



**SAN MATEO COUNTY HEALTH
EMERGENCY
MEDICAL SERVICES**

EMS POLICY	701
Effective:	January 2022
Approval: EMS Director Travis Kusman, MPH	Signed:
Approval: EMS Medical Director Greg Gilbert, MD	Signed:

DOCUMENTATION REQUIREMENTS

I. PURPOSE

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

II. AUTHORITY

California Health and Safety Code Division 2.5, §1797-1797.207 and 1797.227; California Code of Regulations, Title 22, Division 9, §100170

III. DEFINITIONS

Decision-Making Capacity: The ability of a patient who is fully oriented to use and understand information to make a decision, and communicate any decision made.

Electronic Health Record (“EHR”): The official and legal patient care record completed by EMS personnel. Formerly referred to as ePCR.

Emergency Medical Services Agency (“LEMSA”) [or “Agency”]: The San Mateo County EMS Agency is designated as the Local Emergency Medical Services Agency (LEMSA) and is statutorily charged with primary responsibility for administration and medical control of emergency medical services in San Mateo County.

EMS Personnel: San Mateo County EMS system prehospital providers including EMTs and paramedics.



EMS Response: Any 9-1-1 or non-emergency medical response originating in or serviced by San Mateo County EMS Personnel.

Patient: Any person for whom 9-1-1 services have been activated and that EMS personnel encounter (see Patient Contact) and who meets any of the following criteria:

1. Has a chief complaint or demonstrates illness or injury;
2. Is not oriented to person, place, time or event;
3. Requires or requests an assessment, field treatment, or transport; or
4. Is a minor who is not accompanied by a parent or legal guardian and appears to be ill or injured.



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Patient Contact: Any time when EMS personnel encounter a patient and perform any of the following:

1. Offer medical assistance when medically indicated;
2. Perform a visual assessment of clinical acuity;
3. Perform a hands-on physical assessment, including vital signs;
4. Determine the mechanism of injury;
5. Obtain a history of present illness; or
6. Witness any medical care rendered by other parties.

IV. POLICY

- A. EMS Personnel shall complete an EHR for each EMS response when a unit arrives at scene, regardless of outcome. This includes responses where there was no Patient Contact.
- B. All available and relevant information shall be accurately documented in the EHR.

V. EHR AVAILABILITY

The timely delivery of a completed EHR to the receiving facility is a high priority. Every effort shall be made to complete and transmit an EHR at the earliest opportunity.



- A. Transporting agencies shall leave a Field Care Worksheet with receiving facility staff if an EHR cannot be completed prior to clearing the receiving facility (e.g., low system levels).
- B. Non-transporting agencies that have turned over Patient care to transporting personnel should send a Field Care Worksheet with the Patient. Non-transporting agencies are not required to transmit EHRs to receiving facilities.
- C. All EHRs shall be completed and transmitted to the receiving facility, as applicable, and/ or posted to the EHR server as soon as possible, but not more than twenty-four (24) hours after Patient Contact, or end of shift, whichever is shorter.

VI. EHR PROCEDURES

- A. It is the responsibility of all EMS Personnel to properly and thoroughly complete documentation as required by EMS policy.
- B. When a first response apparatus and/ or emergency ambulance arrive at scene and are either cancelled or determine that the person for whom they are called does not meet the



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definition of a Patient or Patient Contact, an EHR shall be completed. This requirement includes documentation of arrival at scene, reason for cancellation, and why a person did not meet the definition of a Patient and/ or Patient Contact.

- C. For multi-apparatus responses (e.g., vehicle accidents, structure fires, hazmat responses), only first response apparatus and ambulances involved in Patient assessment/ care or medical standby are required to complete an EHR. If no apparatus arrived on scene, the first due apparatus is required to complete the EHR.
- D. It is the responsibility of EMS Personnel to assess and render the indicated emergency treatment and transportation for a Patient and create an EHR.
- E. EMS Personnel performing an assessment and/ or providing care to a Patient are responsible for accurately documenting all available and relevant EHR information. This requirement includes transport and first responder personnel.
- F. EMS Personnel shall only document their assessment findings and treatment rendered in the data fields of the EHR. Assessment findings and treatment delivered by other agencies at scene shall be documented in the narrative section of the EHR, not within the data fields.
- G. Use of approved abbreviations is permitted in the narrative section of the record, or as defined in automated EHR pre-designated pick lists (see RF03 – Approved Abbreviations).
- H. Unless cancelled, EMS Personnel should include, at a minimum, the following information in the EHR:
 - 1. Complete demographic information.
 - 2. A clear history of the present illness with chief complaint, the 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.
 - 3. An appropriate, thorough physical assessment that includes all relevant portions of a head-to-toe physical exam. The findings shall be documented in the applicable data sets. 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, at a minimum: Pulse, respirations, blood pressure, pulse oximetry, and estimated patient weight.





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- a. At least one complete set of vital signs should be completed prior to transfer of Patient from first responders to ambulance personnel;
 - b. Vital signs should be repeated and documented after medication administration, prior to patient transfer, and as needed during transport.
 - c. For children \leq three (3) years of age, blood pressure measurement is not required 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 each Patient.
 6. 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 edited for accuracy.
 7. Cardiac monitor data shall be transferred from the device and uploaded into the EHR. 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.
 8. For medication administration, the drug dosage, route, administration time and patient response shall be documented.
 9. A complete list of treatments in chronological order. Response to treatments should also be listed.
 10. For Patients with extremity injury, neurovascular status must be noted before and after immobilization.
 11. For Patients with spinal motion restriction, document motor function before and after motion restriction.
 12. For IV administration or saline lock placement, document the catheter size, site, number of attempts, type of fluid, and flow rate.
 13. A cardiac monitor strip shall be electronically attached for all patients placed on the cardiac monitor. All 12-Lead ECGs shall also be included. Any significant rhythm changes should be documented. Initial, ending as well as pre and post procedural strips should be attached for each therapeutic electrical intervention performed including defibrillation, cardioversion and / or pacing.



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- 14. Any requested Base Hospital orders, whether approved or denied, shall be documented clearly along with the name of the Base Hospital physician.
- 15. All EMS Personnel information, including signatures.
- 16. Completing the record includes marking the record “complete” in the EHR system and uploading the record to the EHR server.
 - I. The EHR shall be completed and distributed in accordance with this policy.
 - J. 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.
 - K. If there is an EHR system failure a paper health record shall be used. If a paper health record 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 correcting EMS Personnel’s initials beside it.
 - L. Any changes made to an electronic EHR shall have documentation of those changes retained in the EHR record database.

VII. ELECTRONIC SYSTEM FAILURE

- A. Electronic documentation system failure is NOT an exemption for completing and providing the required EHR documentation.
- B. LEMSA shall be notified of EHR downtime or transmission difficulties lasting more than twenty-four (24) hours.

VIII. MULTI-CASUALTY (“MCI”) INCIDENTS

- A. EHRs shall be completed for each Patient in a 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.