Documentation

(The reason we went into the medical field)

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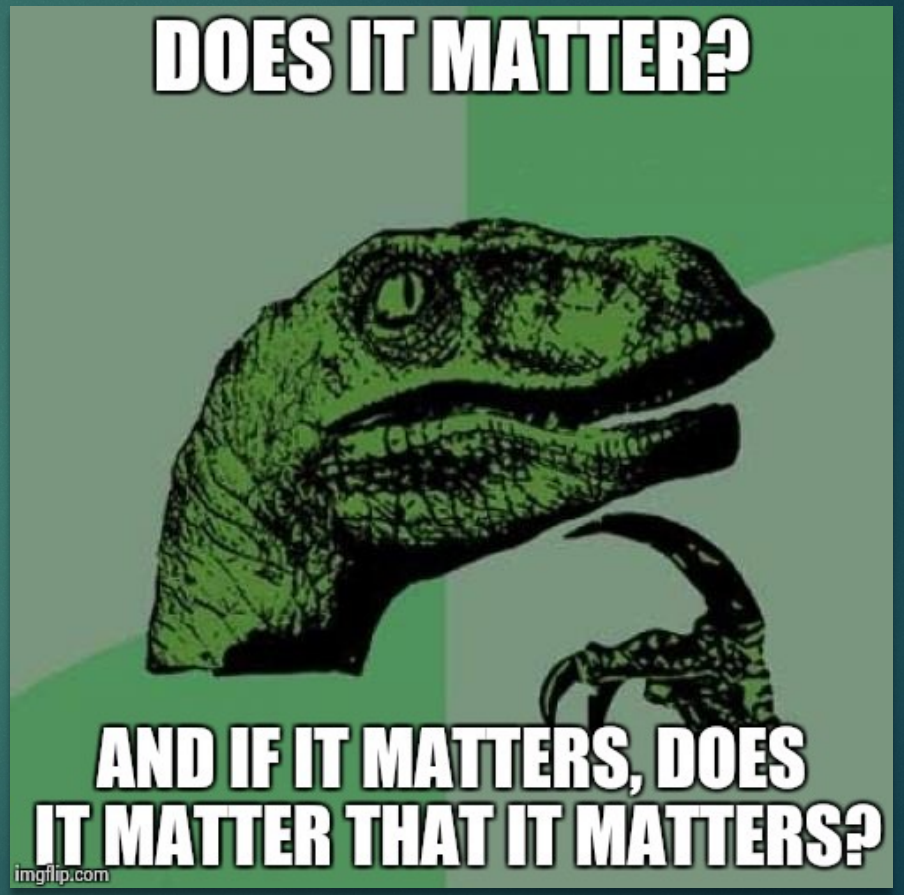
What I think of when someone says documentation

- Torture
- Punishment
- Questioning my life choices
- And why despite all this we all should do better

Objectives

- Why does this matter
- Formats
- How do we get better?



Why does documentation matter?

- Improve patient care
  - What we all care about
- Liability coverage
  - What I care about
- Billing
  - What my boss cares about

Improving patient care

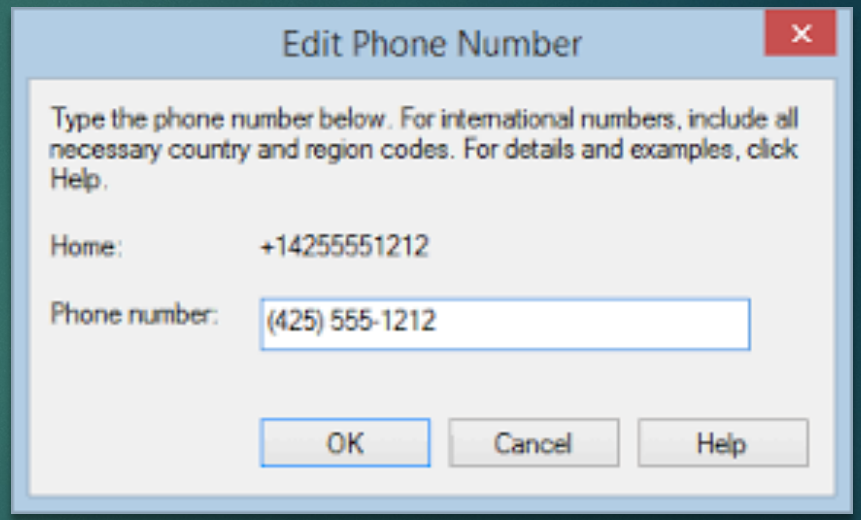
- What happened?
  - Example: Last seen normal?
- How did patient appear on arrival
- Family/friends present
  - Contact information
- Providing copies of advanced directives
  - Goals of care changes the hospital course several times a day in the ED

