient care report. (pp 158-160)
11. Discuss why it is important that documentation be accurate, legible, and professional. (pp 159-161)
12. Explain the procedure to follow should an error occur during or after creating a patient care report. (pp 161-162)
13. Discuss the consequences of intentional falsification of documentation. (pp 161-162)
14. Discuss the importance of being familiar with medical terminology. (pp 163-164)

Skills Objectives

1. Demonstrate completion of a patient care report. (pp 158-161)

Introduction

Although the EMS documentation report may not be the first item that comes to mind when you are thinking of pursuing a career in EMS, it is an important part of the patient care process. Thorough documentation pulls the run together for all parties involved. The adage, "No job is finished until the paperwork is done" is especially true in EMS. Your report, most commonly referred to as the **patient care report (PCR)**, is also sometimes called the prehospital care report, and is the only written record of the events that transpired during the call for service. Writing an accurate and proper PCR is one of the most important skills you will learn as a paramedic. The PCR is the legal record for the call and will be a part of the patient's medical record and the hospital's emergency department chart. A complete patient care documentation report will not only allow other health care providers to obtain information about what has occurred from the start of the call to its conclusion, but will also help guide future patient care via research and quality assurance Figure 1. As a paramedic, you must be able to create a patient care report thoroughly and efficiently.

You need to know what constitutes an EMS documentation report, what information must be included, who might read the report, when the report must be completed, and what terminology may be used. Learning to write effectively and accurately is an important paramedic skill. Information may be categorized as objective or subjective. **Objective information** includes the measurable signs that you observe and record, such as blood pressure. **Subjective information** includes information that is told to you, but which cannot be seen, such as the symptoms patients describe—the degree of pain, for example. You must record objective *and* subjective information and the details of patient care for every call in a written or computer-based report, and in some cases, both. This report needs to be complete, accurate, and legible because it can provide the basis of defense in legal proceedings and is of vital importance to your service or agency for many other reasons as well, including facilitation of quality care, continuity, and billing insurance. Your report should "paint a picture" of the entire call that is accurate and clear to the reader.

Legal Issues of a Patient Care Report

Although you may include subjective information from the patient, such as statements from him or her about symptoms, no bias or personal opinions (subjectivity) of yours should be contained within your report. An example of such would be if you

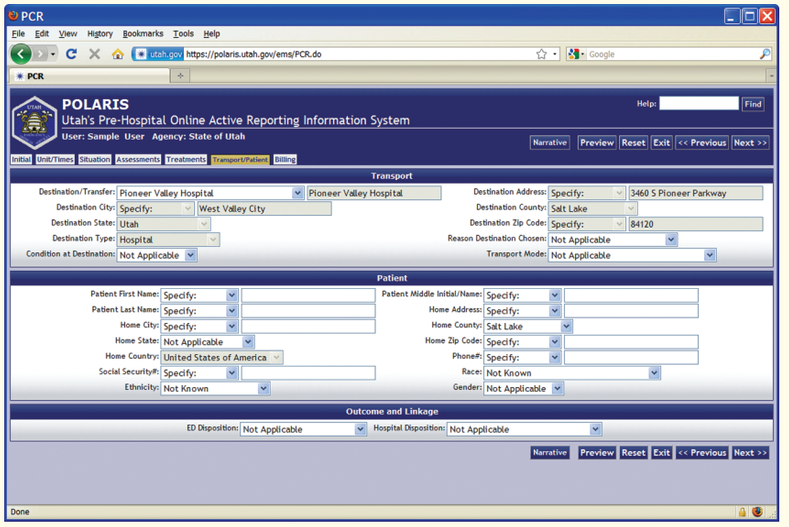


Figure 1 Electronic patient care reports are the standard in EMS documentation. An online patient care report is shown here.

YOU are the Medic PART 1

Your unit has been dispatched to a single-vehicle collision involving a pole near the county courthouse at approximately 1300 hours on a weekday. On arrival, you ensure that the scene is safe before you exit the ambulance. The vehicle appears to have light damage to the front bumper and hood. You don your personal protective equipment and approach the vehicle. As you are walking up, a man opens the door of the vehicle and attempts unsuccessfully to stand up. The man falls back down on the seat exclaiming in a loud, slurred voice, "I need my lawyer." You look past the patient into the passenger compartment and see that the air bags have deployed.

1. What is your first consideration in regard to this patient?
2. What is your first consideration in regard to the scene?

documented "the patient was drunk and out of control" versus "the patient had an altered mental status and stated he had eight beers today." Poorly written, inappropriately documented PCRs could have adverse implications for patient care and for your career. Omissions or errors in your report could lead to further errors in care. Improper and inadequate reports also could result in litigation, loss of job or position, a negative reflection on one's reputation as an EMS professional, and more.

No matter your particular writing style, your report should be complete, well written, legible, professional, and your sole source of information about the call. Your report may also be used in legal proceedings against you or someone else. In some cases, it may be your only defense against a complaint about a call—if you document what happened, you will have solid evidence of your conduct and what transpired on the call. Your memory may not serve you well 5 to 7 years from now, but your written report will remain as a record. If it is well written, it will jog your memory and should provide a picture of the events of the call to all who read it. As a health care professional, it is important that you use proper spelling, proper grammar, and accurate terminology in your report. Do not attempt to use medical terms and abbreviations if you do not fully understand their meaning. Never make up your own abbreviations because they will only be meaningful to you and could confuse others. Doing so could result in patient care errors and leave your professional character at stake if the report is called into question. Your report is the only record of why you performed a certain procedure or why you administered a particular medication to a patient.

The following is an example that illustrates the importance of neat and accurate documentation. A town's EMS agency was being sued for providing inappropriate care to a patient with a spine injury. During the discovery phase of the lawsuit, the attorney for the town decided to settle the case out of court based on the fact that the PCR was sloppy (sloppy documentation implies sloppy care) and incomplete (not clearly documenting whether distal pulses, and motor and sensory functions [PMS] were assessed before and after immobilization of the patient).

Another example of poor documentation was a case where a 15-year-old boy had been involved in a motor vehicle crash and the paramedic crew had to secure his airway because of head trauma. The patient was transferred to a trauma center, where the emergency department (ED) physician found the patient to be extubated. The patient survived but sustained a significant brain injury. The family sued the paramedic crew, claiming that their son was brain damaged from the hypoxia caused by the failed intubation and not the significant head trauma. The crew testified that they had continuous capnography indicating a secured airway throughout transport, yet they had failed to document such readings in their narrative. Although it was likely that the patient was extubated while being moved to the ED exam bed, the crew's failure to document their readings resulted in a finding for the family. The agency lost a significant monetary amount as a result.

Confidentiality and HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. Many people are confused about the legal issues surrounding HIPAA and feel that any release of a patient's private medical information may result in penalties. HIPAA was an attempt to protect a patient's privacy, but it also attempts to permit disclosure of patient care information and other processes for the purposes of treatment, payment, or operations. The HIPAA Privacy Rule, which is the most relevant part of HIPAA for health care providers, is enforced by the Office for Civil Rights. The HIPAA Privacy Rule protects a person's identifiable health information. Additionally, the HIPAA Security Rule is the portion of HIPAA that pertains to protecting electronic health information.

HIPAA was not created to stop the flow and continuity of a patient's health care information, but to control the distribution of information to ensure that a person's privacy is kept. In essence, HIPAA mandates that patient information shall not be shared with entities or persons not involved in the care of the patient. For example, EMS providers may be confused about how HIPAA affects the area of patient follow-up. When you treat and transport a patient to the receiving facility, you may inquire as to what further care your patient required once you transferred care.

One final note on the importance of HIPAA regulations has come about in recent years as social media networks came into existence and gained popularity. Many agencies have created policies to address issues associated with patient care information being shared over Internet media. Some have gone as far as not allowing cellular phones with a camera to be in the possession of EMS providers while on duty. As a paramedic, you must take the first step to ensure that everyone on your call recognizes the importance of not posting any patient information (photos, comments, data, etc) on any social media network.

HIPAA rules and regulations should be taught to all entities involved. Each agency in the United States that is a covered entity defined by the U.S. Department of Health and Human Services should follow HIPAA guidelines to help protect the patient and the provider. Each agency, in compliance with HIPAA, shall have a designated officer who can help you better understand all of the rules and regulations associated with HIPAA and your role in EMS.

Special HIPAA Circumstances

There are times that the HIPAA Privacy Rule acknowledges that patient information must be shared for the betterment of society

Documentation and Communication

To help protect patient information, do not leave PCRs or assessment cards on counters or any other area that is not secured. Many agencies use lockboxes as the location where completed PCRs should be placed.

as a whole. The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. Some of the areas that are included for such information release are births, deaths, disease, or injury that are being investigated or are at risk of causing a public epidemic, and abuse cases. Exchange of health information for a medical need is allowed under HIPAA, and is in fact ethical and necessary. For example, electronic transfer of health information from your electronic documentation report to the receiving hospital is perfectly appropriate. A physician dictating patient information into a dictaphone which is then transcribed into the patient's record is also appropriate. Furthermore, it is perfectly acceptable and permissible under HIPAA for hospitals to share information with the EMS providers about patient outcome for the purposes of quality assurance, quality improvement, and education. It is clearly important and necessary for you to understand the outcome of your interventions so that you can learn. Finally, exchange of health information for insurance and billing purposes is appropriate, although in most cases the billing agency must sign an agreement indicating that the health information will be used for billing purposes only, and will not be shared with outside parties.

Purposes of Documentation

Continuity of Care

The PCR serves as a record of the patient's condition on your arrival at the scene, the care that was provided, any changes in the patient's condition en route, and condition on arrival at the hospital. It is critical that you document everything as clearly as possible because the report will help other health care providers at the hospital understand the particular emergency and assessments and treatments performed thus far. Accurate reporting helps paint a picture of the environment the patient was taken out of, the mechanism of injury, and ultimately leads to better patient care.

Minimum Requirements and Billing

Billing and administration are significant reasons why PCR writing needs to be accurate and complete. Most EMS agencies now need to bill for services to recover the costs of providing patient care. For complete and accurate revenue recovery, you must ensure that all procedures performed are documented, insurance codes obtained, and the appropriate **medical necessity** signature obtained (where required). You need to document why a patient may have needed emergency care, especially in the case of private or scheduled transports, to ensure your service's billing information will result in payment from the responsible insurer, agency, or private payer. It is imperative for you to be accurate and complete in your documentation so that time is not spent correcting the documentation, thus delaying billing processing. You will often be trained by your agency and its billing company about what additional forms you need to complete as a part of each EMS response. EMS providers must understand that completing billing paperwork and supplying the most accurate and defensible information to the EMS agency are necessary portions of the call.

Medicare sets the standard for medical necessity. The chart shown in Table 1 gives some of the significant findings that are required to show that the patient needed to be transported by an ambulance rather than by other means of transportation.

EMS Research

Just as billing has become necessary in EMS, so has research. As mentioned in the chapter, *EMS Systems*, proper documentation done by all EMS providers results in compiled data that are reviewed by researchers who then use that data to justify innovative, lifesaving techniques. Many states now require EMS agencies to submit data to their state EMS office to verify call volumes and skills used. This data may include the number of calls an agency responds to, the types of calls, care provided, and patient outcomes. Such patient care data collection can lead to improvement of the EMS system as a whole.

The National Emergency Medical Services Information System (NEMSIS) stores standardized EMS data from each individual state. This central repository will help assist states in collecting comparable data elements so the entire nation can benefit from research and use the trends for future curriculum development. The goal of NEMSIS is to define EMS care by collecting data to improve patient care, indicating equipment needs, and defining a standard of care across the nation.

Incident Review and Quality Assurance

On occasion, EMS reports may be requested for medical audits and other educational activities. Run reviews, or sessions in which peers and other medical professionals review care reports for adherence to local protocols, quality assurance, and quality monitoring, may occur. Your reports may be used to calculate

Table 1 Significant Findings that Indicate Medical Necessity for Ambulance Transport

- Patient is transported in an emergency fashion (Code 3).
- Patient is in shock.
- Patient needs to be restrained.
- Patient requires emergency treatment while being transported (eg, oxygen therapy, IV therapy).
- Patient must be immobilized for transport or fracture management.
- Patient is experiencing an acute myocardial infarction (AMI) or stroke.
- Patient has uncontrollable hemorrhage.
- Patient is only able to be moved by a stretcher because of a condition.

the number of times you have performed a specific skill, such as medication administration or oral intubation. Always accurately document all skills attempted and performed with patient care.

Documentation and Communication

EMS agencies and departments should have a process to ensure that all reports are well written and a quality assurance program to ensure that what was written in the PCR actually occurred as stated on the call.

Types of Patient Care Reports

EMS has entered an age in which electronic documentation has become the standard. Although some services still use paper documentation, you will most likely document your emergency calls and other reports electronically. Electronic documentation has many benefits as discussed later in this section. Perhaps the most significant benefit is the ability for electronic data to be shared—between the facilities and personnel involved in a patient's care, thereby improving continuity and efficiency, but also among state and national databases to improve national data collection and further the advancement of evidence-based practice.

