



PREHOSPITAL CARE DOCUMENTATION DOCUMENTS: COMPLETION, REVISION, DISTRIBUTION, AND RETENTION

Orig. Date: 4/1/99
Revised:

~~6/15/09~~ ~~10/20/2009~~ 11/12/2009

I. **AUTHORITY:**

Health and Safety (HS) Code 1797.204. The ~~Orange County Emergency Medical Services (OCEMS)~~ local EMS Agency shall plan, implement and evaluate ~~the an emergency medical system~~ services system.

California Health and Safety Code, Division 2.5, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Division 9, Sections 100169 (a) (6) and 100170 (e). California Code of Regulations, Title 22, Division 9, Chapter 4, Article 7, Section 100169 (a) (6) (e). The medical director of the local EMS agency shall establish and maintain medical control in the following manner: (a) Prospectively, by assuring the development of written medical policies and procedures, to include at a minimum: (6) Requirements for the initiation, completion, review, evaluation, and retention of a patient care record as specified in this Chapter. These requirements shall address but not be limited to: (E) Responsibilities for record retention.

California Code of Regulations, Title 22, Division 5, Chapter 3, Article 5, Section 72543.

II. **APPLICATION PURPOSE:**

This policy defines the methodology to be used for the documentation of the delivery of prehospital care by EMS provider agencies and base hospitals and establishes ~~guidelines standards~~ for record report completion, revision, distribution and retention of ~~prehospital patient health care records~~ these records in accordance with federal, state, and local laws and regulations.

III. **DEFINITIONS:**

A. **Patient:** for prehospital care purposes is someone who meets any one of the following criteria:

1. Has a chief complaint.
2. A witness / someone with personal knowledge of the person states the person has a chief complaint, or makes a request for examination or treatment on the person's behalf.
3. Has an obvious symptom or signs of injury or illness.
4. Has been involved in an event with significant mechanism that the average first responder would believe could cause an injury.
5. Appears to be disoriented or to have impaired psychiatric function.
6. Has evidence of suicidal intent.
7. Is dead.



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- B. **Prehospital Care Report (PCR):** a paper-based or electronic form that is used by EMS providers (Paramedics and/or EMT's) to document the delivery of ~~prehospital~~ care in the ~~prehospital setting~~ field.
- C. **Base Hospital Report (BHR):** a paper-based or electronic form that is used by ~~base hospital personnel~~ Mobile Intensive Care Nurses (MICN's) to document on-line medical control.
- D. **Against Medical Advice (AMA):** a paper based or electronic form that is used by EMS providers to document that care and/or transportation has been ~~declined~~ refused by the patient (or the patient's parent/guardian or legal representative) pursuant to Policy 330.65 of the Orange County EMS Policy and Procedures manual. ~~and associated risks have been explained.~~
- E. **Interfacility Transport Form (IFT):** a paper-based or electronic form that is used by Paramedic Receiving Centers (PRC) and transporting paramedics to document the emergent transfer of a patient from one hospital to another when paramedics are requested via the 9-1-1 EMS system.
- F. **Orange County Medical Emergency Data System (OC-MEDS):** a countywide EMS, Trauma, and Certification data management system that has been developed to function as a web-based data repository to capture electronic records pertaining to EMS and/or Trauma care patients.

IV. **RECORD COMPLETION REQUIREMENT INDICATION FOR REPORT COMPLETION:**

- A. A PCR shall be completed for all persons meeting the definition of a patient. This includes a patient who is released on scene, refuses care / leaves AMA, meets criteria for field death, is an interfacility transport, or is involved in a multi-casualty incident (MCI).
 - 1. Contact with persons who do not meet criteria for the definition of a patient should be recorded ~~in the fire department on an organizational agency specific log or~~ incident reporting system (e.g., NFIRS, OCFIRS) to document that assistance was offered and declined. ~~Follow department reporting requirements regarding personal identifying information to be included (e.g., person's name, age / DOB, and gender).~~
 - 2. An EMS evaluation (minimum EMT level) may or may not be required for non-medical requests for assistance (e.g., "service calls" such as back-to-bed requests). A PCR shall be completed for persons meeting patient criteria. If non-patient, document as noted above.
 - 2.3. Triage Tags should be used in lieu of a PCR in the event of a declared MCI pursuant to Policy 900.00 of the Orange County EMS Policy and Procedures manual.
 - 3.4. Other forms should be completed (i.e. AMA, IFT, etc.) if applicable.
- B. A BHR shall be completed when ~~ever~~ paramedics ~~contact a base hospital~~ establish on-line medical control pursuant in accordance with the Orange County EMS (OCEMS) policies and procedures governing base hospital operations.

