OMD Clinical Administrative Policy
Documentation Policy

Effective 10/1/2021, Replaces 9/9/2015 & all prior versions.
Review Before 7/2024

Documentation of Patient Care

- All patients will have their assessment and management fully and accurately documented in a timely manner using the documentation tools provided by their agency. Vital information will be communicated to the hospital at the time of patient turnover. This should include initial, significant, and final vital signs, ECG tracings, pertinent history and physical exam findings, and treatments provided.
- Medical Decision Making (MDM) or Critical Thinking will be documented to encompass thought processes that occur during the evaluation and management of a patient to include:
    - Protocol Deviations
    - Patient care objectives not met secondary to equipment failures or difficulties
    - Attempted but unsuccessful procedures with any complications/unexpected outcomes
    - Circumstances that cannot be accounted for in the general narrative (, weather, traffic concerns, safety, transport times) that influenced patient management.
    - Consults with request and order(s). Include names of all consulting persons.
    - Factors that contributed to treatments completed or deferred during the management of the patient.
- If a physical exam item is/was not assessed, either delete that element so it does not become part of the auto-generated narrative, or if that is not possible in your patient care reporting mechanism, note “not assessed”. Do not write “n/a” which means “not applicable”.
- Any crew member, agency, and/or facility conflicts will be documented separate from the patient care report as specific in the OMD Clinical Administrative Policy: Clinical Errors Event Reporting.
- Refer to the OMD Clinical Administrative Policy Electronic Health Record (EHR) Completion Policy for specific guidance on EHR completion and delivery timeframe expectations.

To facilitate quality patient care, CQI and accurate billings the following minimal elements will be included in the patient care report if applicable:

1. Chief Complaint including pertinent dispatch information, as well as info received from other sources (bystanders, police—which should be attributed or quoted as appropriate).
2. History of Present Illness: including OPQRST (Onset Type, Provocation, Quality, Radiation, Severity, Time of Onset). Include pertinent positives and negatives. This should also include description of unusual circumstances that are pertinent.
3. SAMPLE History: Symptoms, Allergies, Medications, Past Medical History, Last oral intake, Events leading up to 911 call
4. Physical Exam appropriate to patient complaint. This should also include your observations of other pertinent things on scene. Be as specific as possible in your description. HEENT, Neck, Chest, Abdomen, Pelvis, Posterior/Back, Extremities, Neuro/Mental Status, Skin.

5. Vital Signs: In almost every patient should include level of consciousness (LOC), blood pressure (BP), pulse (P), respirations (R), perfusion, oxygen saturation (SpO2) - prior to oxygen supplementation if possible.
    a. For Fire Department agencies, there should be at least one set of vital signs if they arrive sufficiently prior to transport EMS.
    b. For EMSA, there should be at least 2 full sets of vital signs for every patient, or an explanation why that was not possible.
    c. Stable patients should have vital signs monitored at least every 15 minutes and with significant status changes / interventions. Critical patients should have vital signs monitored at least every 5 minutes and with significant status changes / interventions. Vital signs should be recorded within 5 minutes before patient care turnover at hospital. If an invasive airway is placed, capnography waveform is expected to be recorded with each patient movement, including prior to patient movement from ambulance at hospital and once patient is physically on the hospital/helicopter stretcher at time of turnover.
    d. A significant status change may be a change in mentation, increase in pain, development of new symptom (e.g., chest pain) or sign (e.g., seizure).
    e. Downloaded vital signs, including BP, P, end-tidal carbon dioxide (EtCO2), and SpO2, from monitors should be checked and corrected if they are wrong, or conflicts explained in your narrative. For example, in a cardiac arrest, if the pulse reads “110” due to CPR, it must be corrected to “0” because the patient was pulseless.
6. Additional assessment findings as appropriate may include:
    a. 12-lead ECG if indicated (syncope, suspected cardiac chest pain, dysrhythmia or suspected ischemic equivalent)
    b. Glucometry (altered mental status, symptoms of hypoglycemia or hyperglycemia)
    c. Capnography, Los Angeles Prehospital Stroke Scale, Pain scale (1-10) if indicated
7. Provider assessment: what you thought was wrong with the patient and what protocol(s) you followed. Include triage level (red, yellow, green, black) here in the setting of multiple patient incidents (three patients or greater) or mass casualty incidents. .
8. Interventions performed. Document medications, procedures, alerts (STEMI, Stroke, or Trauma), and most importantly, why these were indicated.
9. Reassessment following interventions--(e.g., decreased dyspnea, increased O2 sat, decreased pain scale, improved blood glucose)
10. Turnover: note that verbal (or written) report was given, to whom patient was turned over to and when.
11. Review the written record to assure it paints an accurate and objective picture of the events of the call, and that there are no conflicts between the downloaded information from the monitor and the narrative.

