OC-MEDS - CLINICAL DOCUMENTATION STANDARDS

I. AUTHORITY:

Health and Safety Code, Division 2.5, Section 1797.204 and 1797.227; Title 22, California Code of Regulations, Division 9, Chapter 4, Article 7&8; California EMS System Core Quality Measures (EMSA #166)

II. APPLICATION:

This policy defines and establishes standards for prehospital documentation in the Orange County Medical Emergency Data System (OC-MEDS). The intent of these standards is to ensure that prehospital documentation exceeds the minimum necessary quality to provide an accurate history of prehospital assessment, decision-making, intervention and patient response, as well as to meaningfully contribute to quality improvement activities at all levels of EMS operations and governance.

III. DEFINITIONS:

National Emergency Medical Services Information System (NEMSIS): The national prehospital information system that standardizes, stores and provides access to prehospital data nationwide. NEMSIS defines and operates on a defined standard for what and how prehospital information is collected, stored, and shared. This standard enables accurate assessment of federal level prehospital needs and performance and supports strategic planning for the future. NEMSIS is a collaborative product managed by the National Highway Traffic and Safety Administration (NHTSA).

California Emergency Medical Services Information System (CEMSIS): The California prehospital information that stores and aggregates prehospital data statewide. CEMSIS operates on the NEMSIS standard and defines additional requirements that enables study of variations in local data quality and local capacity for health information exchange. CEMSIS is operated by the California Emergency Medical Services Authority (EMSA) to help develop and coordinate high quality emergency medical care throughout California.

Orange County Medical Emergency Data System (OC-MEDS): The Orange County prehospital information system that collects, stores, aggregates and shares prehospital data countywide. OC-MEDS is a multi-modal system that allows EMS providers including designated receiving centers to document, transmit, and view patient care data in real time. OC-MEDS also links prehospital care data with Specialty Care Patient Registries such as Stroke, STEMI, and Trauma. OC-MEDS operates on the NEMSIS and CEMSIS data standards and defines additional county requirements that enable improved continuity of patient care, public health monitoring, and EMS quality improvement. OC-MEDS is a collaborative product managed by Orange County EMS (OCEMS).

Prehospital Care Reporting System (PCRS): An electronic health information system configured to meet the needs of the prehospital care environment. Per current NEMSIS, CEMSIS, and OCEMS standards a PCRS must enable real-time field documentation and sharing of patient care information.

Prehospital Care Report (PCR): The electronic record of a prehospital response including information on EMS operations (i.e. response time, unit number, and agency name) and patient care (i.e. vital signs, interventions, and treatment response).

IV. GENERAL GUIDELINES:

A. Prehospital Care Reports (PCR) shall be completed and submitted electronically to OCEMS in compliance with standards outlined here and in OCEMS Policies 300.30 and 300.31.

1. In adherence to NEMSIS and CEMSIS standards a data connection must be maintained with OC-MEDS. OCEMS Policy 300.30 provides further specifications.

2. In cases of system downtime, notification must be provided to OCEMS and patient care records should be promptly completed and made available for receiving center physicians and staff per OCEMS Policy 300.20.

B. For continuity of care and for patient safety, the PCR shall be made available to the receiving center before leaving the facility (or, in the case of field death, provided to the coroner before leaving the scene).

C. It shall be the responsibility of the EMS provider and their personnel to document completely and accurately in their PCRS.

1. EMS personnel are encouraged to review each PCR for accuracy *prior* to posting as complete, although OC-MEDS will allow for multiple submissions/updates of the same record.

2. EMS providers must perform quality assurance and quality improvement (QA/QI) reviews of their PCRs and submit any pertinent revisions to OC-MEDS in a timely manner.

3. Documentation practices and quality shall satisfy data submission requirements set forth by CEMSIS and NEMSIS.

4. PCRs shall provide complete and accurate documention of patient care per guidelines set forth below in OCEMS Policies 300.30 & 300.31.

D. Provider agencies may set additional documentation standards on emergency care rendered and patient responses to treatment which are more specific than required by regulation. Examples may include:

1. Requirement of narrative assessment documentation in specific cases, such as trauma: May include description of the scene.

2. Narrative documentation to convey an accurate description of the patient's condition as well as response to interventions.

3. Narrative documentation of unusual situations not covered in required electronic data element fields.

4. Use of a checklist in cases of patients signing Against Medical Advice.

E. OCEMS may request additional documentation of elements related to specific protocols, CQI, field studies, syndromic surveillance or emergency management data collection.

V. DOCUMENTATION STANDARDS:

A. EMS Personnel (EMTs & paramedics) are responsible for accurately completing a PCR for every patient response in a manner compliant with NEMSIS, CEMSIS and OCEMS standards. The PCR shall contain, **but not be limited to**, the following information:

1. Date and time of each incident
2. Time of receipt of the call
3. Time of dispatch to the scene
4. Time of arrival at the scene
5. Location of the incident
6. The patient's:
    a. Name
    b. Age or date of birth
    c. Gender
    d. Weight, if necessary for treatment
    e. Address
    f. Chief complaint
    g. Vital signs
7. Appropriate physical assessment
8. Primary provider impression
9. Care rendered and patient response to such treatments
    a. Documentation of care rendered should use required electronic data element fields (Example: documenting a 12-lead EKG as a procedure).
    b. In addition to required electronic data element fields, narrative documentation of patient assessment, treatment and patient response to treatment may be added.
    c. Narrative documentation may be used to explain deviation from protocols (Example: holding aspirin because it was taken just prior to the 911 call).
10. Patient disposition, including hand-off information if care transferred to another unit
11. Time of departure from scene
12. Time of arrival at receiving facility, if transported
13. Time patient care was transferred to receiving facility
14. Name of receiving facility, if transported
15. Name(s) and license, certification, or accreditation number(s) of the EMTs or paramedics

16. Signature(s) of the EMTs or paramedics

B. Other elements must be documented as required by NEMSIS, CEMSIS, and OCEMS. These are detailed in OCEMS Policy 300.31. Examples include:

1. Name of agency assuming care if care is released to another ALS unit, BLS care, law enforcement or coroner
2. Time of transfer of care to another agency/unit
3. Patient's past medical history including medications and allergies
4. Time contact was made with the patient
5. Time crew/unit completed call and went back in service and any reason for delay
6. Documentation related to specific assessments and interventions as outlined by Medical Director in Standing Orders and other patient care policies

C. California Emergency Medical Services Authority has developed outcome-based Core Measures. Data elements utilized for these core measures shall be included in agency documentation standards. (Reference: EMSA Document 166):

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