Forsyth County EMS

Patient Care Policy: Documentation of the Patient Care Report

1. Patient care and incident response information will be recorded on a document referred to as the **Patient Care Report** (PCR). A sample PCR has been included for reference as Article 13 – Appendix A.

2. Unless directed otherwise, a PCR will be completed on every response and for every patient contact.

3. Dependant upon the situation encountered, a complete PCR may be composed of only the PCR, or the PCR and various combinations of the following:

   - FCEMS Patient Care Data Worksheet (See Article 13 – Appendix B)
   - FCEMS Refusal of Service/Transport Form (See Article 13 – Appendix C)

The following Table indicates what paperwork is required for each type of call:

CALL TYPE/DISPOSITION	TRANSPORT UNIT	SUPERVISOR/TRAINING/ADMIN UNIT
Patient Transport	• PCR • FCEMS Patient Care Data Worksheet	• PCR
10-22 En route	• PCR	• PCR
10-22 Patient Refused Transport Unit Handles Refusal	• PCR • FCEMS Patient Care Data Worksheet • FCEMS Refusal of Service/Transport Form	• PCR
10-22 Patient Refused Supervisor/Training/Admin Unit Handles Refusal	• PCR	• PCR • FCEMS Patient Care Data Worksheet • FCEMS Refusal of Service/Transport Form
10-22 ALS Treat and Release Transport Unit did ALS and Handles Refusal	• PCR • FCEMS Patient Care Data Worksheet • FCEMS Refusal of Service/Transport Form	• PCR
10-22 ALS Treat and Release Supervisor/Training/Admin Unit did ALS and Handles Refusal	• PCR	• PCR • FCEMS Patient Care Data Worksheet • FCEMS Refusal of Service/Transport Form
ALS Assist for Private Provider Or Rescue Squad	• PCR • FCEMS Patient Care Data Worksheet	• PCR • FCEMS Patient Care Data Worksheet

4. General rules for completing PCRs and other forms:

   a) For completion of handwritten forms and signatures, use a black ink pen. The use of red, blue or green ink is not acceptable.

b) All handwriting should be completed in block print form and must be neat and legible.
c) Use only the standard abbreviations listed in Article 14, no other shorthand notations or jargon is acceptable.
d) All times must be written in 24-hour military time format.
e) All dates must be written in the month/day/year format. Each section is a two-digit number. Example 03/09/97.
f) All reference to a hospital will be by approved abbreviation or full name. The use of radio designations is not acceptable
g) **Remember - If you don't write it down, you did not do it and if you did not do it, don't write it down.**

5. FCEMS utilizes a software package entitled EMS Solutions 2000 to generate computer PCR forms.

6. All information required for billing purposes is collected on the computer generated PCR. Therefore, it is imperative that all FCEMS personnel take the time necessary to assure that all information documented is complete and accurate. When the situation occurs that the crew is unable to obtain the patient's name or other pertinent identification the following procedure must be followed:

a) If law enforcement is involved, include officer's name in your report. Also include officer's report # if one exists. If possible get a contact phone number for the officer. Ask the officer to call you with the patient's information later in the shift if possible.

b) "UNKNOWN" should be entered as the patient's last name in the computer if you have not obtained accurate information by the time you complete the PCR. Include as much information as possible about the patient and incident. Complete the remainder of the PCR as you normally would.

c) Inform your supervisor that you have entered an "UNKNOWN" patient so they can monitor the situation. Correct the PCR if you obtain updated information during the shift.

d) Supervisor should assure that attempts are made to obtain information during the remainder of the shift. If no accurate information is obtained, then the supervisor must notify the Operations Officer and forward a copy of the PCR for follow-up.

e) DO NOT FORGET THAT SOMEONE MUST COMPLETE A PCR ON ALL DOA's PRONOUNCED BY FCEMS. This us usually the responsibility of the employee that makes the determination that death

exists. DO NOT ASSUME THAT SOMEONE ELSE ON THE SCENE IS GOING TO DO THIS FOR YOU. ALWAYS FOLLOW UP.

7. Many insurance companies, as well as Medicare and Medicaid require a patient signature, for reimbursement. Therefore, FCEMS personnel must assure that a patient signature is obtained on all “billable” calls.