Interventions in route

- Physical exam findings
  - O2 sats
  - Extremity pulses
- Medication administration
  - ASA, steroids
  - Avoid duplication
- Other interventions
  - Tourniquet

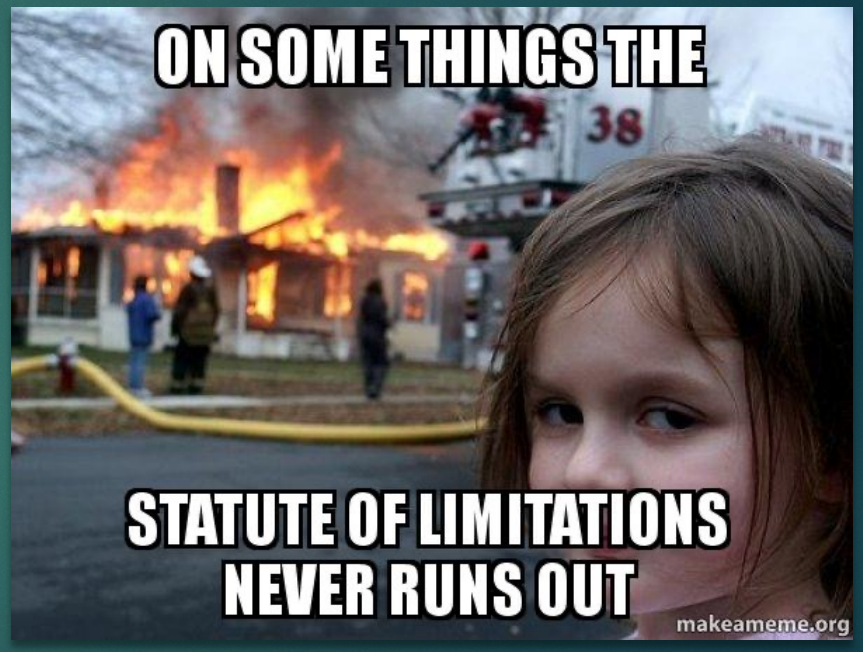
Patient Handoff

- Description of what was accomplished
- Documentation for medical personnel that see the patient later
  - Often times physicians and other providers can't be there for handoff
- Contact information for patients family/friends
  - Stroke team activations
  - WV study – families on scene often report wrong LSN. But having contact information can provide clarification



Liability

- If you didn't write it down it didn't happen
- Statue of limitations
  - Often only clue to remind yourself what happened
- Opportunity to explain why you did what you did
- Not always the cases you think they will be



Liability

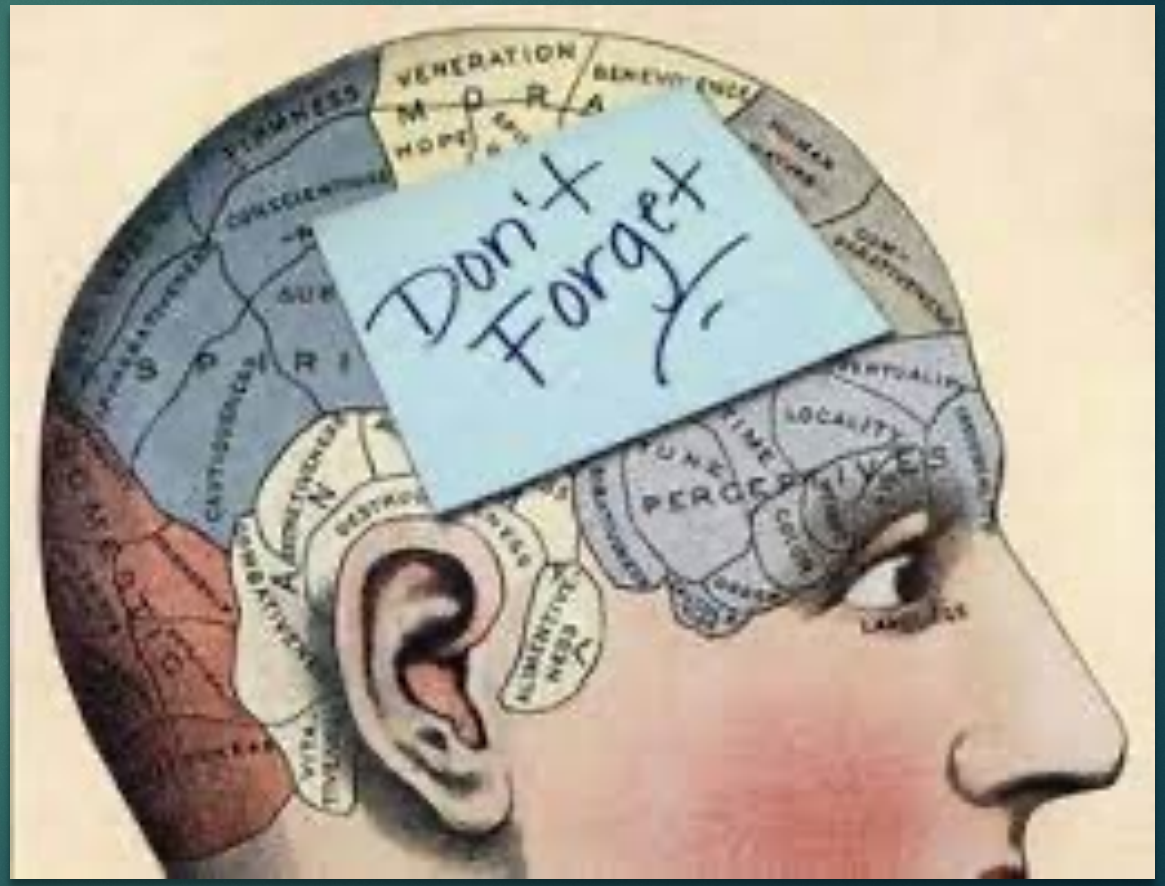
- Know the law
- NM law on forced transport:

24-10B-9.1. Emergency transportation.

Any person may be transported to an appropriate health care facility by an emergency medical technician, under medical direction, when the emergency medical technician makes a good faith judgment that the person is incapable of making an informed decision about his own safety or need for medical attention and is reasonably likely to suffer disability or death without the medical intervention available at such a facility.

Liability

- Remember if its not written down it didn't happen
- If you were to read the chart 6 years from now, would you remember the call?



Liability - Refusals

- Arguably one of the highest risk things we do
- Often we blow off these encounters
- Need to take extra time in documentation
- Or risk having a simple patient with back pain… or a fall
- To be discussed more later this month…

Billing

- No money, no mission
- Tight budget margins for most EMS agencies
- Ongoing changes in reimbursement

Billing

- Know what is billable
- Know what changes may be happening
- New pushes in billing for rural communities and community paramedicine
- Hospital billing just went under a massive overhaul, could speculate this will lead to EMS changes

Different types of Formatting

- DCHART
- SOAP
- RESCUE
  - Not as common
  - Won’t cover today

DCHARTE

- D – Dispatch Information
- C – Chief Complaint
- H – History
- A – Assessment
- R – Rx (Treatment)
- T – Transport
- E - Exceptions

DCHARTE Advantages

- "I think, therefore I am"
- More in depth format
- Favored by many agencies
- Integrates well into many ePCRs

SOAP

- Subjective
- Objective
- Assessment
- Plan

SOAP

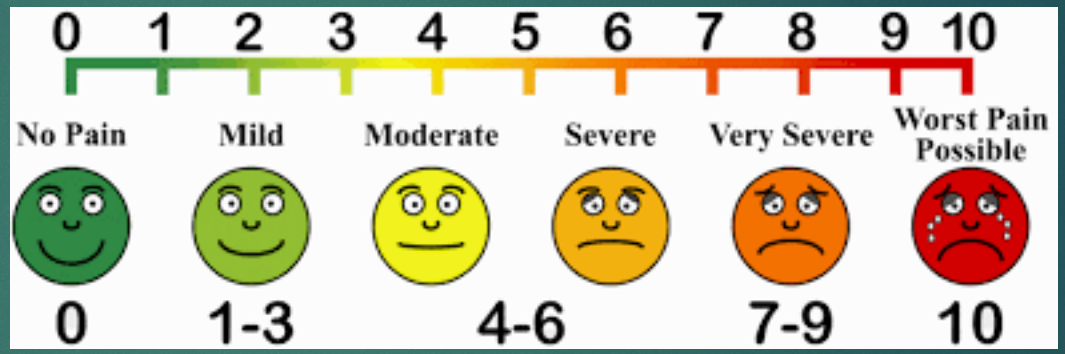
- Simple format
- Easy to remember
- But easy to leave gaps in documentation