A multitude of patient care report designs exist throughout the United States and range from half-page notes to complete and thorough reports. EMS patient care reporting has evolved over the years because the field of medicine has recognized the necessity for information about the patient's condition and interventions performed in the field. The old adage of "it didn't happen unless it was written down" has pressured some services to create run reports that nearly eliminate the narrative section (the section that allows for free-form writing) and replace the space with check boxes, or with electronic dropdown menus with predetermined terms. You may encounter some reports that have hundreds of check boxes allowing for you to mark every action you took. The problem with these types of reports is that the format increases the risk of errors when your eyes become overwhelmed by so many boxes and the wrong boxes are filled in. It is important that, regardless of what form of patient reporting your service may use, that the proper information is obtained and documented.

Paper reporting is becoming a thing of the past because it is a duplication of work in the health care system. To fulfill EMS data collection requirements, handwritten reports must be entered into an electronic system, either by health care agencies or outsourced to separate companies. Along with the additional data entry needs, a paper system also requires space to store the records, possibly for a lengthy period of time depending on state laws. The final reason there is a major shift away from paper reporting systems is error reduction. Oftentimes penmanship and spelling errors lead to medical mistakes when it comes to medication doses and orders; an electronic system minimizes these issues.

With today's technology, a multitude of companies have created a variety of electronic patient care reports. These services range from scanning of paper forms to computer-based programs for desktops, tablets, and laptops, allowing for a more accurate and legible report Figure 2.

Modern data systems can incorporate data from various sources, such as multiple facilities—a feature that is in line with the major effort to improve the quality of cardiac, stroke, and diabetic care, and improve the success of resuscitation efforts. Such cutting-edge systems are being used by hospitals and physicians, and will ultimately involve EMS documentation so

YOU are the Medic PART 2

The engine company that was dispatched with you arrives on scene, parking to ensure scene safety. Your crew directs the engine company to make sure the vehicle is secure while you and your partner attempt to speak to the patient. The patient yells at you to leave him alone. Your partner taps your shoulder and asks you if you smell alcohol and you reply that you do. She also points to an empty vodka bottle on the floor of the vehicle. The patient yells, "You don't know who I am, do you? You're going to pay!" You hear a bystander standing behind you say, "Isn't that Assemblyman Taylor?"

Recording Time: 0 Minutes	
Appearance	Awake
Level of consciousness	Alert
Airway	Open
Breathing	Adequate
Circulation	Appears normal

3. Why is it not acceptable to document the patient's appearance as "drunk" on a PCR?
4. Would it be acceptable to document that the patient is "yelling" for the breathing description on a PCR?

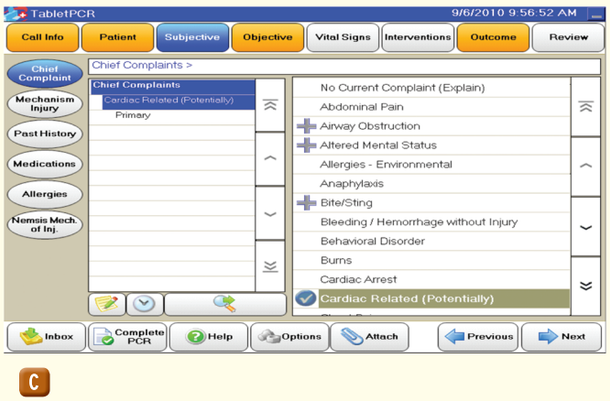


Figure 2 A variety of software programs exist for creating electronic patient care reports, allowing EMS personnel to clearly document details of the call.

that the patient care report contains prehospital information documented in the field, and further data from the hospitals or facilities where the patient was treated, resulting in one comprehensive record of the care the patient received.

Programs for computer-based PCRs should be NEMSIS-compliant to ensure that data can be shared on a national level. As mentioned, data submission to NEMSIS is important for EMS research, and to assess and improve EMS care throughout the country. NEMSIS' goal is to facilitate submission of EMS data from all states, and part of that is to implement electronic documentation systems in all states. The majority of US states and territories are submitting electronic data to NEMSIS, or are actively working toward achieving this in the near future.

Some of the benefits of the electronic reporting system are the ease of data collecting, merging data into hospital systems, and a decrease in patient medication errors. With the growing environment of lawsuits, the electronic report eliminates many of the spelling and legibility issues that have arisen in the past. Regardless of agency size, the major obstacle that often stands in the way of agencies switching from paper format to an electronic format is the cost of purchasing computers and software and yearly maintenance for the electronic PCR; however, most services that bill insurance, Medicare, or the patient noted that though the upfront costs of going to an electronic system were expensive, collection improved significantly once the system became computerized. Another possible obstacle in electronic reporting is that it relies on technology, which is not always reliable. Also, systems need to be interchangeable so data can easily transfer into the hospital ED systems.

Documentation for Every EMS Call

Every EMS call requires documentation. There are standard items that you will document on every call, which are called the minimum data set. The minimum data set is the mandatory clinical assessment standard information that must be documented on every emergency call as set by Medicare and Medicaid, and per the National Highway Traffic Safety Administration (NHTSA) for the purpose of the national data system. The minimum data set is divided into two sections: run data and patient data. Run data consist of such information as incident times, locations, responding units, and crew members working at the incident. Patient data includes basic patient information collected on a PCR, documenting the following:

- Chief complaint
- Level of consciousness (according to the AVPU scale) or mental status
- Vital signs
- Assessment
- Patient demographics (age, gender, ethnic background)

The PCR should contain your objective observations of the scene, as well as the treatments provided, their effects, and any changes that occurred in the patient's condition during the

Documentation and Communication

To understand how electronic data collection can improve operations, consider the following two methods (paper versus electronic).

Paper

- Citizen calls for assistance.
- Dispatcher handwrites the information.
- Ambulance is dispatched with the information given over the radio. Information may need to be reconfirmed two or three times.
- The crew treats the patient and transports to the hospital.
- At the hospital, a handwritten PCR is generated.
- A copy is left at the hospital and the original logged and stored at the station.
- The paperwork is picked up and taken to the headquarters station (sometimes located far away) where it is reviewed, sorted, and coded by the supervisor.
- The paperwork is forwarded to the business office where it is entered into a computer system for billing.
- The supervisor in charge of quality assurance/quality improvement manually sorts through PCRs for review.

Electronic

- Citizen calls for assistance.
- Dispatcher electronically enters information while on the phone with the caller.
- Dispatcher assigns the call to an ambulance in the computer-aided dispatch, immediately pulling up a map on the computer screen showing the exact location of the call.
- Dispatcher pages the crew; crew steps into ambulance.
- If a mobile data terminal is installed in the ambulance, the problem, any hazards associated with the address, and the street address with a location on a computer map are right there.
- EMS arrives on scene and treats the patient. Transport to the hospital is completed.
- The crew fills out a short paper form with the basics of demographics and treatments given. This form is left with the emergency department staff.
- The crew synchronizes its laptop with the server through a Wi-Fi (wireless-fidelity) connection. Information gathered by the dispatcher is downloaded into the patient record.
- En route to the station, the crew uses a touch screen to select information for the PCR, which reduces the narrative required and allows for drawing injuries and complaints on an anatomic model.

emergency call Figure 3. Depending on your transport service type, you may need to differentiate the treatments between those that were scheduled, such as in a transfer transport, and those that were unexpected because of changes in a patient's condition.

Transfer of Care

As the growing need for medical care begins to exceed that which is available, EMS personnel are seeing overwhelmed emergency departments and often find themselves leaving patients in hallways waiting to be seen. In your documentation of patient care, it is important that you are able to show in whose care you left the patient; otherwise, you could face allegations of abandonment. Some agencies have begun to require physician or nurse signatures to verify that the patient was left with a medical professional of a higher level of training. Another situation that may require you to document a transfer of care is when you hand over your patient to another agency such as a paramedic transport crew or an air medical team.

Care Prior to Arrival

More emergency dispatch centers are going to a system called emergency medical dispatch (EMD), which allows the dispatcher to provide directions to the caller for medical care. These programs are becoming very sophisticated, allowing the dispatcher to provide detailed medical care and medication administration via the phone. You may encounter such cases in your response area and it is important not only to obtain the information from the patient or caller as to what care they have provided prior to your arrival, but to also document such findings. A good example of this delivery of care is when a person calls 9-1-1 to an EMD center and tells the dispatcher that he or she is experiencing chest pain. After detailed questioning, the dispatcher may have the patient take 324 mg of aspirin, for example. If you fail to obtain such information from the patient and then relay that information to the hospital via your report, the patient could accidentally be given the same medication again, increasing the risk of complications.

You may also encounter off-duty health care providers and lay personnel providing emergency care prior to EMS arrival. Be sure to include their procedures in your report with specific notations that this care was provided prior to your arrival and by whom it was provided.

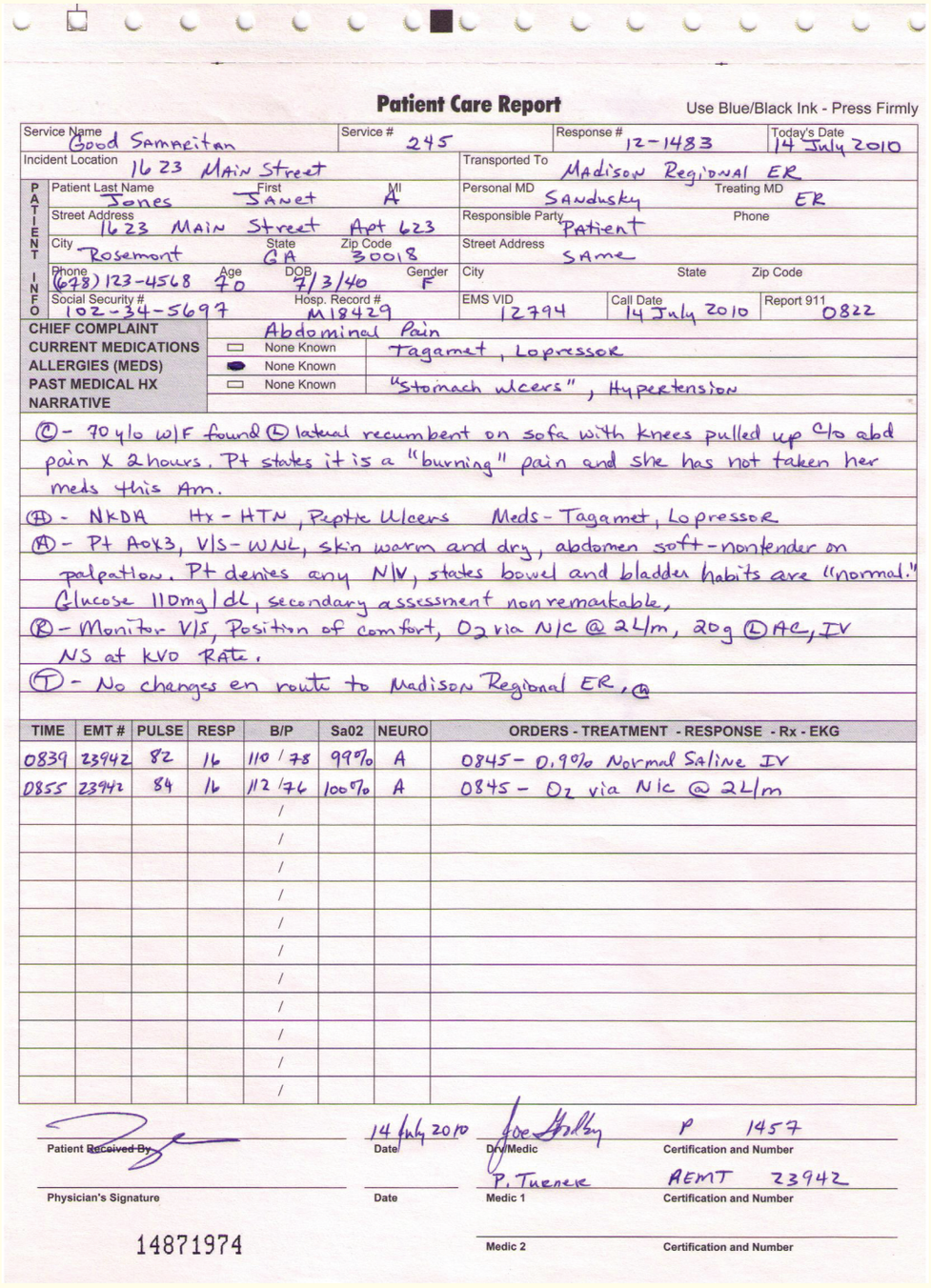
Situations Requiring Additional Documentation

There are special situations that require additional or different reporting procedures. These are discussed in the next sections.

