September 1st, 2022

EL DORADO COUNTY EMERGENCY MEDICAL SERVICES AGENCY

DOCUMENTATION POLICY

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A. DEFINITIONS

ALS Support - All assistive actions performed by an ALS provider, regardless of complexity, when Primary Medical Responsibility is vested in another ALS provider.

EDCEMSA – El Dorado County Emergency Medical Services Agency.

EMS Response - Mobilization of emergency medical resources to an incident, subsequent to the determination by dispatch, of the potential need for medical services on scene.

Incident - Some untoward occurrence prompting a response from any combination of emergency services within a jurisdiction. Such services include, but are not limited to, fire suppression, technical rescue, emergency medical services and law enforcement.

Patient – An individual requesting, or perceived to require, assistance proximate to a medical condition, or for whom an EMS response has been initiated. Any person meeting this definition at any point is a patient until otherwise documented by a provider.

Patient Care - Any manner of interaction, intervention or assistance, regardless of complexity, rendered to a patient wherein the need for assistance derives from an acute or chronic medical condition.

Patient Care Report/Prehospital Care Report (PCR) - A complete record of an EMS response, inclusive of electronic health records when applicable, as captured on a LEMSA approved PCR platform, whether electronic (ePCR) or paper.

Primary Medical Responsibility (PMR) - Central clinical authority for patient care during an EMS Response, as well as the duty to compose a complete clinical record of care for the duration of responsibility.

Protected Health Information (PHI) - All individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or healthcare coverage.

Provider - Any individual legally credentialed under CCR Title 22, Div.9 as an Emergency Medical Technician or Paramedic, having also been accredited by EDCEMSA to operate within El Dorado County in compliance with county protocols, field policies and legal scope.

Provider Agency – An organizational entity/department, employing individual providers to affect ALS response within the County of El Dorado; whether under contract or other instrument of agreement.

Unified Report (Unified PCR) – A single record of EMS activity constituted of two (or more) ePCRs, which when combined, compose a complete clinical and operational account of a given response.

B. AUTHORITY:

The overall responsibility for administration of emergency medical services in the County of El Dorado and the specific responsibility for establishing and operationalizing the EMS documentation system lies with EDCEMSA pursuant to:

A. California Health and Safety Code, Div. 2.5, Ch. 4, Art 1, Sec. 1797.200
B. California Health and Safety Code, Div. 2.5, Ch. 4, Art 1, Sec. 1797.227
C. California Code of Regulations, Title 22, Div. 9, Ch. 4, Art 8, Sec.100171 (ANNEX 1)
D. California Code of Regulations, Title 13, Div. 9, Ch. 5, Art 1, Sec.1100.7

C. GENERAL PROVISIONS:

For any **EMS Response** in El Dorado County:

1) At least one (1) ePCR shall be generated, so as to ensure that every incident categorized as medical at the time of dispatch, has at least one (1) corresponding record in an EDCEMSA approved ePCR system.

    a. Incidents later determined to be non-medical in nature by responding providers shall be documented accordingly on an EDCEMSA approved ePCR system, per the Authoring Responsibility Guidelines attached (ANNEX 2).

2) All providers making contact with a patient shall ensure that any actions they perform in service of that patient, regardless of complexity, are accurately captured on an ePCR, to which the provider's signature shall be affixed.

    a. A provider's signature on an ePCR shall convey to the signatory, proportional authorship of that record, and shall likewise convey accountability for the actions of the signatory as captured on the ePCR.

    b. In cases where multiple providers perform patient care, more than one PCR may be required to compose a complete chronological record of care.

    c. Responsibility for timely authoring and collation of multiple ePCRs into a unified report prior to submission to EDCEMSA is outlined in ANNEX 2, with specific instructions on transferring ePCRs between crews outlined in ANNEX 3.

3) To ensure timely inclusion of ePCR data into the patient's interoperable medical record and to ensure compliance with ANNEX 1, part (h), ePCRs shall be finished and submitted to EDCEMSA and the receiving facility via the ePCR platform within 24 hours of the time of call or before the end of the provider's working shift, whichever is less.

4) Departure from any provision of this policy is permissible only when/if said provision objectively differs from specific, precedent contractual terms.

