Completion of Patient Care Report

This policy provides clarification on the completion time of the Patient Care Report (PCR) via the emsCharts application.

- A patient care report must be generated anytime a dispatch number is assigned by the Communications Center. (If you are dispatched to a call and you are cancelled prior to leaving the base you may ask the Communication Center to simply cancel the dispatch number.)

- All patient care reports must be entered during the duty shift of the employee rendering care to the patient. In addition, the patient care report MUST be locked within twenty-four (24) hours of the call being completed.

    - It is recognized that in some cases, employees have patient care reports to do after the end of their duty shift; furthermore it is recognized that employees must be sufficiently rested at the beginning of their next consecutive duty shift. It is acceptable to leave a patient care report incomplete and finish it at the beginning of the next duty shift in the following conditions:

        - The employee has worked two hours past the end of his/her duty shift either running calls or inputting patient care reports and is scheduled to work the next day/night.

        - ALS calls or any call that may need to be reviewed by a physician, nurse, medical examiner, or other persons who will be involved in the patient's care after EMS care MUST be completely documented before the employee goes home.

        - If the employee wishes to leave any call incomplete, he/she must call the on-duty Shift Supervisor. The employee will advise the supervisor how many calls will be incomplete and give a brief description of the calls. The supervisor can choose to give or deny permission to leave patient care reports incomplete based on the type of calls the employee describes.

        - Page 1 of the emsCharts patient care report MUST be filled out in its entirety for each call not completed prior to leaving, without exception.

        - If an employee is scheduled to be off the next day/night, he/she will complete ALL patient care report for the current shift regardless of how long they may have to work over.

- Only employees of Catawba County EMS will complete a patient care report.

- During times when the Internet is not accessible or the emsCharts web site cannot be accessed, personnel shall not delay inputting the chart. The "emsCharts Mobile" application is to be utilized instead.

    - As soon as the Internet or emsCharts website is functional the crew member that entered the chart will upload the emsCharts Mobile record.

- Once the record(s) is uploaded, the employee will then sign in to the on-line version of emsCharts and complete the chart if necessary. If the chart is completed prior to upload, the employee needs only to electronically sign the chart and complete / lock the chart.
- If an employee enters a chart in emsCharts Mobile and is unable to upload it prior to the end of their shift, that employee is responsible for notifying the on-duty Shift Supervisor that the record has not been uploaded.

This represents the minimal documentation required for any call in which there is patient contact.

- Dispatch Information (Page 1)
  - Complete all blocks and pull down menus that are accessible.
  - Ensure that all times documented in the PCR correlate with those listed on the CAD report.

- Patient Information (Page 2)
  - Complete all blocks and pull down menus.
  - Not required: DL State and Number, Blood Type
  - Ensure that ER number and MR number correlate with the numbers on the patient's demographic sheet.
  - A NPP (Notice of Privacy Practices) must be given to all patients. If this is signed, choose yes.
  - Consent form must be signed for all patients.
  - If a Medical Necessity Form is present and signed by a physician, click "yes." Medical Necessity forms must have the correct date and a signature by a physician with "Dr." or "M.D."

- Patient / Bystander Interview (Page 2)
  - Page 2 reflects initial patient presentation/assessment.
  - Impression/Diagnosis section must be completed.
  - The location the unit is responding from must be documented in the Scene Description section.
  - Indicate Mechanism of Injury in the Scene Description or HPI section.
  - The Chief Complaint and History of Present Illness sections must be completed.
  - Document where and with whom the patient's belongings were left.
  - The Factors Affecting Care section must be completed.
  - Complete the following sections as they pertain to the call: Reasons for Encounter, Drugs/Alcohol, and Additional injury Details, Cardiac Arrest, and Motor Vehicle Incident.

- Neuro / Airway (Page 3)
  - Complete all blocks and pull down menus.
  - This page addresses how things are found in the primary assessment. (Any procedures done by EMS to correct airway issues are documented on page 8.)

- Respiratory / Cardiac (Page 4)
  - Complete all blocks and pull down menus.
  - This page addresses how things are found in the primary assessment.

- If appropriate mechanism of injury/illness is present, additional information regarding the presence/absence of gross bleeding must be included in the circulation comment section.
- Complete sections for the ventilator and pacemaker if they are being utilized prior to your arrival.

- Secondary Assessment (Page 5)
  - Include information that is pertinent to the Chief Complaint, History of the Present Illness, or Mechanism of Injury.
  - Complete all blocks and pull down menus if applicable to the complaint.
  - Complete "Additional Information" section as it applies to the patient.

- Meds/IVs PTA (Page 7)
  - Complete if the patient has any IVs or medications prior to arrival that must be maintained while enroute.

- Activity Log (Page 8)
  - Document all appropriate vital signs, assessments, treatments and time completed. Vitals should be reassessed every 5 minutes on an unstable patient, every 15 minutes on a stable patient, and each time there is a change in the patient condition.
  - Minimal vitals are to include: heart rate and quality, respiratory rate and effort, mental status, and blood pressure as applicable to the patient. Additional vitals should be documented as they pertain to the complaint: skin temperature, O2 saturation, EtCO2, blood glucose, pain scale, and cardiac rhythm. (Each time a 12-lead is obtained, document the findings in the rhythm box as well as the action area.)
  - An appropriate care protocol must be documented anytime an action is completed.
  - Treatment is to be documented utilizing the "Action" button.
    - Medication- complete all drop down menus. Include any improvements or complications
    - Intubation- complete all drop down menus. Include any improvements or complications.
    - Airway- Other- complete all drop down menus. Include any improvements or complications.
    - Initiate IV- complete all drop down menus. Include any improvements or complications. Any fluid given through the IV must be documented in the Medication activity area.
    - Cardiac- complete all drop down menus. Include any improvements or complications.
    - Immobilization- complete all drop down menus. Include any improvements or complications.
    - Medical Consult- complete all drop down menus. Include any orders obtained.
    - Labs- list any available lab values.
    - Drains-document any NG/OG tubes. Include any improvements or complications.
    - Ventilator- complete all drop down menus. Include any improvements or complications. Include ventilator values used while transporting.
    - Hospital notify- complete all drop down menus.

- Indicate the patient's final disposition. Ex: "Patient care was transferred to ER staff in room 13. Call ended."

- Miscellaneous (Page 9)
  - Attach all files pertinent to the call.
    - Signature form (front and back)-A copy of the back must also be left with the receiving facility.
    - Refusal
    - Uninjured Persons form
    - Patient Demographic sheet
    - Medical Necessity form
    - OEMS Airway Evaluation Form (front and back)
    - Cardiac Thrombolytic form
    - CVA Thrombolytic form
    - LA Stroke Screen
    - Restraint checklist
  - Anytime an EKG is obtained, it must be uploaded into EMS Charts.
  - An Addendum can be added if additional information needs to be added.