Refusal of Care Reporting

Legal aspects of patient care were discussed in the chapter, *Medical, Legal, and Ethical Issues*, but this section will cover the necessary documentation in more depth. With the growth in malpractice lawsuits, refusal of care is one of the most difficult elements of patient care documentation, but also one of the most important. Competent adult patients have the right to refuse medical care or to consent to treatment. You must know and understand the rights of your patients. You should also be very familiar with the applicable laws in your state about patient care and who has the right to refuse such care. For a person to refuse care, the decision must be based on the patient's knowledge of his or her situation.

Your most important job is to ensure that your patient is fully informed about his or her current situation, the right to receive and refuse medical care, and the consequences of such a refusal of care. You should have explained and the patient must understand,



Patient Care Report — Use Blue/Black Ink - Press Firmly

Service Name: Good Samaritan	Service #: 245	Response #: 12-1483	Today's Date: 14 July 2010
Incident Location: 1623 Main Street		Transported To: Madison Regional ER	

PATIENT INFO

Patient Last Name: Jones	First: Janet	MI: A	Personal MD: Sandusky / Treating MD: ER
Street Address: 1623 Main Street Apt 623		Responsible Party: Patient	Phone:
City: Rosemont	State: GA	Zip Code: 30018	Street Address: Same
Phone: (678) 123-4568	Age: 70	DOB: 7/3/40	Gender: F
Social Security #: 102-34-5697	Hosp. Record #: M18429	EMS VID: 12794	Call Date: 14 July 2010 / Report 911: 0822

CHIEF COMPLAINT		Abdominal Pain
CURRENT MEDICATIONS	☐ None Known	Tagamet, Lopressor
ALLERGIES (MEDS)	● None Known	
PAST MEDICAL HX	☐ None Known	"Stomach ulcers", Hypertension
NARRATIVE		

C - 70 y/o W/F found L lateral recumbent on sofa with knees pulled up C/o abd pain x 2 hours. Pt states it is a "burning" pain and she has not taken her meds this Am.
A - NKDA Hx - HTN, Peptic Ulcers Meds - Tagamet, Lopressor
A - Pt AOx3, V/S - WNL, skin warm and dry, abdomen soft - nontender on palpation. Pt denies any N/V, states bowel and bladder habits are "normal." Glucose 110mg/dL, secondary assessment nonremarkable.
R - Monitor V/S, Position of comfort, O_2 via N/C @ 2L/m, 20g L AC, IV NS at KVO RATE.
T - No changes en route to Madison Regional ER, @

TIME	EMT #	PULSE	RESP	B/P	Sa02	NEURO	ORDERS - TREATMENT - RESPONSE - Rx - EKG
0839	23942	82	16	110/78	99%	A	0845 - 0.9% Normal Saline IV
0855	23942	84	16	112/76	100%	A	0845 - O_2 via N/C @ 2L/m
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Patient Received By — Date: 14 July 2010 — Drv/Medic: Joe Smith — Certification and Number: P 1457

Physician's Signature — Date — Medic 1: P. Thenese — Certification and Number: AEMT 23942

14871974 — Medic 2 — Certification and Number

Figure 3 The minimum data set includes both patient information and administrative information.

refusal section of the PCR. The refusal documentation should clearly show the process you went through, how was it was documented, and who witnessed it. It is not merely about getting the patient to sign the refusal section.

Unresponsive patients may be treated under implied consent. All paramedics should be familiar with the laws of their state regarding the age of consent, care of minors, emancipated minors, and people with mental or cognitive impairments, such as mental illness or the effects of drug or alcohol use. Above all else, you need to confirm that every reasonable effort has been made to ensure the patient's welfare and best interests.

If the person refusing care has an obvious injury or medical condition that requires immediate medical attention, you should involve online medical control for further guidance and assistance. In such cases where you, the provider, do not agree with the refusal, you should have a protocol or policy in place of what your next steps should be—for example, contact your supervisor, involve law enforcement, or involve medical control. If contact is made with any of those parties, it should be documented on the PCR, including the events that transpired.

It is essential that you have a witness to the process to ensure that your patient has sufficient knowledge of the situation to make an informed choice. If the patient refuses to sign the form for refusing treatment, your witness should also be present. The observations of the witness should be documented, and the name and contact information of the witness should be included.

A complete history and assessment should be performed or attempted when possible and practical. This includes obtaining a full set of baseline vital signs. A patient's refusal to allow such an assessment should be well documented on the PCR. Be sure to in great detail, the potential consequences of refusing medical care when it may be warranted, including the possibility of death. This information needs to be conveyed in a language that the person understands, and this information must be subsequently documented on the PCR. Some agencies will write this on the PCR and have a witness observe them reading it to the patient, and will ask the patient to initial the statement followed by a signature on the

evaluate the patient's mental status. A person's mental status may be considered impaired if the person is not oriented to person, time, or place or makes nonsensical statements. The impairment can be a result of an injury, a medical condition, such as electrolyte imbalance or hypoglycemia, mental illness, or drugs or alcohol.

You should always politely and tactfully explain to patients that they have the right to change their mind and may recall EMS later. Such an exchange of information should be witnessed and documented with signatures and identifying information such as phone numbers of the witnesses involved, who frequently may be law enforcement personnel or others at the scene. Clearly document the care that you intended to provide if the patient had not refused care. Also, be sure that you have proposed all potential methods of care, including alternatives that may be options, even if they are not your first choice of treatment. An example of an alternative could be that the patient is going to be taken to the hospital for further care by a family member. Although that may not be the ideal situation, ultimately the patient will at least be seen at the hospital. Always encourage transport via ambulance because a patient's condition can change at any time, and without medical personnel there to assist, the change could have serious consequences.

The PCR should be thoroughly completed and well documented for all patient refusals of care Figure 4. At times, patients may agree to transport but refuse a particular procedure such as IV therapy or backboarding procedures. In such cases, refusal of the specific procedure(s) should be handled as if it is a refusal of care, including an explanation of associated risks and complications of refusal, a signature by the patient acknowledging refusal of a portion of care, a witness, and complete and accurate documentation.

Table 2 provides a reasonable list of items that should be included within the PCR of a patient refusal.

Workplace Injury and Illness Documentation

With the growing budgetary restrictions in many workplaces, a paramedic often provides workplace medical care rather than a traditional nurse providing it. According to OSHA guidelines, workplace injuries must be logged. Institutions may also have their own forms and requirements for documenting workplace injuries. Many injuries are minor, requiring only basic first aid and thus do not require an OSHA record; however, local documentation may still be required by the company. When documenting workplace injury or illness, be sure to document what precautions were taken and what protective equipment was being worn by the person involved. Companies can be fined heavily for safety violations, so it is important from the employer's and OSHA's point of view that proper documentation occurs. It is important to note that reporting regulations vary from state to state, and you should make yourself familiar with your state's requirements. Paramedics may also perform medical monitoring for hazardous materials (HazMat) teams, may respond to other public employee workplace injuries, or may experience on-the-job injuries or illnesses themselves, which will need to be appropriately documented and reported to supervisors for workers' compensation follow-up.

Special Circumstances

There are many circumstances that you may encounter during your career that can puzzle you with the documentation requirements. Some of those situations could be a multiple-casualty incident (MCI), occupational exposure reports, abuse and neglect cases, and when a physician arrives on the scene of a call. Each of these situations may require specialized forms per your state or local

RELEASE FROM RESPONSIBILITY WHEN PATIENT REFUSES IV THERAPY

This is to certify that I, _____ (patient's name), am refusing IV treatment. I acknowledge that I have been informed of the risk involved and hereby release the emergency medical services provider(s), the physician consultant, and the consulting hospital from all responsibility for any ill effects which may result from this action.

Witness _____ Signed _____ (patient name or nearest relative)

Witness _____ _____ (relationship)

RELEASE FROM RESPONSIBILITY WHEN PATIENT REFUSES SERVICE

This is to certify that I, _____ (patient's name), am refusing the services offered by the emergency medical services provider(s). I acknowledge that I have been informed of the risk involved and hereby release the emergency medical services provider(s), the physician consultant, and the consulting hospital from all responsibility for any ill effects which may result from this action.

Witness _____ Signed _____ (patient name or nearest relative)

Witness _____ _____ (relationship)

RELEASE FROM RESPONSIBILITY WHEN PATIENT REFUSES SERVICES BUT ACCEPTS TRANSPORT

This is to certify that I, _____ (patient's name), am refusing _____ _____.

I acknowledge that I have been informed of the risk involved and hereby release the emergency medical services provider(s), the physician consultant, and the consulting hospital from all responsibility for any ill effects which may result from this action.

Witness _____ Signed _____ (patient name or nearest relative)

Witness _____ _____ (relationship)

Figure 4 A competent adult patient has the right to refuse medical treatment, but it is essential that the paramedic fully inform the patient of potential consequences.

Table 2 Components of a Thorough Patient Refusal Document

Evidence the patient is able to make a rational, informed decision.
Documentation of complete assessment. If the patient refused care or did not allow a complete assessment, document that the patient did not allow for proper assessment and document whatever assessments were completed.
Discussion with the patient as to what care/transportation the provider would like to do.
Discussion with the patient as to what may happen if he or she does not allow care or transportation. Typically these consequences should be listed clearly and should include the possibility of severe illness/injury or death if care or transportation is refused.
Discussion with family/friend/bystanders to try to encourage the patient to allow care.
Discussion with medical direction according to local protocol.
Providing the patient with other alternatives: Going to see his or her family doctor, having a family member drive him or her to the hospital.
Willingness of EMS to return.
Signatures: Have a family member, police officer, or bystander sign the form as a witness. If the patient refuses to sign the refusal form, have a family member, police officer, or bystander sign the form verifying that the patient refused to sign.

agency, so it is in your best interest to become familiar with these local forms of documentation and their requirements for use.

In an MCI, the patient load can very easily overwhelm providers and, in the best interest of patient care, documentation often occurs initially on triage tags. Rather than waiting until an MCI occurs, become familiar with the triage tags, learn where they are stored, the information needed on the tags, and situations that may warrant their use in your agency or department. Although the MCI tag is designed to relay information, it is important for each emergency responder completing the tags to supply as much information as possible on them. When the time comes to transport the patient, the crew in the ambulance should complete a PCR on each patient. Although the information will be limited on the PCR, it is still imperative to complete the report to the best of your ability.

During the course of your work as a paramedic, you will be exposed to many body fluids. If your barrier devices fail or do not offer enough protection, an occupational exposure report should be completed. Because each agency or state creates their own forms for these exposures, it is important that you make yourself familiar with the requirements. Keep in mind that if you treat and/or transport a coworker for an occupational exposure, you should complete a full PCR along with the occupational exposure form.

Additional specialized documentation can be encountered when you are called to scenes of alleged neglect or abuse. It is imperative that you supply as much detail as possible about these circumstances because your initial findings may be the focus of an investigation. Some providers do not document their suspicions of abuse and neglect for fear of allegations from

YOU are the Medic PART 3

You and your partner attempt to reason with the patient to allow you to do an assessment for injuries. The patient tries to push you away and says slurring, "Keep your hands off me! I have rights!" You contact your dispatcher to confirm that law enforcement officers are en route to your location.

Recording Time: 5 Minutes	
Respirations	Unable to measure; appear adequate, approximately 20 to 24 breaths/min
Pulse	Unable to measure
Skin	Unable to measure; appears pink
Blood pressure	Unable to measure
Oxygen saturation (Spo_2)	Unable to measure
Pupils	Unable to measure

5. How should you document that the patient has directed you to "keep your hands off," as well as account for not being able to obtain the patient's vital signs?
6. Does this patient have the right to refuse treatment?

the patient or the abuser of slander. You must document your objective findings and allow the legal system to investigate and make the ultimate determination of abuse or neglect.

When a physician of any specialty arrives or is on the scene of your call, he or she may have the authority under local protocol to interject with patient care and give directives. Most protocols require that once a physician begins care that is beyond the paramedic's scope, he or she must accompany the patient to the hospital to avoid being accused of abandonment. When completing your documentation of such a run, document all orders and actions given by the physician.

You should also document the use of mutual aid services such as helicopters, specialized rescue teams, and other agencies called in to assist. Unusual occurrences should be documented as well, including having to secure the patient with restraining devices for safe transport or other unusual circumstances that arise. If you need to summon an additional crew or specialty vehicle for lifting a heavy patient or if you will have an extended scene time owing to a prolonged extrication, this information should be clearly documented to explain why "something out of the ordinary" occurred. In the event that severe weather conditions delay your response, this should also be documented.

Another special circumstance would be the appropriate documentation, as defined by medical control and your state's laws, concerning drawing a blood sample as evidence for law enforcement personnel who have a driver suspected of being under the influence in their custody. Always follow the policy of your medical director in these special circumstances.

Finally, with the increasing presence of controlled substances in the field of EMS, the paramedic is held responsible for the security and accountability of these medications. Most services require a double signature system any time a controlled substance is checked, used, discarded, or replaced. Documentation of the amount used versus wasted, the patient to whom it was given, date and time, and by whom it was given should all be documented in the PCR along with any specialized accountability forms your agency uses.