Airway Management

1. Any invasive airway placement is expected to have the following elements documented:
    a. Indication for invasive airway placement
    b. Airway placement procedure:
        i. Supraglottic placement
            1. Any difficulties with placement
            2. Waveform capnography to confirm
                a. Initial EtCO2 and EtCO2 on hospital/helicopter stretcher
            3. Breath sounds present, gastric sounds absent
        ii. Endotracheal intubation
            1. Medications (e.g., etomidate) if used
            2. Blade used/Tube size used
            3. Visualization of glottis if orotracheal
            4. Time of intubation
            5. Waveform capnography to confirm
            6. Breath sounds present, gastric sounds absent
            7. Depth at teeth or lips
            8. Tube secured (e.g., tube holder)
        iii. If applicable, note that CPR was not interrupted
        iv. Any complications encountered (e.g., vomitus, foreign body airway obstruction)

Respiratory Distress

1. History:
    a. Time course of onset
    b. Potential aspiration
        i. If foreign body obstruction: ability to speak, move air, inspiratory stridor, cause
    c. Respiratory past medical history:
        i. COPD, asthma, frequency of use of home meds, tobacco use or exposure, triggers of respiratory distress, home oxygen (what baseline amount), home continuous positive airway pressure (CPAP) use, prior intubation(s)
        ii. CHF, medication(s), medication or dietary noncompliance
        iii. Prior response to therapy
    d. Assessment of severity:
        i. Severe: significant retractions, tripoding, # of words able to speak between breaths, “shark fin” capnography waveforms
        ii. Lung exam: wheezes, rales, rhonchi
        iii. JVD, peripheral edema - difference from baseline
    e. Presence, duration, and character of any chest pain or known anginal equivalent
2. Reassessments including respiratory rate, oxygen saturation and EtCO2 trending
3. If inhalation injury: Type of gas, duration of exposure, area of exposure (enclosed room), associated burns / singing (oral, nasal, facial area)

Cardiac Arrest

1. Events prior to collapse
2. Description / location of patient on arrival
3. Last time seen alive, estimated down time
4. Presence of DNR documentation (note whether valid or not, date executed, and physician name/witness names/power of attorney names if legible)
5. Bystander CPR prior to EMS system arrival or not
6. Medical history including any recent hospitalization or illness. Name of primary care physician if known.
7. All care events during the resuscitation (starting chest compressions, electrical, airway/capnography, vascular access, meds)
8. Any cardiac rhythm changes during resuscitation
9. If field termination of resuscitation, document medical control information including name and facility

Post Resuscitation

1. Time of ROSC and initial ROSC rhythm
2. Oxygenation/ventilation care - use of ventilator, ventilator settings
3. Perfusion care - IV fluids, cardiac meds, vasopressor
4. Post-resuscitation vital signs and 12-lead ECG acquisition, interpretation, transmission
5. Mental status, including spontaneous respiratory effort and movement(s)
6. Use of therapeutic hypothermia and how much fluid administered

Acute Coronary Syndrome

1. OPQRST and SAMPLE
    a. Cardiac risks: hypertension, diabetes, hyperlipidemia, smoking, obesity, family history of “early” coronary disease (< age 50 family with MI)
    b. Prior cardiac history, symptoms same or different, recent cardiac evaluation (stress test, cath) and results if known
    c. Name of cardiologist if applicable
    d. Nitro: If prescribed last time taken, If given by EMS, impact on pain
    e. Exertional level vs. pain at rest
    f. Radiation or pain and to where
    g. Associated symptoms: dyspnea, diaphoresis, nausea
2. Aspirin given since 911 called, contraindication if any. Note “Prior to arrival” if appropriate.
3. Treatments:
    a. 12-lead ECG acquisition and interpretation time (within 10 minutes of patient contact) and transmission
    b. Medications – aspirin, nitroglycerin, fentanyl
    c. If STEMI, ED alert time?
4. Reassessments: Pain scale, repeat vital signs, any cardiac rhythm changes

Cardiac dysrhythmias:

1. Criteria for patient unstable / symptomatic (or not) and needing intervention
    a. what signs of inadequate perfusion due to bradycardia—hypotension/shock, altered mental status,
    b. why bradycardia felt to be primarily cardiac in origin
2. Medication list beta blockers, calcium channel blockers, anti-dysrhythmics
3. 12-lead ECG acquisition, interpretation, and transmission
4. If electrical therapy required, document any sedation if administered

Acute Stroke

1. Time of last accurately known baseline neurological status (last "normal" for patient)
2. Los Angeles Prehospital Stroke Scale assessment
3. Blood glucose
4. Contact information for witness/family if not transported with patient
5. ED Stroke Alert activation time
6. Any change in neuro status during scene/transport care
7. Family cell phone number(s) obtained for treatment authorization purposes

