Contra Costa Emergency Medical Services

October 2010

EMS BEST PRACTICES

The Bottom Line: Prehospital Documentation Matters!

Timely patient care record (PCR) completion is essential to assure safe patient care. Emergency department physicians rely on the prehospital record to determine appropriate next steps.

The Expectation: A hardcopy prehospital patient care record is required at emergency department patient handoff. This requirement can be met by giving the nurse a paper PCR, draft or completed electronic PCR. The final electronic PCR must be completed in accordance with county policy. If the document is a draft, all key prehospital interventions and patient responses are to be included.

Who	Expectation	Comments
Transported Patients	Hardcopy draft or completed PCR at patient handoff	All EMS providers who transport the patient (ambulance or first responders who retain care of the patient) have a more rigorous expectation because they are responsible for assuring that ED personnel have all the information they need to provide for safe patient care.
All Others	PCR within 24 hours of patient contact	EMS recommends that this be done ASAP to assure that documentation is not only timely but accurate and complete.

EMS Best Practice Is Documentation Compliance

- ⇒ **Transport providers must submit a draft paper or printed electronic PCR with patient handoff in the emergency department**
- ⇒ **Transport and Fire Rescue providers who retain patient care to the hospital must complete their PCR within 2 hours**
- ⇒ **First responders should submit their NCR worksheet to the transporting medic to assure that all prehospital interventions are captured**
- ⇒ **First responders must complete an electronic PCR for every patient contact within 24 hours**
- ⇒ **All prehospital interventions and patient response should be documented in compliance with EMS prehospital protocols**

County Policy: All transport providers and those fire rescue providers who retain patient care to the hospital, must complete an electronic PCR within 2 hours of patient arrival at the receiving facility. For all other patient contacts EMS requires an electronic PCR be completed within 24 hours. **In the case of transported patients, EMS strongly recommends that the PCR be personally handed to the nurse receiving the patient so it does not get lost and to eliminate the "perception" that a record was not completed.**

Patient documentation is a professional responsibility: Federal, state and county mandates exist for prehospital documentation to support patient care from the field to the hospital. We have all heard the adage "If you didn't write it you didn't do it" but professional documentation is also about "taking credit for what we do." Data from prehospital documentation is used to determine the "efficacy" of what prehospital providers do. In other words, your compliance with PCR completion makes a difference! Don't short change your contribution to the process.

Measuring Compliance: EMS and provider agencies are responsible for monitoring ePCR completion and routinely reviewing patient care documentation. Documentation compliance is performed continuously and there is room for improvement. It is a responsibility that relies on everyone to be accountable. In the future, prehospital records will be electronically pushed and linked with the patient's hospital medical record. We are not there yet but one of our EMS system long-term goals is to get there as soon as possible. In the meantime, document accountably.

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CONTRA COSTA HEALTH SERVICES

Evidenced-Based EMS Practice : A Report on the Impact of 2010 Naloxone Protocol Changes

Joe Barger MD, EMS Medical Director

Treatment indications for the use of naloxone changed fairly radically in January 2010, refining the use of naloxone to the treatment of respiratory depression as the primary consideration rather than altered level of consciousness. Additionally, we added intranasal administration of naloxone as a safer and faster way to administer the medication. The goal was to improve the protocol guidance for prehospital providers and assure that naloxone was appropriately utilized in the EMS system. Under the new protocol guidance we expected to see naloxone being more reliably used in cases with ALOC (Altered Level of Consciousness) with respiratory depression (a respiratory rate < 10 breaths per minute).

Naloxone Use	2009	2010
Frequency of administration	—	Down 33% compared to 2009
Use in patients with RR <10 breaths per minute	43%	61%
Frequency of administration routes	72% IV 28% IM	31% IN 58% IV 11% IM
Frequency of RR improvement in patients with RR <10 with intranasal naloxone		90 %

As the chart demonstrates, in 2010 prehospital providers demonstrated naloxone is more reliably being used for ALOC with respiratory depression under the new protocol.

There has been a question as to whether intranasal naloxone works as well as the other routes. Our data suggests that the answer is yes. Of 57 patients given intranasal naloxone, 81% had improved respiratory status. This compares quite favorably with IV and IM use – a sample of those cases showed improvement in 70%. Of the 57 patients receiving intranasal naloxone, 7 received addition IV or IM medication. Six of those patients actually had a documented increase in respiratory rate before the additional medication, but were not awake. In four of those cases the patient had not received the full 2 mg intranasal dose to begin with, so an initial full dose may have eliminated the need for more drug in some cases. There will always be patients who will need additional naloxone – some who get initial IM or IV doses also end up receiving more to get a response. Focusing on those patients with respiratory rates of 10 or less, intranasal naloxone was effective in improving respiratory rates in 90%, while IV/IM was effective in 85%.

Overall, the improvements in naloxone use are remarkable, and paramedics are to be congratulated for such a rapid change in results. There is still some room for improvement:

⇒ Some patients continue to receive naloxone solely for treatment of altered mental status without respiratory depression. There will be borderline cases so we will never have 100% of patients with respiratory rates of 10 or less, but we still want to avoid reversing the effects of narcotics simply to treat ALOC because the side effects of naloxone can be significant (e.g., acute withdrawal symptoms, cardiac problems, combativeness, seizures).

⇒ There appear to be many more patients who can be treated with intranasal naloxone. Use of the intranasal route appears to have reduced IM use more than IV. It may be that some paramedics are not yet comfortable or do not trust that intranasal administration works. Our data is compelling to say that it does, particularly in patients who have respiratory depression!

⇒ Remember to give the full 2 mg dose of naloxone when the drug is administered intranasally. Titration, if indicated, needs to be done IV.

We will continue to monitor usage in the future, and it is my hope that we will see further improvement in terms of patient selection and use of the intranasal route.

2010 Education Needs Survey Finds One-Page Newsletters a Hit!

The Contra Costa Fire EMS Training Consortium recently completed its annual education needs assessment. Over 330 EMTs and Paramedics participated. The survey revealed that > 60% read EMS Best Practices and > 48% read STEMI News. Of those who reported reading the field oriented newsletters > 55% of respondents felt the newsletter informs them on issues they need to do their job! We are pleased to have hit the mark but now need your help. Please spread the word and help us reach your co-workers. Missed a newsletter? Go to www.cccems.org and catch up!

REMINDER... EMS Annual Update to Debut in 2011!

In order to include the new standards for CPR and Advanced Life Support for children and adults coming out in November 2010, Contra Costa's EMS Update training has been changed to January-March 2011.

Please contact us with your comments or concerns—visit our website at www.cccems.org