Completing a Patient Care Report

Paramedics must know and understand that EMS documentation is a required and necessary element of patient care. Just as you take pride in your patient care skills, you should take pride in your documentation skills. Now that you have been given an overview of the various aspects of the PCR along with special situations to document, you will learn how to complete the patient care report.

The PCR Narrative

As mentioned earlier, the PCR contains check boxes as well as a narrative portion. The narrative portion of the PCR should be a detailed segment indicating the elements of the call. It should be written in a format accepted by your agency and should be accurate and complete. Simply writing "followed ACLS protocols" may not be sufficient documentation for your agency or medical director. Specifics of the call should be recorded such as "the patient was intubated with a 7.5 ET tube and ventilatory assistance provided with supplementary oxygen at 15 L/min. ET tube placement was confirmed by breath sounds, chest rise, and a tube check, before securing the ET tube at the mark of 22 at the teeth. The end-tidal CO_2 detector and pulse oximeter were placed immediately and their readings were: SpO_2 94% and $SQECO_2$ 35 mm Hg." (Always be sure to clarify which is which.) Also, some services will attach a copy of the reading to their documentation; you may wish to do this. Table 3 provides guidelines on how to write the narrative portion of your report.

Any medical control orders received and medical advice given should be documented in the narrative section. In some EMS systems, items such as consultations, orders requested or received from medical control, and any refusal situations in which medical control has been consulted should be documented in detail in the narrative section. Simply writing "see refusal on back" is not an effective method of patient care documentation.

Many methods for narrative documentation exist. Your EMS agency or medical director may prefer a specific method to be used when documenting PCRs. Be familiar with the approved methods and all required elements for report writing for your agency. Some examples of narrative writing styles for reports are as follows:

- **Chronological order.** This is telling the narrative in a story format from the time of the initial dispatch until the call was completed. This format allows you to explain the call from start to finish Figure 5.
- SOAP method: **Subjective, Objective, Assessment, and Plan (for treatment).** Simple and logical method used to document various aspects of the patient care encounter Figure 6.
- CHARTE method: **Chief complaint, History, Assessment, Treatment (Rx), Transport, and Exceptions.** This is similar to the SOAP method, but allows you to break the narrative down into logical sections similar to that of your EMS assessment Figure 7.
- **Body systems/parts approach.** In this format, assessment of each body system is documented from head to toe. This method of report writing may be difficult to apply in EMS and may be too time-consuming for paramedics.

Regardless of the style of narrative report writing you and your service agree on, be sure to follow it routinely. Switching from one format to another or attempting to change formats during report writing may cause you to forget certain elements or essential details that should have been included. Proper grammar and spelling are essential when writing reports. You might consider carrying a pocket guide, reference, or medical terminology book in your ambulance to avoid spelling errors.

Pertinent negatives should be documented when writing your EMS report. This is a record of negative findings that warrant no care or intervention but indicate that a thorough and complete examination and history were performed. For example, "The patient denies any shortness of breath with his chest pain, patient denies any radiation of the chest pain to

Table 3 How to Write a Narrative

Topic	Items to Include
Standard precautions	Were standard precautions initiated? If so, state which precautions you used and why.
Scene safety	Did you have to make your scene safe? If so, what did you do and why did you do it? Did this create a delay of patient care?
Mechanism of Injury/Nature of Illness	Simply state. For example, "motor vehicle crash" or "difficulty breathing."
Number of patients	Record only when more than one patient is present. "This is patient 2 of 3."
Additional help	Did you call for help? If so, state why, at what time, and what time the help arrived. Was transport delayed?
Cervical spine	State what cervical spine precautions were initiated. You may want to include why; "Due to the significant MOI . . ."
Initial general impression	Simply record, if not already documented on the PCR.
Level of consciousness	Be sure to report LOC, any changes in LOC, and at what time changes occurred.
Chief complaint	Note and quote pertinent statements made by the patient and/or bystanders. This includes any pertinent denials; "Patient denies chest pain . . ."
Life threats	List all interventions and how the patient responded; "Assisted ventilations with oxygen (15 L/min) at 20 breaths/min with no change in LOC."
ABCs	Document what you found, and again, any interventions performed.
Oxygen	Record if oxygen was used, how it was applied, and how much was administered.
Primary and secondary assessment, patient history, or reassessment	State the type of assessment used and any pertinent findings; "Secondary assessment revealed unequal pupils, crepitus to right ribs, and an apparent closed fracture of the left tibia." Note the time each assessment was made and the findings.
SAMPLE/OPQRST	Note and quote any pertinent answers.
Vital signs	Your service may want you to record vital signs in the narrative portion, as well as other places in the PCR. Record the times when vital signs were taken, and the findings.
Medical direction	Quote any orders given to you by medical control and who gave them.
Management of secondary injuries/treat for shock	Report all interventions, at what time they were completed, and how the patient responded.

Abbreviations: ABCs, airway, breathing, and circulation; LOC, level of consciousness; MOI, mechanism of injury; OPQRST, mnemonic used to evaluate a patient's pain; PCR, patient care report; SAMPLE, mnemonic used to facilitate obtaining a brief patient history.

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other parts of the body." This would indicate that you not only obtained the information about the chest pain, but also inquired about shortness of breath and radiation of the pain.

The use of pertinent spoken accounts made by your patient and others on scene may be essential to the continuum of patient care. If you use any spoken accounts made by the patient or others, be sure to indicate who made the statement and place the exact words in quotation marks.

This may include statements about the patient's behavior, the mechanism of injury (MOI), and safety-related information such as the use of weapons. Information that may be useful to criminal investigators as a part of their investigation, disposition of valuables, admissions of suicidal intentions made by a patient, or any first aid interventions provided by bystanders before the arrival of EMS can also be useful to list in the narrative section.

Elements of a Properly Written Report

Documentation accuracy depends on all information being provided, such as times, narrative information, and check boxes, and it must be comprehensive and precise. All sections should show that you have completed them, even if a section was not applicable to the call. For example, if your PCR has a section of check boxes for specific information on cardiac arrest calls but the call you are documenting was not a cardiac arrest call, note that on the report in a manner that is approved by your agency. Simply leaving the boxes blank may raise questions about the completeness of the report.

When using a handwritten report, all reports should be legible and written in ink. The color of ink used may be determined by your EMS agency. Standard ink colors of black and blue are most commonly selected. Handwriting, especially in

Squad called to residence for ill man. On arrival found an alert and oriented 78 yo man sitting on the couch reporting CP. Pt sts this began approximately 30 min prior when he was mowing the lawn. Pt denies any radiation of the pain and rates it at a "7" out of 10 on pain scale. Pt has a known cardiac history with an MI 2 years prior. Pt is compliant with all meds as listed above. Pt denies any SOB or N/V with this episode. V/S stable, lungs CTA, Spo_2 96% RA, Skin pale/warm/dry to touch, PEARRL 4 mm, GCS 15. Pt placed on O_2 @ 15 L/min via NRB. Monitor showed RSR @ 88 bpm without ectopy. IV of NS was established in L AC with 18 g @ TKO (medic 785). 2 × 81 mg ASA were given PO @ 1501 (medic 785). Pt was given 1 SL 0.4 mg nitro @ 1503 with relief down to a "4" on scale (medic 785). V/S still stable. Secondary exam showed negative new findings. Med control contacted with negative orders. Left pt in care of ED staff with report in room 7.

Figure 5 Example of a narrative written in chronological order.

Note: In this example, "(medic 785)" identifies which provider performed the intervention. His or her initials may also be used. It is important to document who performed the procedure, because the person who is writing the narrative may not have been the crew member to perform the procedure or administer the medication.

(S) Called to scene for 78 yo man complaining of chest pain. Pt states pain began approximately 30 min prior to arrival when he was mowing the lawn. Pt denies any radiation of pain. States pain is "7" out of 10 on pain scale. Pt has known cardiac hx with an MI 2 yrs prior. Pt denies SOB or N/V. Pt has no allergies and is compliant with all meds listed above.

(O) U/A found Pt sitting on the couch. Pt alert and oriented with NARD and strong radial pulse. Pt calm and cooperative. Skin: Pale/warm/dry. Pupils PEARRL 4 mm, GSC 15. Lungs CTA. No noted JVD. Abd soft and nontender. PMS × 4. Secondary exam unremarkable.

(A) Possible MI.

(P) Primary, secondary Hx, V/S as listed above. Assisted pt to cot. Cardiac monitor: showed RSR @ 88 bpm without ectopy. IV: NS 18 g in L AC @ TKO (BW); Spo_2 – 96% RA, O_2 @ 15 L/min via NRB – 100%; 2 × 81 mg ASA given PO, 1 SL 0.4 mg nitro (BW) – pain down to "4". Transported to _____. Pt care transferred to ED with report.

Figure 6 Example of a narrative written with the SOAP method.

(C) 78 yo man complaining of chest pain without radiation. Pt sts pain is a "7" out of 10 on pain scale.

(H) Pt has a known cardiac history with an MI 2 years prior.

(A) Pt denies any SOB or nausea/vomiting with this episode. Vital signs stable, lungs clear to auscultation, Spo_2 96% RA, skin pale/warm/dry to touch, PEARRL 4 mm, GCS 15. Monitor showed RSR @ 88 bpm without ectopy.

(R) Pt placed on O_2 @ 15 L/min via NRB. IV of NS was established in L AC with 18 g @ TKO (medic 785). 2 × 81 mg ASA were given PO @ 1501 (medic 785). Pt was given 1 SL 0.4 mg nitro @ 1503 (medic 785).

(T) Pt improved during transport, pain went down to a "4" on the scale, V/S remained stable, and patient care was transferred to ED staff.

(E) None.

Figure 7 Example of a narrative written in the CHARTE method.

the narrative portion of the report, needs to be neat and easily read by others. In addition, take great care to not contaminate your written reports with any liquids found in the field. Place all your completed reports in a secure location agreed on by you and your partner that protects the patient's privacy, until they can be secured in the proper place at your EMS agency office or headquarters.

The PCR needs to be timely, even in EMS systems where call volume is high. If you respond to multiple calls without accurately completing PCRs before proceeding to the next call, details may be forgotten and important information left out, or worse, inaccurate information may be written. Your EMS agency should allow you a reasonable amount of time to complete your reports, replenish supplies, and clean and disinfect vehicles *before* returning them to service. Many paramedics use assessment cards during their calls to take notes, and use the ECG monitor to note times and vital signs; then after the call, they complete the PCR (rather than on the bumpy ride to the hospital). Time should be set aside at the hospital to neatly complete all documentation. If you do not have time to complete the full PCR while at the hospital, a written record still must be left with the patient. In these cases, most systems will have a "drop report" or "transfer report" **Figure 8**. These single-page, abbreviated forms are used as a memory aid during an EMS call. If you are unable to remain at the hospital to complete the PCR, copy these documents and leave them with the nurse or physician. Some states require that copies of written reports be supplied to the receiving facility or hospital within a specific time frame, such as 24 hours. Know the applicable laws and requirements of your state and EMS system. In some systems, EMS providers fax the completed form to the emergency department because the hospital has a secure fax location that meets HIPAA requirements. You should consider your call incomplete until you have completed the documentation process.

As mentioned previously, all PCRs should be free of jargon, slang, and opinions of the EMS provider. Be certain that your documentation is not libelous. **Libel** is writing a false statement that could be harmful to a person's current or future reputation. Only true and accurate statements should be documented. If quotes of bystanders or statements made by the patient are used, be sure to indicate who made them and place the exact words in quotation marks on the report.

All reports should be reviewed by the paramedic who authored them before submitting them to the receiving medical facility and to the paramedic's EMS agency. Always reviewing your PCR for completeness, accuracy, grammar, spelling, and

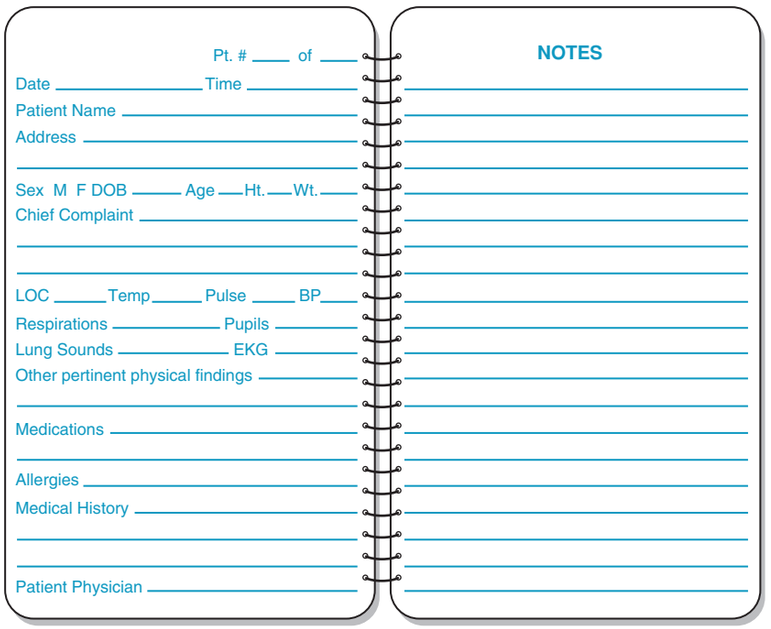

Figure 8 A sample prehospital notepad, also called a drop report or transfer report.