Within HPI SAMPLE

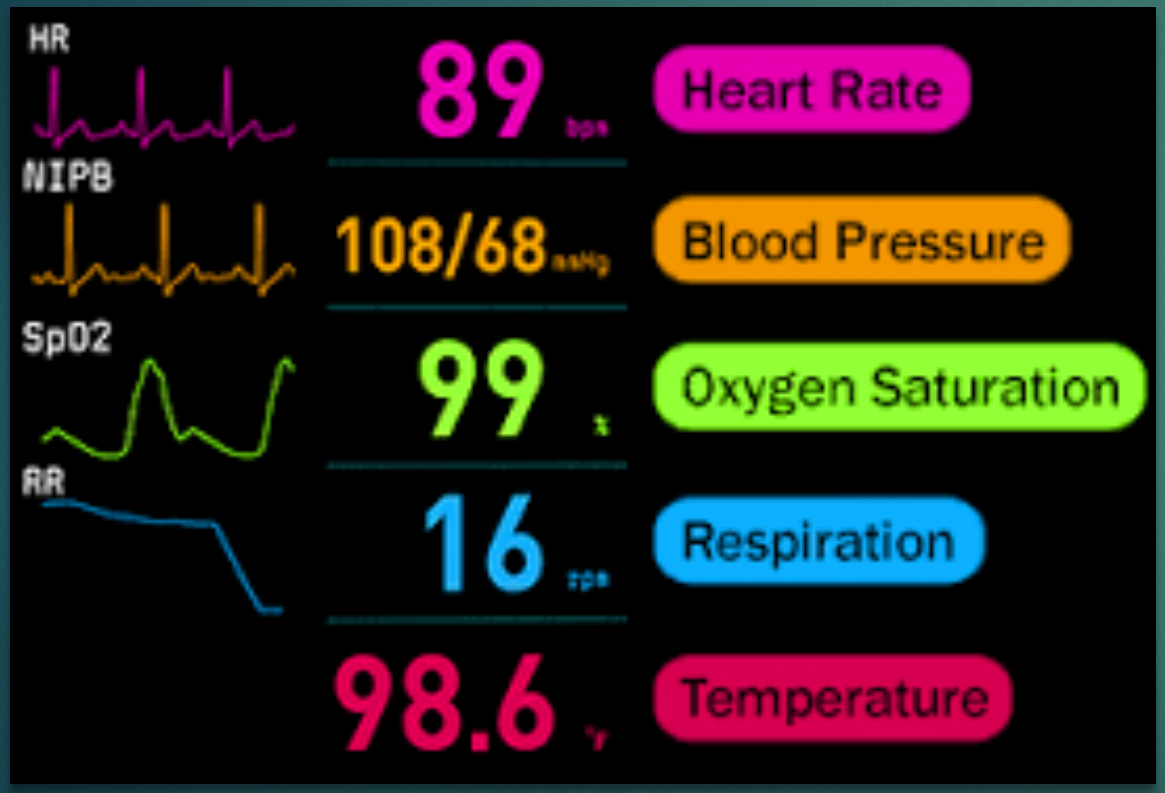
- S – Signs and symptoms
- A - Allergies
- M - Medications
- P - Past Medical History
- L - Last oral intake
- E - Events leading up to injury

Pain

- O - Onset
- P - Provocation
- Q – Quality
- R – Radiation
- S – Severity
- T - Time



What we often forget to document



- Repeat vitals… or even a full set of vitals
- Repeat assessment after an intervention
  - CSM after splinting
  - Pain score after medication

Forgotten forms of documentation

- Body Cam
- Audio recordings
- Photographs

Body Cameras

- You never know who is watching
  - There could also be security footage, or bystander cell phone
- Can be very effective in documenting an encounter
- Remember to always be professional

Audio Recordings

- Radio transmissions
- MCEP calls
- Always good to think before transmitting and speaking clearly

Photographs

- Some ePCRs allow for photos directly into a chart
- This can include documenting injuries, appearance of scene or recording another crews 12 lead
  - Can provide context for say an MVC
  - Or pre extremity reduction
- If photographing a patient ask for permission is possible and do not leave photos on phone

How do we get better? Patient Care

- Note presentation
- When were they last normal
- Any interventions?
- How do we reach family/friends

QA

- Review of charting allows for targeted education
- Direct feedback on how we can be better

QI

- Able to analyze gaps in the care we provide
- Allows for practice changing interventions
  - Reduce Toradol use when contraindicated
- See if interventions are improving overall care

Population data

- Able to track community well-being
  - Increasing overdoses
  - Flag violent residents
  - Bariatric patients

Planning for the Future

- Plan for future community needs
  - Obtaining medical equipment or training
  - Where to build a new fire station
- Funding for department expansion and training
  - USFS

Summary

- Our documentation can have a huge impact on patient care
- It can protect us from litigation
- We can generate revenue to pay for our services
- Data is collected that can make us better clinicians but also anticipate future needs for our community and departments

Questions?