

Documentation of the Electronic Health Record

I. PURPOSE

This policy defines the requirements for patient care documentation and the procedure for completion, distribution and retention of the electronic health record (EHR) applicable to all EMS transport providers, ALS first responders, and EMT first responders.

II. POLICY

- A. EMS personnel shall complete an EHR on all EMS responses regardless of outcome. This includes responses where a unit responded and there was no patient contact.
- B. All available and relevant information shall be accurately documented in the EHR.

III. EHR AVAILABILITY

The timely delivery of a completed EHR to the receiving facility is a high priority. An EHR for each transported patient must be left with receiving facility staff prior to clearing the receiving facility.

- A. Transporting agencies shall leave a partially completed or preliminary EHR, marked as such, with receiving facility staff if an EHR cannot be completed prior to clearing the receiving facility. If the EHR cannot be completed and a copy left with receiving facility staff before departing the facility, the narrative section of the call report should explain the delay.
- B. Non-transporting agencies that have turned over patient care to transporting personnel may send a partially completed or preliminary EHR, marked as such, with the patient. Non-transporting agencies are not required to transmit EHRs to receiving facilities.
- C. Except as outlined in III(A) above, all EHRs shall be completed, delivered to the receiving facility as applicable and posted to the EHR server within twenty-four (24) hours of patient contact.

IV. EHR PROCEDURES

- A. Personnel providing patient care are responsible for accurately documenting all available and relevant patient information on the EHR. This requirement includes transport and first responder personnel.
- B. Use of usual and customary abbreviations is permitted in the narrative section of the record or as defined in automated EHR pre-designated pick lists.
- C. An EMS provider's EHR should include, at a minimum the following information:
 - 1. Complete demographic information.
 - 2. A clear history of the present illness with chief complaint, onset time, associated complaints, pertinent negatives, mechanism of injury, etc. The information should accurately reflect the patient's chief complaint as stated by the patient to the EMS provider and should be sufficient to refresh the clinical situation after it has faded from memory.
 - 3. An appropriate physical assessment that includes all relevant portions of a head-to-toe physical exam. When appropriate, this information may be supplemented in the narrative section of the EHR.
 - 4. At least two (2) complete sets of vital signs for every patient including: pulse, respirations, blood pressure and pulse oximetry. These vital signs should be repeated and documented after drug administration, prior to patient transfer and as needed during transport. For children \leq three (3)



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years of age, blood pressure measurement is not required for all patients, but should be measured if possible, especially in critically ill patients in whom blood pressure measurement may guide treatment decisions.

5. A pain scale shall be documented for all patients with a GCS > 14.
 6. Only approved medical abbreviations may be used – see appendix.
 7. The CAD to EHR interface embedded within the EHR system should be used to populate all EHR data fields it supplies. When 9-1-1 center times were improperly recorded, these may be properly edited.
 8. When the cardiac monitor is applied, data will be transferred to the EHR from the device. If transferred automated vital sign values do not correlate with manually obtained values, or are not consistent with the patient's clinical condition, providers should manually check vitals and record manual results.
 9. For drug administrations, the drug dosage, route, administration time and response shall be documented.
 10. A complete list of treatments in chronological order. Response to treatments should also be listed.
 11. For patients with extremity injury, neurovascular status must be noted before and after immobilization.
 12. For patients with spinal motion restriction, document motor function before and after motion restriction.
 13. For IV administration or saline lock placement, the catheter size, site, number of attempts, type of fluid, and flow rate.
 14. A cardiac monitor strip should be attached for all patients placed on the cardiac monitor. All 12-Leads should also be included. Any significant rhythm changes should be documented. For cardiac arrests, the initial strip, ending strip, pre and post defibrillation, and pacing attempts, should be attached.
 15. Any requested medical control orders, whether approved or denied, should be documented clearly.
 16. Any waste of controlled medications should include the quantity wasted, where wasted and name of the person who witnessed the waste. Only agency approved personnel should be utilized to witness controlled substance waste.
 17. All personnel information, including signatures.
 18. ALL crew members are responsible for, and should review, the content of the EHR for accuracy.
 19. Completing the record includes marking the record "complete" in the EHR system and uploading the record to the EHR server.
- D. The EHR shall be completed and distributed in accordance with this policy.



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- E. Once the EHR is completed and posted, the EHR may not be modified for any reason. Corrections or additions should be in the form of an addendum to the EHR.
- F. If a paper EHR is used, or a change is made on a hard copy of an automated EHR, documentation errors shall be lined through (e.g., ~~Like this~~), and the correction shall have the patient attendant's initials beside it.
- G. Any changes made to an electronic EHR shall have documentation of those changes retained in the EHR record database.

V. ELECTRONIC SYSTEM FAILURE

- A. Back-up systems to provide for paper EHR documentation must be in place for use should an electronic documentation system fail. Electronic documentation system failure is NOT an exception for providing the required EHR documentation.
- B. The LEMSA shall be notified of downtime or transmission difficulties lasting more than twenty-four (24) hours for all electronic EHR system outages.

VI. MULTI-CASUALTY (MCI) INCIDENTS

- A. EHRs shall be completed for all patients in MCI unless requirements have been shifted to documentation on triage tags per MCI plan directives.
- B. In incidents with large numbers of persons refusing treatment or transport, efforts should be made to document as much information as possible. For persons not meeting patient criteria, a Release at Scene Log may be completed and attached to an EHR for the incident.