Documentation and Communication

Remember to document problems encountered when responding to or during the call (eg, an infectious disease exposure, a delayed response, a conflict at the scene with family or other response agencies, an MCI, an injury to an EMS provider that happened while providing care to the patient, etc).

proper use of medical terminology and abbreviations will help ensure you have a well-written and well-documented report.

Too often, the importance of report writing and documentation in EMS is ignored. Always remember that the report that you write reflects directly on you. When you file a complete, well-documented, legible report, you have done the most important part of the completion of your call.

The Effects of Poor Documentation

Documentation may affect the quality of care provided after you have delivered the patient to the hospital. Inappropriate, inaccurate, and poor documentation can adversely affect the quality of care received by patients after arrival at the hospital. For example, you administered a breathing treatment en route to the hospital but forgot to document the medication and procedure and the administration times. The hospital would not be aware of this and the patient could be treated inappropriately because of your failure to document the care you provided. Another example is to remember to document the specific time a suspected stroke patient was last seen "normal" by family members; this is important to the window of time for treatment using fibrinolytics in a stroke center. Documenting what the patient or family members tell you and your findings from examining the patient enhances the quality of care. For example, if hospital personnel know that a patient has a seizure disorder or that a patient who has had transient ischemic attacks in the past had symptoms of stroke en route to the hospital, proper care can be planned.

As mentioned previously, there are legal implications of documentation. Poorly written, inaccurate, or illegible reports might lead a judge or jury to decide in favor of the plaintiff. Conversely, a lawyer may decide not to pursue a case when the documentation reveals a correctly written and well-documented report.

Poor documentation skills can also affect a paramedic's reputation. Poorly written, inappropriate, or inaccurate reports might make others question the care provided, whereas a well-written report shows organizational skills, knowledge of patient conditions and needs, and respect for organizational policies and procedures. Part of being a good paramedic is completing the paperwork and reports as required. If you find it difficult to write reports, seek additional classes or study report writing skills to enhance your abilities. Your agency or service might have an educational program to assist you with such education and training.

Errors and Falsification

At times, it may be necessary to revise or correct your PCR. Although every attempt should be made to create an accurate and legible initial report, if a report has to be revised or corrected, you must note the date and time of the revised report and the purpose for writing the revision or making the correction. Never discard or destroy the original PCR.

Only the person who wrote the original report can revise it. Additions or notations added by others after the completion of the report may raise questions about the authenticity of the report and the confidentiality practices of your agency. Routine administrative report handling and reviews are necessary for entering information into computer databases, billing for

services, and quality assurance monitoring. At no time should administrative activities involve altering or rewriting the report or portions of it.

When writing your report, if you make an error, place a single line through the error and initial and date the line, preferably in a different color ink. Write the corrected information next to it Figure 9. Do not erase information, scribble through errors, use correction fluid, or use correction tape. Remember, the PCR is a legal document.

If an error is discovered after an electronic report has been submitted, most systems will allow for amendments but will prevent erasure in a completed document. Refer to the system's directions as to how to make an amendment to the original document. In the event that there is no way to electronically change the report, the same procedure should be followed as for a written document. Simply follow the correction method used for a handwritten report on a printout of the electronic report. Most electronic PCR systems keep good records of who made an alteration to the report and when it was made.

If you forgot to include important information, you may need to write an addendum to your report. You may also need to write an addendum if you are asked to write statements of events for matters related to quality assurance or risk management and to answer complaints. An addendum added to your original report should be noted as added to the original and the reason for the late entry and should include the date of entry, the time of entry, and signature of the author.

Supplemental narratives also may be needed if additional information becomes available after the original report has been written. Such reports should be documented with the date, the time, and the reason for the added information and should be signed by the author. Some EMS services use a supplemental report to write lengthy information when space on the original report is limited. Follow your service's policies for using supplemental reports and the procedures for writing them. Regardless of when the supplemental reports are added, they should be attached in some way to the original report for record-keeping purposes.

You may be required to obtain and document billing information for the EMS service provided. You need to understand the sensitive and confidential nature of such information and the laws and regulations pertaining to billing and documentation security under HIPAA. EMS agencies should take care not to add additional information provided by billing clerks or others after the report has been submitted. Doing so might be in violation of local, state, or federal laws. If you have additional information to document after handing in the form, follow the policy of your agency regarding whether a supplementary form is needed. Always be honest and thorough in your documentation process.

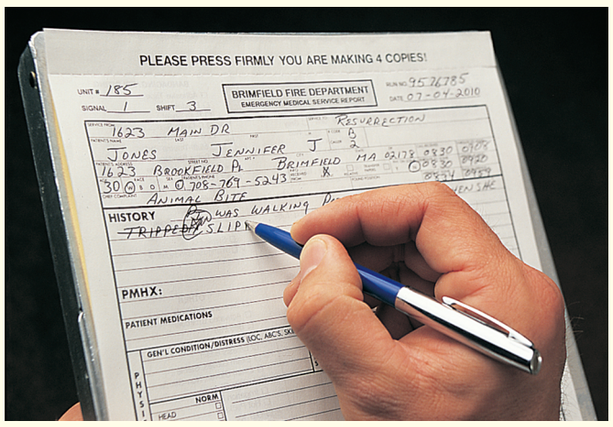

Figure 9 If you make a mistake in writing your report, the proper way to correct it is to draw a single horizontal line through the error, initial it, and write the correct information next to it.

Controversies

Because of strict guidelines for what is considered a medical necessity for emergency ambulance transportation, some agency leaders urge providers not to document certain findings with the patient, such as the patient's ability to ambulate. Other leaders have urged field personnel to document findings that meet the medical necessity standards to help bring in revenue. Intentionally documenting inaccurate or fraudulent information is unethical, as well as illegal, and could lead to the loss of your certification.

Lost reports pose huge legal implications for paramedics, EMS agencies and departments, and medical directors. All paramedics are responsible for ensuring that their reports are completed and turned in as required by policy or procedure. (Do not keep copies of your reports—if you need to document numbers of procedures or ages of patients for your paramedic internship, follow the specific policy of your training center.) If lost reports are an ongoing problem for an agency or provider, steps should be taken to correct the problem. Know that attempting to recreate PCRs is irresponsible and possibly illegal. Also, record keeping may be a legal requirement in your state, and there may also be a specified time requirement for submission of reports.

Documentation and Communication

Reports should be complete to the point that people reviewing them, whether your medical director or the administrative office clerk billing for the service provided, can read them and understand exactly what transpired on the EMS call. If your report does not paint a clear picture of what happened, it is not written well. Remember, your report is a reflection of your actions and your professionalism.

Documenting Incident Times

Keeping good records of time is essential to all EMS operations. The role of timekeeper falls to dispatchers. You must also keep track of time during your documentation of the incident. You should compare your times with those of the dispatcher to ensure accuracy and proper timekeeping, and ensure that your and your dispatcher's clocks are synchronized. If your ECG monitor reports or documentation times are not in sync with the dispatcher's time, this could create a controversy in the courtroom. It is important that the reported times of all the events are accurate.

Several times are absolutely vital to be kept and documented for accurate report writing. The vital incident times to track are as follows:

- **Time of call.** Time when the call for help is placed or requested
- **Time of dispatch.** Time when call is toned or alerted for a response
- **Time of arrival at the scene.** Time when EMS unit arrives on scene
- **Time with patient.** Time recorded when patient contact is made (this may not be the same as time of arrival, for example, when responding to a patient on the 17th floor of a high-rise building; should include the time it takes to physically get to the patient)
- **Time of medication administration.** Time when medications are administered for adherence to protocols (1 × 0.4 mg of nitroglycerin was given SL at 1804 without relief [medic 785])
- **Time of medical procedure.** Time when a procedure is conducted on the patient such as when vital signs are taken, when a patient is intubated, or when a child is delivered. (Example: Pt was intubated with a 7.5 fr endotracheal tube with confirmation of negative epigastric sounds, clear bilateral lung sounds in all fields, and a wave-form capnography reading of 35 mm Hg at 1807 [medic 785])
- **Time of departure from scene.** Time recorded when EMS unit leaves the scene
- **Time of arrival at medical facility.** Time when arriving at medical facility (if a patient is transported)
- **Time of transfer of care.** Time when care was transferred to another health care professional at the receiving facility (if a patient is transported)
- **Time back in service.** Time when EMS unit and crew are ready for return to service

It is standard procedure to use military time in EMS documentation. This ensures that each time is unique; for example, 1 AM cannot be confused with 1 PM. Military times are shown in Table 4.

Table 4 Military Times

Regular Time	Military Time	Regular Time	Military Time
Midnight	0000	Noon	1200
1:00 AM	0100	1:00 PM	1300
2:00 AM	0200	2:00 PM	1400
3:00 AM	0300	3:00 PM	1500
4:00 AM	0400	4:00 PM	1600
5:00 AM	0500	5:00 PM	1700
6:00 AM	0600	6:00 PM	1800
7:00 AM	0700	7:00 PM	1900
8:00 AM	0800	8:00 PM	2000
9:00 AM	0900	9:00 PM	2100
10:00 AM	1000	10:00 PM	2200
11:00 AM	1100	11:00 PM	2300

Medical Terminology

Using medical terminology correctly is essential to EMS communications. You should learn the established and accepted medical terms and abbreviations for your EMS operations. Some EMS systems have specific approved lists of medical abbreviations and terms that must be used.

Medical terminology may seem to be a foreign language; however, most terminology comes from the ancient Roman language, Latin. In addition, you may encounter some common slang terms used in EMS such as "packaging a patient for transport" or "bagging the patient during airway management." Be sure to know acceptable terms and words used in your EMS agency. The wider your vocabulary base, the more competent you will seem to the rest of the medical community and the better the patient care you will be able to provide. An ongoing review of the anatomy and physiology chapter can help you become familiar with medical terminology. Understanding terminology involves breaking words down into their separate components of prefix, suffix, and root word and having a good working knowledge of those parts. The next section provides a more in-depth look at commonly used medical terms and their meanings.

Prefixes

A prefix appears at the beginning of a word and generally describes location or intensity. Prefixes are frequently found in general language (ie, autopilot, submarine, tricycle), as well as in medical and scientific terminology. When a medical word (ventilation) contains a prefix (hyper), the meaning of the word is altered (hyperventilation). Not all medical terms have prefixes.

By learning to recognize a few of the more commonly used medical prefixes, you can figure out the meanings of terms that may not be immediately familiar to you. Table 5 lists common prefixes.

Suffixes

Suffixes are placed at the end of words to change the original meaning. In medical terminology, a suffix usually indicates a procedure, condition, disease, or part of speech. A commonly used suffix is -itis, which means "inflammation." When this suffix is paired with the root word arthro-, meaning "joint", the resulting word is arthritis, an inflammation of the joints. Sometimes it is necessary to change the last letter or letters of the root word or prefix when a suffix is added to make pronunciation easier. Table 6 lists common suffixes.

Root Words

The main part or stem of a word is called a root word. A root word conveys the essential meaning of the word and frequently indicates a body part. With a combining form, the root word and a combining vowel such as i, e, o, or a may be combined with another root word, a prefix, or a suffix to describe a particular structure or condition.

A frequently used term in EMS is CPR, which stands for cardiopulmonary resuscitation. When the word is broken down, cardio is a root word meaning "heart," and pulmonary is a root word meaning "lungs." When you perform CPR, you are introducing air into the lungs and circulating blood by compressing the heart to resuscitate the patient. Some root words may also be used as prefixes or suffixes; those already appear in the earlier tables. Table 7 lists common root words.

Medical Abbreviations

Medical abbreviations can be very useful for documentation purposes, but you must be certain the abbreviations you are using are consistent with approved medical abbreviations in your EMS system. Incorrect or inappropriate medical abbreviations can cause confusion and, in the worst cases, could lead to medication and treatment errors. You should learn the approved medical abbreviations for your service area before you use them in a report. For example, some agencies do not use "SOB" to abbreviate "shortness of breath." Each EMS system should have a list of approved medical abbreviations available for use and documentation purposes. Once again, accuracy, neatness, and completeness reflect a professional writing style. Note that many abbreviations have more than one meaning, so extreme care is needed when using them. (For patient safety reasons, hospitals are required by The Joint Commission to have a list of approved abbreviations; certain abbreviations are prohibited by the commission.) Table 8 lists commonly used medical abbreviations. It is important that you learn your agency's approved terminology.