8. **Patient care information is confidential**. Therefore, FCEMS personnel should take steps to assure that this information is only discussed with those having a need-to-know, that it is not discussed in a forum that can be easily overheard by the public, etc. PCRs and Patient Care Data Worksheets should be protected and secured for delivery to the supervisor. Computers should be shutdown to the point that patient information is not accessible by others. **FCEMS employees will comply with the FCEMS HIPPA Manual related to the confidentiality of protected health information (PHI).**

9. FCEMS PATIENT CARE DATA WORKSHEET

   a) The purpose of the FCEMS Patient Care Data Worksheet is to:
      i) Provide a means of documentation to collect pertinent information concerning patient condition and care rendered to leave with the receiving facility when a PCR cannot be completed prior to the unit leaving the facility.
      ii) Provide a form for the collection of pertinent signatures to include the patient, the receiving nurse and the physician authorizing prehospital ALS treatment, and an acknowledgement of receipt of the FCEMS Notice of Privacy Practices (NPP) by the patient, guardian, or family.
      iii) Provide a form for the collection of information needed to complete a PCR at a computer workstation.

   b) Transport Units must complete a FCEMS Patient Care Data Worksheet on all patient contacts.
   c) Supervisor/Training/Admin Units must complete a FCEMS Patient Care Data Worksheet on all calls where they transport the patient onboard a unit from a Private Provider or Rescue Squad, or when the Supervisor/Training/Admin Unit handles the refusal on a 10-22 Patient Refused call.

10. Instructions for completing REFUSAL OF SERVICE/TRANSPORT FORM

   a) See Article 16 for details on patients refusing service.

   b) For convenience, the Refusal of Service/Transport Form is located on the back of the white copy of the FCEMS Patient Care Data Worksheet.

c) Call Report Number - same as the incident number for the PCR
d) Date - same as date on PCR
e) Time - time the form is signed by the patient or guardian.
f) Read Part A to the patient.
g) After the patient or guardian acknowledges understanding of Part A, have them sign the form in the appropriate space.
h) The employee should print the patient's name in a neat and legible fashion and enter the patient's age in the space provided.
i) Have a witness sign in Part B. The employee should print the name of the witness in a neat and legible fashion in the provided space.
j) The employee will complete Part C as appropriate.
k) After completing the Refusal Form, the employee will attach same to the front of the **PROVIDER** copy of the PCR with 1 staple in the upper most left hand margin.

11. INCIDENT REPORTS will:

a) Be generated according to the best judgment of the employee(s) and/or at the direction of an FCEMS officer.
b) **NOT** be generated in the PCR system, but rather, be handwritten utilizing the Forsyth County Incident Report Form or a Supplement Sheet, or typed in a Microsoft® Word document.
c) **NOT** be referenced in any way in any PCR narrative.
d) Reference the PCR by Log Number (if applicable).
e) Be signed by the employee(s) generating the report. (Separate Incident Reports may be generated by individual employees on the same incident depending on need, preference, and circumstances.)
f) Be submitted directly to a shift supervisor or the FCEMS officer requesting the report.
g) Be attached to the corresponding PCR for filing after the shift supervisor is satisfied that the Incident Report is complete and accurate.
h) Finally, be copied along with the corresponding PCR and sent to Administration for review.

Approved by:
COL Dan Ozimek
EMS Director
October, 2003

Approved by:
Dr. R.L. Alson
Medical Director
October, 2003

ARTICLE 13 - APPENDIX A

Patient #: 1 Of: 1 Page 1 of 2

PREHOSPITAL PATIENT CARE REPORT

Incident #:	Date:	Medical Record #:
123456	3/20/00	

PATIENT INFORMATION	
Name: PATIENT JOHN L	Type of Patient: **Medical** — Chest Pain (cardiac origin); Syncope; Respiratory Distress-acute
SSN: 000-00-0000 Phone: (000) 000-0000	
Address: 0001 OLD HOLLOW RD, Kernersville NC 27284	Other's on Scene: KPD; ED Disposition: Transferred
Gender: Male; Weight: 60 Kgs; Date of Birth: 1/1/01; Age: 99 Years	Pay Source: ; Family Physician: ; Employer:

CALL INFORMATION	
Provider: Forsyth County EMS	First Responder: Kernersville Fire Dept
Unit #: 25 Call Origin 911	Receiving Hospital: Wake Forest University Medical Cent
Time Onset: 17:00 Time Dispatched: 18:00	Destination Decision: Most Accessable Receiving Facility
Call Disposition: Emergency Department Transport	Base/Contact: Wake Forest University Medical Cent
To: Emergent From: Non-Emergent	Map Zone X: Map Zone Y:
Transport Provider: Forsyth County EMS	Dispatch/Scene District: Station 5 Squad 22
Unit # 25 Transport Mode: Ground	Pt. Mileage: Radio Protocol: ALS Prior to Base Contact
Incident Location: 0000 OLD HOLLOW RD	Total Mileage: Scene County/Zip: Forsyth County 27284

System Assessment			Pertinent Findings
Head/Face	Normal		Chief Complaint: MY CHEST HURTS
Neck	Normal		
Chest	Normal		Reason for Call: Chest Discomfort/Pain
Abdomen	Normal		Severity Impression: Moderate
Neck/Spine	Normal		Mechanism of Injury:
Pelvis	Normal		Safety Equipment:
Pelvis/Genit.	Normal		Initial Trauma Score: Initial GCS: 15
Upper Extremities	Normal		Pt Vehicle: Est. Blood Loss:
Lower Extremities	Normal		Pt Position:

Signature On File: Yes

Special Scene - Delay in EMS Access	Special Scene - Crowds	Current Med - GLUCOPHAGE
Current Med - ASA	Current Med - Insulin	Allergy - None
Med Hx -High Blood Pressure	Med Hx -Diabetes	

« Provocation : Moderate Physical Activity « Radiation : Left Arm « Radiation : Neck & Jaw « Severity : 6-7 « Time : 61 - 120 Minutes « Signs/Symptoms : Nausea « Signs/Symptoms : Shortness of Breath « Signs/Symptoms : Syncopy « Duration : 61 - 120 Minutes « Level of Distress : Moderate « Related Findings : Chest Pain « Duration of Episode : > 1 Minute « Other Symptoms : Nausea/Vomiting

Comments/HPI:

IL= 0000 OLD HOLLOW RD.

ATF 99YRO MALE WITH CC OF SEVERE CHEST PAIN AND SOB THAT BEGAN WHILE WALKING TO CHURCH APPROX. 1

Crew1/Primary		Crew 2		Crew 3	Received By
Black Timonthy	EMT-P	Ziglar Daren	EMT-P		T. NURSE, RN
Intern				MICN/RN	
Medical Control:	R. DOCTOR, MD			M.D. Signature:	

EMS Case Number: 999999999 Printed: 3/20/00 4:29:15 PM

Patient #: 1 Of: 1 Page 2 of 2

PREHOSPITAL PATIENT CARE REPORT

Incident #:	Date:	Medical Record #:
123456	3/20/00	

HR AGO. PT. AO X 3, SKIN W&D, VITALS AS LISTED. PLACED PT. ON 15LPM O2 VIA NRB. PT. HAD TAKEN 2 OF HIS OWN NITRO TABS AND REPORTED RELIEF OF CHEST PAIN. STARTED IV X 1 OF NS @ KVO. PT. RESTED COMFORTABLY DURING TRANSPORT TO WFUBMC. PT. TURNED OVER TO CARE OF ED STAFF (T. NURSE, RN) WITHOUT INCIDENT.

