OMD Clinical Administrative Policy
Electronic Health Record Completion Policy

Draft for MCB Review/ & Approval 1/15/20,
Effective 4/1/20; replaces 10/1/2013 (Patient Care Report) & all prior versions

An electronic health record (EHR) is required if patient contact is made.

Patient contact occurs when any member of a Medical Control Board affiliated agency is

a) On-duty representing that agency;

b) Responding to a request for medical assistance;

c) Inquires as to the well-being of a patient and/or renders medical treatment to a patient.

All EHRs are to be completed by the responsible medical personnel prior to their leaving that shift in which the involved patient inquiries and/or treatments occurred.

The medical personnel responsible for completing a EHR shall make all reasonable effort to personally document the contents of the EHR and proofread the EHR to avoid need to make further edits after the EHR is left at the destination.

Unless emergency transports are awaiting ambulance assignment, EHRs shall be completed and left at the destination at the time of patient delivery to the destination. In the event of emergency transports awaiting ambulance assignment, EHRs not completed at the time of patient delivery to the destination shall be completed and transmitted to the destination within 2 hours of patient delivery unless in times of disaster operations approved/declared by the Chief Medical Officer or his/her designee within the Medical Control Board/Office of the Medical Director.

If any changes are made to a EHR after its preliminary/initial version is left at the destination (for example, hospital emergency department), then the final version of the EHR shall also be transmitted to the destination by or on behalf of the responsible medical personnel within 2 hours of patient delivery unless in times of disaster operations approved/declared by the Chief Medical Officer or his/her designee within the Medical Control Board/Office of the Medical Director.

If EHR changes are made that could be critical to patient care decisions (eg. notation of altered mental status/syncope; abnormal vital signs; abnormal ECG findings; medications/doses of medications administered; unusual responses to treatment), then the responsible medical personnel is to personally contact the treating physician and/or mid-level provider in the ED via telephone no later than at the time those EHR changes are made.