It is important for you to be familiar with abbreviations that have a significant potential to be misunderstood. In 2004, the Joint Commission identified abbreviations that lead to errors, and should therefore not be used. Table 9 lists those abbreviations, as well as others that can be confusing and therefore should not be used. In most instances, the term should be written out in full; for example, rather than using the "at" symbol (@), write out "at."

YOU are the Medic — PART 4

Law enforcement officers arrive on scene. At about that time the patient yells, "Great! Officers, arrest these people. They're harassing me!" One officer tells the patient to relax and do what the EMS crew asks, saying, "All they are trying to do is make sure you're OK." The officer asks the patient, "Have you been drinking today?" The patient replies, "I had a few at lunch is all. I'm just fine." The officer asks for, and receives, the patient's driver's license. He says to the patient, "I'm sure you are aware Assemblyman Taylor, there are laws that you have to obey and it would look much better to your constituents if you cooperated. Going to the hospital in an ambulance is much better than in a police cruiser." The patient agrees and you can finally assess the patient and prepare for transport.

Recording Time: 15 Minutes	
Respirations	16 breaths/min with adequate tidal volume
Pulse	100 beats/min, strong and regular
Skin	Warm, dry, pink
Blood pressure	130/80 mm Hg
Oxygen saturation (Spo_2)	97% on room air
Pupils	Equal and react to light

7. Is it important to document the interaction between the patient and law enforcement officers when there is no patient care involved?
8. What is the legal basis to determine whether a patient is competent to refuse care?

Table 5 Common Prefixes

Prefix	Meaning	Prefix	Meaning	Prefix	Meaning
a-	without, lack of	dermat(o)-	pertaining to the skin	lith(o)-	pertaining to a stone
ab-	away from	di-	twice, double	macro-	large
abdomi(n)-	abdomen	dia-	through, completely	mal-	bad or abnormal
acr(o)-	to, toward	dys-	difficult, painful, abnormal	medi-	middle
aden(o)-	pertaining to a gland	ect(o)-	out from	mega-	large
an-	without, lack of	electro-	pertaining to electricity	melan-	black
ana-	up, back, again	end(o)-	within	mening(o)-	pertaining to a membrane, particularly the meninges
angio-	vessel	enter(o)-	pertaining to the intestines	micro-	small
ante-	before, forward	epi-	upon, on	mono-	one
anti-	against, opposed to	erythr(o)-	pertaining to anything red or to erythrocytes (red blood cells)	myel(o)-	pertaining to the spinal cord, the bone marrow, or myelin
arteri(o)-	artery	eu-	easy, good, normal	my(o)-	pertaining to muscle
arthro-	pertaining to a joint	ex(o)-	outside	nas(o)-	pertaining to the nose
auto-	self	extra-	outside, in addition	ne(o)-	new
bi-	two	gastr(o)-	pertaining to the stomach	nephr(o)-	pertaining to the kidney
bi(o)-	pertaining to life	glyc(o)-	sugar	neur(o)-	pertaining to a nerve or the nervous system
blast(o)-	germ or cell	gynec(o)-	pertaining to females or the female reproductive organs	noct-	night
blephar(o)-	pertaining to an eyelid	hemat(o)-	pertaining to blood	olig(o)-	little, deficient
brady-	slow	hemi-	half	oophor(o)-	pertaining to the ovary
calc-	stone; also heel	hem(o)-	pertaining to blood	ophthalm(o)-	pertaining to the eye
cardi(o)-	pertaining to the heart	hepat(o)-	pertaining to the liver	orchid(o)-	pertaining to the testicles
cephal(o)-	pertaining to the head	heter-	other, different	orchi(o)-	pertaining to the testicles
cerebr(o)-	pertaining to the cerebrum, a part of the brain	hom-	same or like	oro-	pertaining to the mouth
cervic(o)-	pertaining to the neck or the uterine cervix	hydr(o)-	water	ortho-	straight or normal
chole-	pertaining to bile	hyper-	over, excessive	oste(o)-	pertaining to bone
chondr(o)-	pertaining to cartilage	hypo-	under, deficient	ot(o)-	pertaining to the ear
circum-	around, about	hyster(o)-	pertaining to the uterus	para-	by the side of
contra-	against, opposite	infra-	below	path(o)-	pertaining to disease
cost(o)-	pertaining to a rib	inter-	between	per-	through
cyan(o)-	blue	intra-	within	peri-	around
cyst(o)-	pertaining to the bladder or any fluid-containing sac	iso-	equal	phag(o)-	pertaining to eating, ingesting, or engulfing
cyt(o)-	pertaining to a cell	latero-	side	pharyng(o)-	pertaining to the throat, or pharynx
de-	down from	leuk(o)-	pertaining to anything white or to leukocytes (white blood cells)	phleb(o)-	pertaining to a vein

Continues

Table 5 Common Prefixes, continued

Prefix	Meaning	Prefix	Meaning	Prefix	Meaning
pneum(o)-	pertaining to respiration, the lungs, or air	pyel(o)-	pertaining to the kidney or pelvis	sub-	under, moderately
poly-	many	py(o)-	pertaining to pus	super-	above, excessive, or more than normal
post-	after, behind	quadr(i)-	four	supra-	above
pre-	before	quar-	four	tachy-	fast
pro-	before, in front of	quat-	four	therm-	pertaining to temperature
proct(o)-	pertaining to the rectum	retr(o)-	backward or behind	thorac(o)-	pertaining to the chest
pseud(o)-	false	rhin(o)-	pertaining to the nose	trans-	across
psych(o)-	pertaining to the mind	salping(o)-	pertaining to a tube	tri-	three
pulm(o)-	pertaining to the lung	scler(o)-	hard; also means pertaining to the sclera	uni-	one
pur-	pertaining to pus	semi-	half or partial	vas(o)-	vessel

Table 6 Common Suffixes

Suffix	Meaning	Suffix	Meaning	Suffix	Meaning
-algia	pertaining to pain	-megaly	enlargement of	-ptosis	drooping
-asthen(o)	weakness	-ology	science of	-rrhage	abnormal or excessive flow or discharge
-blast	immature cell	-oma	tumor	-rrhagia	abnormal or excessive flow or discharge
-cele	pertaining to a tumor or swelling	-osis	pertaining to a disease process (see also -sis)	-rrhaphy	suture of; repair of
-centesis	pertaining to a procedure in which an organ or body cavity is punctured, often to drain excess fluid or obtain a sample for analysis	-ostomy	surgical creation of an opening, or hole	-rrhea	flow or discharge
-cyte	cell	-otomy	surgical incision	-scope	instrument for examination
-ectomy	surgical removal of	-pathy	disease or a system for treating disease	-scopy	examination with an instrument
-emia	pertaining to the presence of a substance in the blood	-phagia	pertaining to eating or swallowing	-sis	a process, action, or condition
-genic	causing	-phasia	pertaining to speech	-taxis	order, arrangement of
-gram	record	-phobia	pertaining to an irrational fear	-trophic	pertaining to nutrition
-graph	a record or the instrument used to create the record	-plasty	plastic surgery	-uria	pertaining to a substance in the urine or the condition so indicated
-itis	inflammation	-plegia	paralysis		
-lysis	decline, disintegration, or destruction	-pnea	pertaining to breathing		

Table 7 Common Root Words

Root Word	Meaning	Root Word	Meaning	Root Word	Meaning
acou-	hear	digit	finger or toe	pleur-	rib, side
adip-	fat	ede-	swelling	pod-	foot
alb-	white	-esthesi(o)-	pertaining to sensation or perception	pto-	fall
alges-	pain	febr-	fever	ptyal-	saliva
andr-	male	flex	bend	pyr-	fire
aorta	large artery exiting from the left ventricle of the heart	foramen	opening	radius	the forearm bone on the thumb side; also a line from the center of a circle or sphere to the edge
aqua-	water	fract-	break	ren-	kidney
asphyxia	lack of oxygen or excess of carbon dioxide in the body that results in unconsciousness	gest-	carry, produce, congestion	retina	inner nerve-containing layer of the eye
asthen-	weak	gno-	know	sangui(n)-	blood
audi-	to hear	-gram	something written or recorded	sebum	a fatty secretion of the sebaceous glands
bronch-	windpipe	graph-	write, record	sect-	cut
bucc-	cheek	humerus	the bone in the upper arm	sepsis	the presence of microorganisms or their toxins in the blood; also the toxic condition caused by such presence
bursa	pouch or sac	idi-	separate, distinct	sept-	wall, divider; also seven
callus	hard, thick skin; also a meshwork of connective tissue that forms during the healing process after a fracture	iod(o)-	iodine	serum	the clear portion of body fluids, including blood
carcin-	cancer	lact-	milk	sinus	cavity, channel, or hollow space
carotid	great arteries of the neck	lingu-	tongue	som(a)-	body
carpus	wrist	men-	month	spir-	coil
cent-	a fraction in the metric system; one hundredth or 100	ocul-	eye	stasis	slowing or stopping of the normal flow of a fluid, such as blood
cente-	to puncture (a body cavity)	ov-	egg	stature	height
cili-	eyelid	palpate	to examine by touch	stern(o)-	sternum (breastbone)
cleid(o)-	clavicle	ped-	child or foot	stoma	any small opening on the surface of the body, such as a pore; also, the opening created in the abdominal wall for the passage of urine or feces
cubitus	elbow	percuss	to examine by striking	tact-	touch
cycl-	circle or cycle	phot-	light	tetra-	four

Continues

Table 7 Common Root Words, continued

Root Word	Meaning	Root Word	Meaning	Root Word	Meaning
tom-	cut	varic-	varicose vein	xen-	foreign (material)
toxic	poisonous	vertigo	a disordered sensation in which one's own body or the surroundings are perceived as moving	xer-	dry
trich-	hair	viscer-	internal organs		
ur-	urine	viscous	sticky		

Table 8 Common Abbreviations*

Abbreviation	Meaning	Abbreviation	Meaning	Abbreviation	Meaning
A&P	anatomy and physiology	A-line	arterial line	AV, A-V	atrioventricular, arteriovenous
ā	before	ALS	advanced life support	AVPU	alert, verbal, pain, unresponsive
āā	of each (used in writing prescriptions)	AMA	against medical advice	BBB	bundle branch block
ABC	airway, breathing, circulation	amb	ambulatory	BG	blood glucose
abd	abdomen	AMI	acute myocardial infarction	BGL	blood glucose level
ABG	arterial blood gas	AMS	altered mental status	bid	twice daily
ac	before meals	ant	anterior	bilat	bilaterally
AC	antecubital fossa	AO × 3	alert and oriented to person, time, and place	BKA	below the knee amputation
ACLS	advanced cardiac life support	AOB	alcohol on breath	BLS	basic life support
ad lib	as much as desired	AP	anteroposterior, front-to-back, action potential, angina pectoris, anterior pituitary, arterial pressure	BM	bowel movement
ADL	activity of daily living	APAP	acetaminophen	BP	blood pressure
AED	automated external defibrillator	APC	atrial premature complex, activated protein C, aspirin-phenacetin-caffeine	bpm	beats per minute
AF	atrial fibrillation	Aq	water	BS	blood sugar, breath sounds, bowel sounds, bachelor of science (degree)
AICD	automated internal cardiac defibrillator	ARDS	acute respiratory distress syndrome	BSA	body surface area
AIDS	acquired immunodeficiency syndrome	ASA	aspirin (acetylsalicylic acid)	bx	biopsy
AK	above the knee	ASAP	as soon as possible	c̄	with
AKA	above the knee amputation	ASHD	arteriosclerotic or atherosclerotic heart disease	°C	degrees Celsius (centigrade)

Continues

Table 8 Common Abbreviations*, continued

Abbreviation	Meaning	Abbreviation	Meaning	Abbreviation	Meaning
C2	code 2 (nonemergent)	CP	chest pain, chemically pure, cerebral palsy	DOS	dead on scene
C3	code 3 (emergent)	CPR	cardiopulmonary resuscitation	DPT	diphtheria and tetanus toxoids and pertussis vaccine
Ca	calcium	CRNA	certified registered nurse anesthetist	DSD	dry sterile dressing
CA	cancer, cardiac arrest, chronological age, coronary artery, cold agglutinin	CRT	capillary refill time, cathode ray tube	DtaP	diphtheria and tetanus toxoids and acellular pertussis vaccine
CABG	coronary artery bypass graft	CSF	cerebrospinal fluid	DTP	diphtheria and tetanus toxoids and pertussis vaccine
CAD	coronary artery disease	CSM	carotid sinus massage, cerebrospinal meningitis	DTs	delirium tremens
CAO	conscious, alert, and oriented	c-spine	cervical spine	DVT	deep venous thrombosis
CBC	complete blood count	CT	computerized tomography (CAT scan)	Dx	diagnosis
CC or C/C	chief complaint	CTA	clear to auscultation	ECG	electrocardiogram
CCT	critical care transport	CTL	cervical, thoracic, lumbar spine	ED	emergency department
CCU	coronary care unit	CVA	cerebrovascular accident	EDC	estimated date of confinement
CHB	complete heart block	CVP	central venous pressure	EEG	electroencephalogram
CHF	congestive heart failure	Cx	chest	eg	for example
CHI	closed head injury	CXR	chest x-ray	EKG	electrocardiogram
Cl^-	chloride	D_{50}	dextrose 50%	EMS	emergency medical services
clr	clear	D_5W	dextrose 5% in water	ENT	ears, nose, and throat
cm	centimeter	D&C	dilation and curettage	ER	emergency room
cm^3	cubic centimeter	defib	defibrillation	ET	endotracheal tube, endotracheal
CMS	circulation, movement, sensation	diff	differential	ETA	estimated time of arrival
CNS	central nervous system	dig	digoxin	ETOH	ethyl alcohol
c/o	complaining of	DKA	diabetic ketoacidosis	ETT	endotracheal tube
CO	cardiac output, carbon monoxide	DM	diabetes mellitus	Exp	expansion
CO_2	carbon dioxide	DOA	dead on arrival	°F	degrees Fahrenheit
COLD	chronic obstructive lung disease	DOE	dyspnea on exertion	FA	forearm
COPD	chronic obstructive pulmonary disease	DON	director of nursing	FBS	fasting blood sugar