Event Chronology

Time	Procedure	Description	Attendant
18:00 Time Call Received:			
18:00 Time Unit Dispatched:			
18:00 Unit Enroute:			
18:10 Arrived at Scene:			
18:11 Patient Contact:			
18:11	OXYGEN	Non-Rebreather w/Reservoir 15 LPM	Kernersville Fire Dept - EMT-D J. FIREFIGHTER
18:12	ASSESS LUNG SOUNDS	Left Lung Sounds: Clear Right Lung Sounds: Clear	-
18:12	ASSESSMENT	SKIN Color: Normal / Pink- Moisture: Normal / Dry- Temp: Normal Cap Refill: < 2 Seconds- Pupils: L: Mid-Position- R: Mid-Position- PERL: Yes GCS: 15 - Eye: Spontaneous- Motor: Obeys Verbal- Verbal: Oriented	-
18:12	VITAL SIGN	SBP/DBP: 126/72 Radial- Pulse: 86 Regular- R-Rate: 14 Labored- EGC: Normal Sinus Rhythm- Ectopy: Not Observed -	-
18:13	IV / IO	Solution: NS- Site: LF - Left Forearm- Rate: TKO- Total ccs: 100- Gauge: 18 Successful- Attempts: 1	Black Timonthy - EMT-P
18:20 Depart Scene:			
18:28	ASSESS LUNG SOUNDS	Left Lung Sounds: Clear Right Lung Sounds: Clear	-
18:28	ASSESSMENT	SKIN Color: Normal / Pink- Moisture: Normal / Dry- Temp: Normal Cap Refill: < 2 Seconds- Pupils: L: Mid-Position- R: Mid-Position- PERL: Yes GCS: 15 - Eye: Spontaneous- Motor: Obeys Verbal- Verbal: Oriented	-
18:28	VITAL SIGN	SBP/DBP: 126/72 Radial- Pulse: 86 Regular- R-Rate: 14 Labored- EGC: Normal Sinus Rhythm- Ectopy: Not Observed -	-
18:42 Arrived Destination:			
19:01 Unit Available:			

Crew1/Primary		Crew 2		Crew 3	Received By
Black Timonthy	EMT-P	Ziglar Daren	EMT-P		T. NURSE, RN
Intern			MICN/RN		
Medical Control:	R. DOCTOR, MD		M.D. Signature:		

EMS Case Number: 999999999 Printed: 3/20/00 4:29:15 PM

ARTICLE 13 – APPENDIX B

FORSYTH COUNTY EMS PATIENT CARE DATA WORKSHEET

Provider Number 0340109

DATE CALL RECEIVED | PATIENT NAME: LAST, FIRST, MIDDLE | PATIENT NO. /

LOG NUMBER | AGE | DOB | RACE/SEX | PHONE | SSN | MEDICAID #

UNIT DISP | : |

ARRIVE SCENE | : |

ARRIVE AT PT. | : |

DEPART SCENE | : |

ARRIVE DEST. | : |

READY FOR SVC. | : |

ADDRESS | CITY | STATE | ZIP

EMPLOYER | INS. CO.

BILL TO | POLICY # | PRIM/SEC

POL OWNER | POL. TYPE

GROUP ID# | INDIV. ID #

BILLING ADDRESS | ADDRESS | CITY | STATE | ZIP

PT. WEIGHT

UNIT | DISPATCHED FROM | DISPATCHED TO | TRANSPORTED TO

DRIVER

ATTENDANT 1 | MEDICAL HX

ATTENDANT 2 | MEDS

DISTRICT CODE

CAUSE | ALLERGIES

PT. LOCATION | ORDERS

DISPATCHED AS

PT'S C/C | CHIEF COMPLAINT

VITAL SIGNS		PULSE		RESPIRATIONS		PUPILS	TREATMENT
TIME	B.P.	RATE	REG/IRREG	RATE	QUALITY		
:	/		☐ Reg ☐ Irreg		☐ Normal ☐ Labored ☐ Shallow ☐ Agonal	☐ Equal ☐ Unequal	☐ Oxygen ___ @ ___ LPM by ___ ; ☐ IV #1 ___ with ___ ga. in ___ : By
:	/		☐ Reg ☐ Irreg		☐ Normal ☐ Labored ☐ Shallow ☐ Agonal	☐ Reactive ☐ Nonreactive	☐ IV #2 ___ with ___ ga. in ___ : By ___
:	/		☐ Reg ☐ Irreg		☐ Normal ☐ Labored ☐ Shallow ☐ Agonal	☐ Dilated ☐ Constricted	☐ Defib 1 ___ joules : ; ☐ Defib 2 ___ joules : ; ☐ Defib 3 ___ joules :