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V. DOCUMENTATION APPLICATION:

A. Record Completion

1. Documentation of prehospital care ~~on either~~whether on paper-based or electronic ~~report forms shall~~reports shall be permanent, either computer generated or legibly written in ink.
2. ~~Records PCR's~~ shall be completed by prehospital personnel as soon as feasible possible after patient care has been transferred to another healthcare provider (hospital, other EMS provider agency, etc.), ~~but no later than the end of a shift or before leaving when care has been turned over to another provider~~. Under most circumstances, the record should be completed upon arrival at a receiving hospital, upon transfer to another EMS provider agency, and/or prior to the dissemination of copies.
- ~~2.3.~~3.4. BHR's shall be completed by MICN's as soon as possible after the cessation of radio contact with paramedics has ended.
- ~~3.4.~~ If available, electronic prehospital care reports (ePCR) and/or electronic base hospital reports (eBHR) will include the minimum data set requirements as established by OC-MEDS Data Standards (See Resource List below) and will be transmissible in an approved web-based extensible mark-up language (XML) format.

B. Editing Records

1. Once a ~~form report~~ is initiated, it becomes a patient care record and is subject to retention guidelines and should not be destroyed and/or re-created. OCEMS Documentation Guidelines have been developed to assist providers on how best to complete the paper-based PCR (See Resource List ~~below~~in Section VIII of this policy).
2. Records may be edited in three ways, late entry, correction, and addendum. All must include the date of the entry and signature of the person making the addition or change. Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, name of editor, and the reason for the change.
 - a. Corrections: To correct an error the provider should draw a single line through the original entry in such a way that the original entry remains legible (~~ex.e.g.: incorrect entry~~). The provider should not alter the original record in any way by trying to erase, cover, or remove the incorrect information. ~~The provider should state the reason for the correction, and initial, date, and time the entry~~The provider should initial, date and time the entry. If the reason for the correction is not obvious by context, then the provider should explain why the change was made.



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b. Late Entries: Late entries supply additional information that was available at the time the document was created, but was omitted from the report. Late entries may be added to a ~~patient care record~~ PCR or BHR by starting a new entry with the note "Late entry", the additional information, current date, time and initials. Late entries may be documented by the ~~addition of~~ use of a supplemental ("Page 2") ~~of the PCR.~~

c. Addendums: An addendum is unlikely to be used in the prehospital setting. It is used to provide information that was not available at the time of the original entry. Addendums should include the date and time of the entry, reason for the addition or clarification, and initials of the person making the addition. If an entry is being made by a person other than those whose name and signature exists on the original form, then the name and initials of the person making the addendum should be included next to the addition.

3. Paper-based PCR's and/or BHR's should not be used to take simple patient care notes but should rather be used as the official medical record of care that has been provided.

a. It is not the intent of this policy to inhibit the collection of pertinent patient care notes (i.e. e.g. Blood Pressure written on a sheet, patient medications written on a blank note pad, etc.) that are frequently used by prehospital personnel to facilitate field patient care.

b. It is understood that previously written or completed PCR's and/or BHR's may occasionally need to be rewritten due to circumstances beyond a providers control (i.e. biohazard / chemical contamination, unintentional destruction, etc.) in order to provide a legible record of patient care.

1. If contact with the base hospital was established, paramedics must notify the contacted base hospital of the re-written record as soon as feasible and report the new PCR ID (Sequence) Number.

2. The PCR ID (Sequence) Number (or other PCR ID number) of the original PCR should be documented by paramedics in the "Treatment / Response" (Comment) section of the newly rewritten PCR.

3. The PCR ID (Sequence) Number that was written on the BHR should be corrected by drawing a single line through the original entry and documenting the new number directly above or below. The MICN should also note the date/time that the change was made and the name of the person who provided the new information

~~3. that have been unintentionally destroyed, submerged, soiled, or otherwise significantly damaged may be re-written so that patient care can be documented appropriately. The usage of a paper based PCR or BHR to document patient care~~



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~~notes that are subsequently transcribed onto a separate form is not permissible. If a PCR must be re-written, EMS providers must:~~

~~a. Document the original Sequence Number in the "Treatment / Response" section of the re-written PCR.~~

~~b. If specifically requested by OCEMS, attach a copy of the original damaged or destroyed PCR form to the newly re-written PCR. If a copy is not obtainable, attach a dated memo on organizational letterhead that explains the circumstances that lead to the re-creation of the PCR.~~

~~c. If contact with the base hospital was established, paramedics must notify the contacted base hospital of the re-written record as soon as feasible and report the new PCR Sequence Number.~~

~~4. Deliberate falsification of medical records is a crime which may result in criminal prosecution and/or organizational/personal liability. Examples of falsifying records include creation of new records when records are requested, back-dating entries, pre-dating entries, writing over, or adding to the existing documentation (except as described in late entries, addendums and corrections above).~~

VI. DISTRIBUTION:

A. Paper-based PCR Distribution

1. If patient is transported to a paramedic receiving center (PRC), distribute as follows:

- a. Top copy: Retained by provider agency
- b. Second copy: Sent to the assigned base hospital (within 7 Calendar Days)
- c. Third copy: Left at PRC with the patient
- d. Fourth copy: Sent to ~~Orange County~~ EMS (within 30 Calendar Days)
- e. Fifth copy: Extra copy; as per provider agency policy
- f. Information and treatment summary: Used / retained at discretion of provider agency.