Continues

Table 8 Common Abbreviations*, continued

Abbreviation	Meaning	Abbreviation	Meaning	Abbreviation	Meaning
Fe	iron	Hb	hemoglobin	IVP	intravenous push
FHR	fetal heart rate	HB	heart block	J	joule
FHT	fetal heart tones	Hct	hematocrit	JVD	jugular venous distention
FHx	family history	HEENT	head, ears, eyes, nose, throat	K^+	potassium
F_{IO_2}	fraction of inspired oxygen	Hg	mercury	KCl	potassium chloride
fL	femtoliter	Hgb	hemoglobin	KED	Kendrick extrication device
fl	fluid	HH	hiatal hernia	kg	kilogram
fld	fluid	HI	head injury	KUB	kidneys, ureters, and bladder
FSH	follicle-stimulating hormone	HIV	human immunodeficiency virus	KVO	keep vein open
fx	fracture	H_2O	water	L	liter
g	gram	H_2O_2	hydrogen peroxide	LAC	laceration, laparoscopic-assisted colectomy
GB	gallbladder	hosp	hospital	LAD	left anterior descending, left axis deviation
GCS	Glasgow Coma Scale	HPI	history of present illness	LAH	left anterior hemiblock
GERD	gastroesophageal reflux disease	hr	hour	lb	pound
GI	gastrointestinal	HR	heart rate	LBB	left bundle branch block
gm	gram	HTN	hypertension	LE	lower extremity, left eye, lupus erythematosus
gr	grain	Hx	history	LGL	Lown-Ganong-Levine syndrome
GSW	gunshot wound	Hz	hertz	LLL	left lower lobe of the lung
gtt	drop(s)	I&O	intake and output	LLQ	left lower quadrant of the abdomen
GTT	glucose tolerance test	IC	intracardiac, inspiratory capacity, irritable colon	L/M	liters per minute
GU	genitourinary	ICP	intracranial pressure	LMP	last menstrual period
gyn	gynecology	ICS	intercostal space	LOC	level of consciousness, loss of consciousness
h	hour	ICU	intensive care unit	LPH	left posterior hemiblock
(H)	hypodermic	IDDM	insulin-dependent diabetes mellitus	LPM	liters per minute
H	hypodermic	IM	intramuscular	LPN	licensed practical nurse
H&H	hemoglobin and hematocrit	IO	intraosseous	LR	lactated Ringer's
H&P	history and physical	IPPB	intermittent positive pressure breathing	LS	lung sounds
H/A	headache	IUD	intrauterine(contraceptive) device	LSB	long spineboard
H/P	history and physical	IV	intravenous	LSD	lysergic acid diethylamide

Continues

Table 8 Common Abbreviations*, continued

Abbreviation	Meaning	Abbreviation	Meaning	Abbreviation	Meaning
LUL	left upper lobe of the lung	MVP	mitral valve prolapse	N/V/D	nausea, vomiting, and diarrhea
LUQ	left upper quadrant of the abdomen	N	normal	NVD	neck vein distention
LVN	licensed vocational nurse	Na	sodium	O_2	oxygen
m	meter	NA, N/A	not applicable	OB	obstetrics
mA	milliamps	NaCl	sodium chloride	OBS	organic brain syndrome
MAE	moves all extremities	NAD	no apparent distress, no appreciable disease	Occ	occipital
MAEW	moves all extremities well	$NaHCO_3$	sodium bicarbonate	OETT	oral endotracheal tube
MAP	mean arterial pressure	NARD	no apparent respiratory distress	OM	otitis media
MAST	medical antishock trouser	NATO	not able to obtain	OP	outpatient
MCA	motorcycle accident	NEB	nebulizer	OPA	oropharyngeal airway
mcg	microgram	NETT	nasal endotracheal tube	OR	operating room
MCL	midclavicular line, modified chest lead	NC	nasal cannula	OS	left eye
meds	medications	NG	nasogastric	OU	both eyes
mEq	milliequivalents	NICU	neonatal intensive care unit	oz	ounce
mg	milligram (mgm is a former symbol)	NIDDM	non–insulin-dependent diabetes mellitus	p̄	after
MI	myocardial infarction	NKA	no known allergies	PA	physician assistant
MICU	mobile intensive care unit; medical intensive care unit	NKDA	no known drug allergies	PAC	premature atrial contraction
min	minute	NL	nonlabored	palp	palpation
mL	milliliter	NP	nasopharyngeal	PASG	pneumatic antishock garment
mm	millimeter	NPA	nasopharyngeal airway	pc	after meals
mm Hg	millimeters of mercury	NPO	nil per os (nothing by mouth)	Pco_2	partial pressure of carbon dioxide
MOE	movement of extremity	NRB	nonrebreathing mask	PDR	*Physician's Desk Reference*
MOI	mechanism of injury	NS	normal saline	PE	pulmonary embolism, physical examination
MRI	magnetic resonance imaging	NSR	normal sinus rhythm	PEA	pulseless electrical activity
MVA	motor vehicle accident	NTG	nitroglycerin	PEARL	pupils equal and reactive to light
MVC	motor vehicle crash	N/V	nausea and vomiting	ped(s)	pediatric

Continues

Table 8 Common Abbreviations*, continued

Abbreviation	Meaning	Abbreviation	Meaning	Abbreviation	Meaning
PEEP	positive end-expiratory pressure	PTA	prior to admission, plasma thromboplastin antecedent	RSI	rapid sequence intubation
PERL	pupils equal and reactive to light	PTSD	posttraumatic stress disorder	RUL	right upper lobe of the lung
PERRL	pupils equal, round, and reactive to light	PTT	partial thromboplastin time	RUQ	right upper quadrant of the abdomen
PG	pregnant	PVC	premature ventricular complex, polyvinyl chloride	Rx	prescription
P#/G#	para #/gravida # (Example: P1G1)	PVD	peripheral vascular disease	s̄	without
pH	hydrogen ion concentration	Px	pain	Sao_2	oxygen saturation
PID	pelvic inflammatory disease	q	every	sec	second
PJC	premature junctional contraction	RA	rheumatoid arthritis, right atrium, room air	SICU	surgical intensive care unit
PMS	pulse, movement, sensation	RAD	reactive airway disease, right axis deviation, radial pulse	SIDS	sudden infant death syndrome
PN	pneumonia	RBB	right bundle branch block	SL	sublingual
PND	paroxysmal nocturnal dyspnea	RBC	red blood cell	SMOE	sensory, movement of extremity
po	per os (by mouth)	RCA	right circumflex artery	SOB	shortness of breath
PO	postoperative, "post op"	resp	respiration	s/p	status post
Po_2	partial pressure of oxygen	Rh	Rhesus blood factor, rhodium	Spo_2	oxygen saturation
POP	pain on palpation	RHD	rheumatic heart disease	$SQETCO_2$	semi-quantitative end-tidal CO_2
post	posterior	RL	Ringer's lactate	S/S	signs and symptoms
PR	per rectum; rectally	RLL	right lower lobe of the lung	ST	S-T segment elevation (relative to ECG)
PRI	P-R interval (relating to ECG)	RLQ	right lower quadrant of the abdomen	stat	immediately
PRN	pro re nata (as needed)	RN	registered nurse	STD	sexually transmitted disease
psi	pounds per square inch	R/O	rule out	Sub Q	subcutaneous
PSVT	paroxysmal supraventricular tachycardia	ROM	range of motion, rupture of membranes	sux	succinylcholine
pt	patient	ROSC	return of spontaneous circulation	SVT	supraventricular tachycardia
PT	physical therapy	RR	respiratory rate	Sx	symptoms

Continues

Table 8 Common Abbreviations*, continued

Abbreviation	Meaning	Abbreviation	Meaning	Abbreviation	Meaning
sym	symptoms	UA	urinalysis	wt	weight
synch	synchronous (switch on defibrillator)	UE	upper extremity	yo	year old
sz	seizure	UGI	upper gastrointestinal	x̄	except
TA	traffic accident	URI	upper respiratory infection	1°	first, first degree, primary
tab	tablet	USP	United States Pharmacopeia	2°	secondary, second degree
TB	tuberculosis	UTI	urinary tract infection	↑	increase(d)
TBA	to be admitted, to be announced	V	volt	↓	decrease(d)
tbsp	tablespoon	VD	venereal disease	®	right
TCA	tricyclic antidepressant	VF	ventricular fibrillation	Ⓛ	left
TCP	transcutaneous pacemaker	V fib	ventricular fibrillation	α	alpha
tech	technician, technologist	vol	volume	β	beta
temp	temperature	VS	vital signs	~	approximately
TIA	transient ischemic attack	VT	ventricular tachycardia	×2	times two
tid	three times a day	V tach	ventricular tachycardia	/	per
TKO	to keep open	w/	with	≠	not equal
TPR	temperature, pulse, respiration	WBC	white blood cell	?	questionable, possible
trans	transport	W/D/G	warm, dry, good skin	Δ	change
tsp	teaspoon	WNL	within normal limits	–	negative
Tx	treatment	w/o	without	♀	female
U/A	upon arrival	WPW	Wolff-Parkinson-White syndrome	♂	male

**Sometimes abbreviations are written with periods (for example, abd. and a.c.), and sometimes different capitalization might be used and might convey a different meaning. Not all possible meanings for the abbreviations in this table are given here. Unless you are certain about the meaning, ask the person who used the abbreviation.*

Table 9 Abbreviations That Lead to Errors (DO NOT USE)

Abbreviation	Intended Meaning	Possible Error; Solution	Abbreviation	Intended Meaning	Possible Error; Solution
BT	bedtime	Confused with BID (twice daily); write out	D/C	discontinue, discharge	Multiple meanings can lead to premature discontinuation or premature discharge; write out
cc	cubic centimeter	Confused with U; write mL	hs	at bedtime, half-strength	Meanings confused for each other; write out

Continues

Table 9 Abbreviations That Lead to Errors (DO NOT USE), continued

Abbreviation	Intended Meaning	Possible Error; Solution	Abbreviation	Intended Meaning	Possible Error; Solution
IJ	injection	Confused with IV; write out	U	unit	Mistaken for number "0"; write out
IU	international unit	Can be mistaken for IV; write out, or use "units"	Ø	no, not, none	Mistaken for other numbers; write out
$MgSO_4$	magnesium sulfate	Can be confused with morphine sulfate; write out	@	at	Confused with the number 2; write out
MS	morphine sulfate, magnesium sulfate, multiple sclerosis	Multiple meanings can be confusing; write out	µ	micro	Confused with "m" (milli-), causing possible overdose; use "mc"
MSO_4	morphine sulfate	Can be confused with magnesium sulfate; write out	/	(slash mark)	Mistaken for number "1"; write "per"
nitro drip	nitroglycerin infusion, sodium nitroprusside infusion	Confused for each other; write out	&	(and)	Mistaken for number "2"; write out
OD	overdose, once daily, right eye, optical density, outside diameter, doctor of optometry	Mistaken for each other; write out	+	(plus, and)	Mistaken for the number "4"; write out
qd	every day	Mistaken for other similar abbreviations (qh, qid, qod); write out	>	greater than	Confused with various numbers or letters (such as the number 7); write out
qh	every hour	Mistaken for other similar abbreviations (qd, qid, qod); write out	≥	greater than or equal to	Confused with various numbers or letters; write out
qid	four times a day	Mistaken for other similar abbreviations (qd, qh, qod); write out	<	less than	Confused with various numbers or letters (such as the letter L); write out
qod	every other day	Mistaken for other similar abbreviations (qd, qh, qid); write out	≤	less than or equal to	Confused with various numbers or letters; write out
SC	subcutaneous, secretory component	Mistaken for "SL"; write out	Abbreviations for drug names		Misinterpreted due to various abbreviations; write out full drug names
SQ	subcutaneous	Mistaken for "5 every"; write out	Apothecary units		Uncommon, not understood; use metric units
ss	half	Mistaken for "55"; write out	Inclusion of period after units	Example: mg.	Period mistaken for the number "1"; do not include period after units

Continues

Table 9 Abbreviations That Lead to Errors (DO NOT USE), continued

Abbreviation	Intended Meaning	Possible Error; Solution	Abbreviation	Intended Meaning	Possible Error; Solution
Lack of commas in drug dosages	Example: 100000	Number of zeros mistaken; include comma in proper location or spell out (in this example, 100,000, or 100 thousand)	Trailing zero	Example: 2.0 mg	Decimal point is missed (this example would be misinterpreted as 20 mg); write whole number only (change this example to 2 mg)
Lack of preceding zero	Example: .4 mg	Decimal point is missed (this example would be misinterpreted as 4 mg); include a zero before the decimal point (change this example to 0.4 mg)			

Data sources: Facts About the Official "Do Not Use" List. The Joint Commission. Available at http://www.jointcommission.org/assets/1/18/Official_Do%20Not%20Use_List_%206_10.pdf. Accessed April 21, 2011.
ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations. Institute for Safe Medication Practices. Available at http://www.ismp.org/tools/errorproneabbreviations.pdf. Accessed April 21, 2011.