MEDICATIONS ADMINISTERED

Name ______ Dose ______ Time ___ : ___ By ______

Name ______ Dose ______ Time ___ : ___ By ______

Name ______ Dose ______ Time ___ : ___ By ______

Name ______ Dose ______ Time ___ : ___ By ______

SKIN

CAPILLARY REFILL

Airway Management: ☐ E.T. ☐ Oral ☐ Nasal; Size ___ : By ___; ☐ BIAD : By ___

☐ Pacing : By ___

☐ Other

NOTES

LIFETIME PATIENT SIGNATURE AUTHORIZATION

I request that payment of authorized medical benefits be made either to me or on my behalf to Forsyth County EMS. I authorize Forsyth County EMS to release to my Insurance Company and its agents any information or documentation in their possession needed to determine these benefits or the benefits payable for related services. Patient/Beneficiary Signature ______________

TREATMENT AUTHORIZED BY ______ , M.D. PRINTED

PATIENT RECEIVED BY ______ , RN/MICN/M.D. PRINTED

CREW MEMBER #1 SIGNATURE

☐ EMT ☐ EMT-I ☐ EMT-P Signature Printed EQUIP. #

CREW MEMBER #2 SIGNATURE

☐ EMT ☐ EMT-I ☐ EMT-P Signature Printed EQUIP. #

PINK - FMH TRIAGE COPY

ARTICLE 13 – APPENDIX C

FORSYTH COUNTY EMERGENCY MEDICAL SERVICES
REFUSAL OF SERVICE/TRANSPORT FORM

Call Report Number: __________________ Date: _____ / _____ / _____ Time: ______ : ______

****

PART A.
A mentally competent patient has the right to refuse medical treatment and transportation to a medical facility.

1. Because I have refused the offer/recommendation by Forsyth County Emergency Medical Services ("EMS") that I be ☐ **TREATED** ☐ **TRANSPORTED**, I have been fully informed by EMS that I may call EMS back (by dialing 9-1-1) if I change my mind or if I feel worse;
2. I hereby accept full responsibility for my knowing and willful refusal to accept the EMS offer/recommendation that I be medically treated/transported;
3. I fully understand what EMS has told me and what is printed on this Form above my signature line; and
4. In consideration for having received an assessment of my medical condition, I knowingly and willfully agree to release, indemnify, and hold harmless Forsyth County and its officers, agents, and employees from any and all claims, actions, causes of action, damages, and liabilities of whatever kind or nature, including but not limited to attorney's fees, arising out of or in connection with my refusal to accept the offered medical treatment and/or transportation.
5. I acknowledge receipt of Forsyth County EMS's Notice of Privacy Practices.

Patient's Signature: ____ **Date:** _____ / _____ / _____

Patient's Name (Printed): ____ **Age:** ________

****

Because I am the patient's legal guardian in this situation, I am acting for the patient and have read the above information and I knowingly and willfully refuse medical treatment/transportation for the patient.

Guardian's Signature: ____ **Date:** _____ / _____ / _____

Guardian's Name (Printed): ____ **Relationship:** ____________________

☐ **Medical Power of Attorney**

PART B.
I witnessed the above-named patient (or the patient's legal guardian) refuse the ambulance crew's offer/recommendation of medical treatment/transportation for the patient.

Witness's Signature: ____ **Date:** _____ / _____ / _____

Witness's Name (Printed): ____

PART C.
As the attending EMS Emergency Medical Technician, I have offered/recommended to the patient (or the patient's legal guardian) medical treatment/transportation to a medical facility for the patient. The patient (or the patient's legal guardian) refused said medical treatment/transportation, and I believe that the patient (or the patient's legal guardian) is mentally competent. S/he is alert and oriented as to person, place and time.

☐ I have contacted Dr. _________________________ (physician) at ___________________________________ (hospital) and advised him/her of the patient's/guardian's decision to refuse medical treatment/transportation.

☐ I have explained this Refusal of Service/Transport Form to the patient (or the patient's guardian) and s/he verbalizes an understanding of this Form.

Signature: ____ **Date:** _____ / _____ /_____

☐ **Law Enforcement Officer present** ☐ **Follow-up requested.**

☐ **Patient/Patient's Guardian refused to sign this Form.** ☐ **Pre-Hospital DNR Order presented.**