2. If patient is NOT transported or refuses care / leaves against medical advice (AMA), distribute as follows:

- a. Top copy: Retained by provider agency
- b. Second copy: Sent to the assigned base hospital
- c. Other copies: As per provider agency policy

3. If patient is declared dead (reference Policy 330.50) and not transported, distribute as follows:

- a. Top copy: Retained by provider agency
- b. Second copy: Sent to the assigned base hospital
- c. Third copy: Left with the body for the coroner's office
- d. Other copies: As per provider agency policy

B. Paper-based BHR Distribution

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1. Top copy: _____ Retained by Base Hospital
2. Second copy: _____ Sent to ~~Orange County~~ EMS

C. Electronic Record Distribution / Transmission

1. OCEMS will establish ~~Data Use Agreements (DUA) with each standards and processes to define the receipt of and access to prehospital care data EMS provider agency, Base Hospital, Trauma Center, and Paramedic Receiving Center as outlined described~~ in the OC-MEDS System Guidelines document (See Resource List ~~below~~ in Section VIII of this policy) ~~for more information and DUA templates.~~
- ~~2. EMS provider agencies should establish DUA's between themselves and with hospitals to ensure for uniform and secure data transmissions.~~
2. Data transmissions between provider agencies, hospitals, and OCEMS shall be conducted to ensure patient confidentiality pursuant to the California Confidentiality of Medical Information Act (CMIA) and the federal Health Insurance Portability and Accountability Act (HIPAA).
3. OCEMS will securely transmit prehospital care records as requested by the California EMS Authority (EMSA) to the California EMS Information System (CEMIS) pursuant to existing and future agreements and/or regulations.
- ~~3. Data transmissions between provider agencies, hospitals, and OCEMS shall be conducted to ensure for patient confidentiality pursuant to California Confidentiality of Medical Information Act (CMIA) and federal Health Insurance Portability and Accountability Act (HIPAA), via encrypted web-based File Transfer Protocol (FTP) or other encrypted web based data transfer method.~~
- ~~4. Data transmission schedules between providers, hospitals, and OCEMS will be determined as agreed pursuant to established DUA's.~~

VII. RETENTION:

A. EMS Provider / Hospital

1. Each provider is the owner and custodian of the records ~~their agency generates~~ generated by their agency.
- ~~1.2.~~ Providers should consult with their risk management and legal advisors to ensure these that their agency adheres to minimum guidelines standards as established by law are appropriate.
- ~~2.3.~~ Patient care records include the OCEMS report form PCRs and any supporting documentation documents. Supporting documentation documents may includes, but are is not limited to: cardiac monitoring strips, 12-lead EKG reports, and copies reports, copies of Do-Not-Resuscitate forms, etc.
- ~~3. Patient care records may be securely retained in paper-based (hard copy) format; however, it is recommended that providers consider converting paper files to an encrypted electronic format.~~

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- ~~4. Patient care records (paper or electronic) will be maintained for a minimum of 7 years.~~
- ~~5. Patient care records for minors (less than 18 years old) will be maintained until after the minor turns 19 years old, but never less than 7 years. Thus, the records of any patient 12 years or older must be retained for 7 years. Records of any patient younger than 12 must be retained for greater than 7 years (e.g. newborn records must be retained for 19 years).~~
- ~~6. Patient care records associated with or pertaining to capital offenses will be maintained indefinitely.~~
- ~~7. If records are lost or destroyed prior to the expected termination date, the provider shall inform OCEMS in writing within three (3) business days.~~
- 8.4. Patient care records are confidential and subject to personal privacy protection laws and regulations. Providers should develop internal policies and procedures for the disclosure of this information in accordance with federal, state, and local laws and regulations.

B. OCEMS

1. All prehospital care records ~~sent to~~received by OCEMS (paper or electronic) will be maintained for a minimum of 7 years.
- ~~4.2. Patient care records for minors (less than 18 years old) will be maintained until after the minor turns 19 years old, but never less than 7 years. Thus, the records of any patient 12 years or older will be retained for 7 years. Records of any patient younger than 12 will be retained for greater than 7 years (e.g. newborn records will be retained for 19 years).~~
3. Records that are in the possession of OCEMS will be held in compliance with state and federal patient privacy laws and regulations.
 - ~~Paper (hard copy) records will be maintained in a secure high density filing system.~~
 - ~~Electronic records will be maintained via encrypted local or vendor hosted server with regular system back-up~~
- ~~2. Paper (hard copy) records will be maintained in a secure high density filing system.~~
- ~~3. Electronic records will be maintained via encrypted local or vendor hosted server with regular system back-up.~~

VIII. RESOURCES:

- A. OCEMS Documentation Guidelines
- B. OC-MEDS EMS Data Standards
- C. OC-MEDS System Guidelines

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