YOU are the Medic

SUMMARY

1. What is your first consideration in regard to this patient?

The patient is not well enough to stand up when he attempts to exit the vehicle under his own power and appears to have inadequate balance. At this point you do not know whether the patient has been drinking. The patient's behavior could be the result of medical conditions such as diabetes, an allergic reaction, or cardiac insufficiency. Trauma may also be present. The patient may have struck his head, which could be affecting his balance. He also may have something as simple as a foot injury that is painful to stand on. Slurred speech may be caused by loose teeth or dentures from the crash. Do not assume a patient has been drinking. You must obtain more information in order to make the determination.

2. What is your first consideration in regard to the scene?

The visible damage to the vehicle appears to be minor, but there may still be hazards ranging from leaking fluids to sharp, torn metal. Because of potential hazards, it is essential that all responders wear personal protective equipment to ensure their safety, even if the scene initially appears to be safe. The county courthouse would be a busy place at 1300 hours on a weekday, and you should be concerned with traffic control as well as crowd control. Ensure that a law enforcement response has been dispatched to the incident.

3. Why is it not acceptable to document the patient's appearance as "drunk" on a PCR?

Document only the facts. Do not describe the situation according to your first suspicions, such as describing the patient as "Awake and appears drunk." Statements such as this will come back to haunt you. Perform a thorough assessment before determining whether a patient is intoxicated.

4. Would it be acceptable to document that the patient is "yelling" for the breathing description on a PCR?

The patient is obviously breathing since he is attempting to extricate himself from the vehicle. You do not have the other points of direct assessment to determine rate, rhythm, and quality. You are directly witnessing the patient yelling, which is an accurate description of your initial observation, so you could document this.

5. How should you document that the patient has directed you to "keep your hands off," as well as account for not being able to obtain the patient's vital signs?

You should use the patient's words as much as possible. It would be acceptable to write, "When attempting to approach the patient to begin an assessment, the patient stated, 'Keep your hands off of me.' We were unable to assess pulse, respiration, blood pressure, pupils, Spo_2 or skin signs other than visually until after the intervention of law enforcement." Review the chapter, *Medical, Legal, and Ethical Issues*, for information on the concepts of patient consent and refusal.

6. Does this patient have the right to refuse treatment?

The patient is exhibiting signs associated with being intoxicated. The patient told the officer that he had had a few drinks at lunch. You also saw an empty bottle of alcohol on the floor of the car.

YOU are the Medic

SUMMARY, continued

Because the patient's decision-making ability has been impaired, you should not accept a refusal request. You also need to further assess the patient's level of orientation to person, time, and place.

7. Is it important to document the interaction between the patient and law enforcement officers when there is no patient care involved?

It is essential that you document the interaction between the law enforcement officer and the patient. Usually state laws allow officers to detain people if they are a "danger to themselves or others." Please review the rights of law enforcement officers in relation to patients for your area. In this case, the officer appealed to the patient's sense of self to convince him of the better of two courses of action so detaining the patient was not necessary. When you are documenting interaction between law enforcement personnel and a patient, make sure to document the officer's name, badge number, and agency on your form. This will help you and your agency if you should need more information on the call.

8. What is the legal basis to determine whether a patient is competent to refuse care?

All paramedics should be familiar with the laws of their state regarding the age of consent, care of minors, emancipated minors, and people with mental or cognitive impairments, such as mental illness or the effects of drug or alcohol use. Above all else, you need to ensure that every reasonable effort has been made for the patient's welfare and best interests. Do not assume the patient is "just drunk," and always provide the highest level of care.

EMS Patient Care Report (PCR)

Date: 06-01-11	**Incident No.:** 890	**Nature of Call:** MVC		**Location:** 200 First Street	
Dispatched: 1300	**En Route:** 1301	**At Scene:** 1305	**Transport:** 1335	**At Hospital:** 1345	**In Service:** 1350

Patient Information

Age: 60 **Sex:** M **Weight (in kg [lb]):** 113 kg (250 lb)	**Allergies:** No known drug allergies **Medications:** None **Past Medical History:** None **Chief Complaint:** MVC

Vital Signs

Time: 1320	**BP:** 130/80	**Pulse:** 100	**Respirations:** 16	**Spo_2:** 97%
Time:	**BP:**	**Pulse:**	**Respirations:**	**Spo_2:**
Time:	**BP:**	**Pulse:**	**Respirations:**	**Spo_2:**

EMS Treatment (circle all that apply)

Oxygen @ _____ L/min via (circle one): **NC NRM Bag-mask device**		**Assisted Ventilation**	**Airway Adjunct**	**CPR**
Defibrillation	**Bleeding Control**	**Bandaging**	**Splinting**	**Other**

Narrative

Arrived on scene to find a single-vehicle crash involving a pole in front of the county courthouse. On exiting our unit, we witnessed a man open the driver's door of the vehicle involved in the crash and attempt to exit the vehicle without assistance. He could not keep his balance and sat back down on the driver's seat. Once we approached the vehicle, we determined that the air bag system had deployed on impact. There is minimal visible damage to the front of the vehicle. When attempting assessment of the pt's blood pressure, pulse, respiration, and Spo_2 level, the pt, in slurred speech, stated "I need my lawyer" and "Keep your hands off me." The pt exhibited signs associated with being intoxicated. Open empty vodka bottle was clearly visible on the floor of the vehicle. Confirmed that law enforcement was en route. Officer B.D. Smith, Badge 1345, Downtown Police Dept, and officer Jenkins, Badge 1429, also from Downtown, arrived to assist. Officer Smith was able to convince the pt to allow our assessment, treatment, immobilization, and transport without further incident. This accounts for the initial delay in obtaining vital signs on this pt. Pt was cooperative and his condition remained unchanged during transport. Primary and secondary assessment findings were normal. Radio report called in to Downtown Hospital during transport and verbal report given to Shelley RN on pt transfer. **End of report**

Prep Kit

Ready for Review

- For each emergency call, you must complete a formal written report before you leave the hospital. This action is a vital part of providing emergency medical care and ensuring the continuity of patient care. This information guarantees the proper transfer of responsibility, complies with the requirements of health departments and law enforcement agencies, and fulfills administrative needs.
- Your written report, or patient care report, is the only record of events that transpired during the call and serves as a legal record. It should be complete, well-written, legible, and professional.
- Your report may be used in legal proceedings against you or someone else, and is the only record of the care you provided and why.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was designed to protect a person's health information, but permits disclosure of patient care information when necessary for the betterment of society as a whole, such as when data are used to protect or improve public health.
- The patient care report (PCR) may be handwritten or electronically written. Either way, it will include a checklist and a narrative portion. The report should be objective, accurate, and neat; this reflects good patient care.
- If a patient refuses care, ensure that you have obtained vital signs and a complete history, fully inform the patient of the situation, involve medical control if needed, and thoroughly document the situation.
- Special situations that may require filling out different or additional forms include injuries that occur in the workplace, multiple-casualty incidents, exposure to potentially infectious diseases, cases that involve potential abuse or neglect, transfer of care to an on-scene physician, interfacility transports, calls involving controlled substances, cancelled emergency calls, and calls involving other agencies. Reporting regulations vary from state to state, and you should make yourself familiar with your state's requirements.
- There are many methods for writing the narrative in your patient care report, including chronological order, the SOAP method, the CHARTE method, and the body systems approach. Learn the method used by your system.
- The patient care report needs to be filled out in a timely manner. Be sure to fill it out directly after the call.
- If you must revise or correct your patient care report, note the date, time, and purpose for the correction. Place a single line through the error and write the correct information next to it. Write down what did or did not happen and the steps that were taken to correct the situation.
- Falsifying information on the patient care report may result in suspension and/or revocation of your certification/license.
- Inaccurate or poor documentation could lead to subsequent caregivers providing inappropriate care to the patient. It could also be detrimental for you if a lawsuit is initiated, and could negatively affect your reputation.
- Proper use of terminology is essential. Learn common medical abbreviations.

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Prep Kit, continued

Vital Vocabulary

CHARTE method A narrative writing method that allows the narrative to be broken down into logical sections similar to the steps of the EMS assessment; components include chief complaint, history, assessment, treatment, transport, and exceptions.

Health Insurance Portability and Accountability Act (HIPAA) The law enacted in 1996 that provides for criminal sanctions as well as civil penalties for releasing a patient's protected health information (PHI) in a way not authorized by the patient.

libel Making a false statement in written form that injures a person's good name.

medical necessity A standard used by Medicare to determine whether a patient's condition requires ambulance transport in a particular situation.

minimum data set The mandatory clinical assessment standard information that must be documented on every emergency call as set by Medicare and Medicaid, and per the National Highway Traffic Safety Administration (NHTSA) for the purpose of the national data system.

objective information Information that you observe and that is measurable, such as a patient's blood pressure.

patient care report (PCR) A written record of the incident that describes the nature of the patient's injuries or illness at the scene and the treatment provided; also known as the prehospital care report.

pertinent negatives Findings that warrant no medical care or intervention, but which, by seeking them, show evidence of the thoroughness of the patient examination and history.

slander Verbally making a false statement that injures a person's good name.

SOAP method A narrative writing method in which information is organized into four categories, including subjective information, objective information, assessment, and treatment plan.

subjective information Information that is told to you, but which cannot be seen, such as the symptoms a patient describes.

Assessment in Action

You and your partner are dispatched to a local stadium where a football game is in progress. A player is unresponsive after being tackled. On arrival, your unit is directed onto the field by security. As your vehicle approaches the area where the player went down, you see numerous flashes apparently coming from cameras. A law enforcement officer walks up to your vehicle and tells you that the scene is safe and the crowds and press are under the control of law enforcement personnel. You exit the vehicle and wade into the press to get to the patient. The athletic team trainers as well as the team physician are taking care of the patient by placing him in full spinal precautions. As you bend down to the patient, a reporter sticks a microphone in front of you and asks, "Is this kid's career over?" You look over your shoulder for your partner, who is making his way toward you through the reporters.

1. During patient care activities in a chaotic environment, it is most important to maintain effective communication with:
   - **A.** the dispatcher.
   - **B.** law enforcement personnel.
   - **C.** your partner.
   - **D.** medical control.

2. What is the term used to describe documentation of a false statement that injures a person's reputation?
   - **A.** Slander
   - **B.** Ethics violation
   - **C.** Verbal assault
   - **D.** Libel

3. Which aspect of the Health Insurance Portability and Accountability Act (HIPAA) is the most important to pre-hospital care?
   - **A.** Ensuring that patient privacy is protected
   - **B.** Recovering patient care information from the archive
   - **C.** Ensuring that crew privacy is protected
   - **D.** Ensuring that all documentation is complete and accurate

4. What does the HIPAA Privacy Rule of Operations allow EMS providers access to?
   - **A.** Insurance and billing information
   - **B.** Patient name, birth date, address, and next of kin
   - **C.** Patient files and records at the receiving facility
   - **D.** Patient care required after the patient was in the care of the facility

5. Documentation of the chief complaint, vital signs, level of consciousness, patient demographics, and assessment information is referred to as the:
   - **A.** minimum data set.
   - **B.** maximum data set.
   - **C.** HIPAA data set.
   - **D.** patient care report.

6. What information is generally allowed to be disclosed without authorization to public health officials under the HIPAA Privacy Rule?
   - **A.** Information concerning preventing or controlling disease
   - **B.** Information concerning prevention of injuries
   - **C.** Information concerning prevention of disability
   - **D.** All of the above

Additional Questions

7. Referring back to the scenario, if you answered the reporter about the future of the patient's sports career, are you in violation of HIPAA?

8. How is the right of the press to cover stories balanced with HIPAA requirements for privacy?

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