



Documentation

McHenry Western Lake County
EMS System



Documentation

○ Purposes

- Preserves basic patient information
- Records changes in patient condition
- Justifies your treatment
- Allows continuity of patient care
- Satisfies regulatory requirements
- Provides data for Quality Improvement



Documentation

- Protection for the EMS personnel
- Reflection of good patient care



Documentation

An accurate, complete medical record implies accurate, complete, organized assessment and management of your patient



Documentation

- Characteristics of a good medical record
 - Accurate
 - Complete
 - Legible
 - Free of extraneous information



Accurate

- Document facts, observations only
- Do NOT speculate about the patient or the incident
- Double check numerical entries
- Recheck your spelling of:
 - Person
 - Location
 - Medical terms



Accurate

If you make a
mistake...document it.

It is better to record your own
mistakes than for someone
else to uncover them



Complete

- Include all requested information
- If information requested does not apply, then note “not applicable” or “N/A”
- Includes at least two sets of vital signs on every patient
- Failure to document implies failure to consider
- If you look for something and it isn't there, document the absence



Complete

If it isn't documented...

It wasn't done!



Legible

- If you can not make sense of your report, you may be unable to determine what happened when asked to.
- Documents presented in court
“Speak for themselves”
- If the document does not make sense, the jury has the right to ignore it altogether



Legible

If the report is sloppy, then others will assume that the care was equally as sloppy



Free of Extraneous Information

- Avoid labeling patients (“drunk, psych patient”)
- Describe the observations you made
- Preface comments made by the patient with “per the patient” or “patient stated”



Free of Extraneous Information

- Record hearsay only if applicable
- Do NOT record hearsay as factual
- Use quotation marks only if a statement is accurate word-for-word



Free of Extraneous Information

Avoid interjecting humor

The public does not regard EMS as a funny business



Documentation

- A copy of the report must be filled out and left at the receiving hospital.
 - A green sheet may be left until the actual medical report has been produced and faxed to the hospital
- The person who rode with the patient writes the report
- All personnel who participated in the care, should review the report before signing



Documentation

- If something needs to be corrected, correct it
- The sooner an error is corrected, the more credible and reliable the change is
- Use the addendum form in IEMS to make your changes
- This will be saved with the original document with the date and time of the change



Documentation

Do not hesitate to write a long report.

Better to document findings now, than to try and recall later



Documentation

- Avoid stating diagnostic impressions
- Report facts and observations
- If you must state a diagnostic impression:
 - Do so within the scope of your training
 - Include the observations that led to the impression



Documentation

Avoid using “possible” or “?”
when the observation would
have been obvious to anyone



Documentation

- If a patient complains of pain in an area, state what you found when you examined the area
- Failure to record your observations implies that you noted the complaint, but then did not investigate it



Documentation

- On MVC's you need to report:
 - Type of collision, (head on, rollover, lateral impact, etc)
 - Degree of damage to vehicle
 - Location of the patients
 - Use of seat belts
 - Air bag deployment?



Documentation

- On falls report:
 - Where the patient fell from
 - How far the patient fell
 - The surface the patient fell onto
 - Why the patient probably fell



Documentation

- On head injuries report:
 - Level of consciousness
 - Pupil response to light
- Presence or absence of:
 - Discharge from nose and ears
 - Cervical pain, muscle spasm, tenderness or deformity
 - Altered PMS (pulses, movement, sensation)



Documentation

- On chest injuries report:
 - Position of trachea
 - Status of neck veins
 - Breath and Heart sounds
 - Presence or absence of
 - Crepitus
 - Subcutaneous air
 - Paradoxical movement of chest wall



Documentation

- On extremity injuries report:
 - Distal skin color and temperature
 - Presence or absence of:
 - Distal pulses
 - Motor function
 - Sensory function



Good documentation is
NOT C.Y.A.

Good documentation is a
reflection of
Good Patient Care



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