Altered Mental Status

1. Baseline mental status for patient (per whom)
2. ETOH or other substance use history
3. Traumatic injuries
4. Blood glucose level. If low/high, history of diabetes. If diabetic:
    a. Use of insulin and/or oral meds, last dose of meds, changes to meds
    b. Etiology of hypoglycemia: missed meal, increased exercise, vomiting / nausea / recent illness
    c. Post-treatment reassessment of mental status and verification of baseline
5. Other potential causes, EtCO2 in patient with COPD hx

Seizure

1. Any injuries (mouth, head, tongue) due to seizure, or evidence of head trauma that may have caused seizure in patient with no history of seizure
2. Duration and number of seizures, whether patient fully regained consciousness between seizures (criteria for status epilepticus)
3. Time to return to baseline LOC
4. Prior history of seizures—type, medications / drug use, last time patient had breakthrough seizure
5. Potential etiology(s) of seizure: medication noncompliance, changes to medications, alcohol withdrawal, sleep deprivation

Syncope / Dizziness

1. Symptoms leading up to event:
    a. Activity preceding syncope or onset
    b. Recent illness (e.g., vomiting/diarrhea, GI bleeding)
2. Associated symptoms:
    a. Chest pain, dyspnea, nausea
    b. Neurologic: headache, focal weakness, slurred speech, visual or sensory changes
    c. Vertigo (room spinning) vs. dizzy (feeling lightheaded)
3. Medications: any new meds
4. Last meal
5. Blood glucose level
6. 12-lead ECG
7. In females of childbearing age: pregnancy, last menstrual period

Behavioral Emergencies

1. Documentation is to follow the specifications in Section 7: Psychiatric/Behavioral Disorders of the MCB Treatment Protocols.
2. Any patient statements regarding intent for harm to self or others (preferably in quotes)

Toxic Ingestion / Exposure/ Burns

1. Name of substance (note MSDS # if applicable to hazmat)
2. Ingestion:
    a. Amount taken, route, and approximate time ingested
    b. Vomiting since ingestion – note if pills visible
    c. Intentional vs. accidental ingestion, prior attempts if intentional
    d. Oral or nasal mucosa burns
3. Exposure (toxic gas / smoke / liquid / solid):
    a. Enclosed space
    b. Estimated length of exposure time
    c. Associated signs / symptoms (i.e., singed hairs, burns)
4. Systemic symptoms/toxidrome
5. Documentation of contact with poison control (time) and their recommendations.
6. Any patient statements regarding intent for harm to self or others (preferably in quotes)

Allergy / Anaphylaxis

1. Cause of reaction, time from exposure to onset
2. Prior similar reactions
3. Presence / absence of specific signs of allergic reaction or anaphylaxis
    a. Dyspnea, stridor, altered voice
    b. Facial / airway (tongue, lips) edema
    c. Urticaria and/or pruritis
    d. GI symptoms of nausea, vomiting, and/or diarrhea
    e. Hemodynamic changes – hypotension, tachycardia
4. Treatment provided and treatment response(s)

Pain Management

1. Indication for pain management
2. Comfort measures provided (positioning, splinting)
3. Objective evidence for pain noted (e.g., trauma findings, tachycardia, hypertension)
4. Patient able to follow commands / hemodynamically stable
5. Initial pain scale, pain scale following treatment

Spinal Motion Restriction

1. Documentation is to follow the specifications in Protocol 10O: Splinting of Injuries Adult and Pediatric of the MCB Treatment Protocols.

Environmental Emergencies

1. Circumstances of exposure:
    a. Suspected etiology
    b. Symptoms
2. Any decontamination that was performed

Active Labor and Childbirth: Separate documentation report required for mother and each neonate delivered

1. Obstetric SAMPLE history
2. Non-delivery:
    a. Estimated weeks gestation / due date, last menstrual period
    b. Known intrauterine pregnancy
    c. Gravida - Para
    d. Any complications of prior or current pregnancy
    e. High risk (multiple gestation pregnancy)
    f. Abdominal pain
    g. Sensation of fetal movement
    h. S/S preeclampsia: peripheral edema, headache, visual disturbance, hypertension, seizure
3. Possible labor, add:
    a. Time of onset of contractions
    b. Frequency of contractions (duration & frequency and whether palpable)
    c. Vaginal discharge / bleeding
    d. Rupture of membranes, discoloration of amniotic fluid
    e. Vaginal exam: crowning
4. Delivery, add:
    a. Presenting part
    b. Birth info:
        i. Time of birth
        ii. Male / female
        iii. Newborn resuscitation care events & APGAR scores

Informed Patient Consent/Refusal

1. Documentation is to follow the specifications in Section 14: Response, Scene Issues, and Patient Transportation of the MCB Treatment Protocols.