D. MANDATORY DOCUMENTATION ELEMENTS:

1) Pursuant to 22 CCR § 100171. "Record Keeping" (ANNEX 1), the paramedic is responsible for accurately completing a NEMSIS/CEMSIS compliant record for every interaction with a patient, which shall contain, but not be limited to, the following information when such information is available to the paramedic:

Dispatch Elements

a. The date and estimated time of incident.
b. The time of receipt of the call (available through dispatch records).
c. The time of dispatch to the scene.
d. The time of arrival at the scene.
e. The location of the incident.
f. Confirmation of positive or negative patient contact
g. In cases where a patient is later deemed a *non-patient*, the paramedic will document a clear rationale for his/her determination in an ePCR; explicitly confirming the absence of:
    i. An acute complaint, or,
    ii. A present need, deriving in any measure from a chronic medical condition.

Demographic Elements *(when patient contact is made)*

h. Surname, given name and any additional names in the correct ePCR fields
i. Age, expressed as date of birth
j. Sex *(as well as identified gender when specified by the patient)*
k. Weight, if necessary for treatment
l. Patient address *(not to be confused with item (e) above when the two are not the same)*

Clinical Elements

m. Chief complaint (to include cause of injury code where applicable)
n. Subjective and objective assessments, expanded upon as necessary over the duration of care

o. Vital signs at intervals determined by applicable protocol
p. Information derived from diagnostic tools (cardiac rhythm, $EtCO_2$, etc.)
q. Chronological account of care rendered (procedures) and the patient's response(s) to that care
r. Provider's impression
    i. Primary Impression = *The differential diagnosis to be ruled out (i.e. most consequential/severe based on findings)*
    ii. Secondary Impression = *Most likely alternate differential diagnosis.*

<u>Concluding Elements</u>

s. Patient disposition
t. Time of departure from scene
u. Base contact details where applicable
v. Time of arrival at receiving facility (if transported) and facility name
w. Time of transfer of care at receiving facility
x. Patient signature (authorizations, permissions and HIPAA acknowledgement)
y. Name(s), unique identifier number(s) and signature(s) of the paramedic(s) in accordance with the General Provisions of this policy.
z. Time back in service

2) In cases where a patient is unable to sign (per part y. above) the authoring provider will document, in detail, the circumstance(s) making signature acquisition impossible (*i.e. 'unable to sign due to altered LOC'* or *'unable to sign due to bilateral hand amputation'*, etc.*).* In such cases, the signature of a responsible party such as a family member, or the receiving RN, will suffice.

3) The authoring provider shall document any diagnostic scores, scales or screening results pertinent to the patient's clinical presentation, in the designated sections of the ePCR and in accordance with applicable protocols. These include, but are not limited to:
    i. Glasgow Coma Scale
    ii. Trauma Score
    iii. Pain Scale
    iv. Stroke Screen results
    v. APGAR Score

4) Where applicable, the authoring provider shall document their professionally informed interpretation of any device output, such as ECG strips, alongside the interpretation of the device, and shall likewise ensure that the attached outputs are sufficiently free of artifact to support their interpretation. Non-diagnostic strips, such as the monitor 'boot-up' sequence, lead faults and pseudo-ectopy from road vibration, may be omitted.

5) Mnemonic devices and acronyms such as SOAP or CHART (ANNEX 4) may be employed to help the authoring provider structure their narrative and capture the clinical elements of the record. Discretion in the use of such formats is reserved to the provider agencies, or to individual providers, insofar as 22 CCR § 100171 requirements are met.

6) While it is understood that the timeline of assessments, procedures and findings may derive from multiple unsynchronized clocks, the authoring provider shall document their timeline of care as accurately as possible, making fullest use of the chronological ePCR fields and ensuring that any approximated times are logical in light of other events on their documented timeline.

7) Any abbreviations used, either in the narrative or other sections, must be included in the EDCEMSA approved abbreviation list attached as ANNEX 5. Symbols or non-Latin characters may not be used.

8) The above elements shall be considered a minimum; expanded upon as necessary to create a medico-legally comprehensive and reimbursable record of the EMS response.

E. DOCUMENTATION PLATFORM

1) Under normal operating circumstances, the required documentation elements will be captured on an EDCEMSA approved Electronic Prehospital Care Report (ePCR) platform.

2) If, in the opinion of the EMS Administrator, some condition obviating the use of the ePCR platform should manifest (i.e. mass casualty incident, sustained network failure, etc.), hard copy documentation on EDCEMSA approved forms may be temporarily employed. In such cases, transcription of hard copy data into the electronic dataset may be required after the issue is resolved.

3) The hospital admissions information sheet (‘face sheet’), as well as any other paper documents in the clinical record, will be attached to the ePCR using the image capture capabilities of the provider agency hardware and the ePCR platform. The authoring provider shall ensure that all attachments captured by tablet are ‘posted’ to the central ePCR server and are fully viewable from a desktop workstation prior to submission.

4) Any ePCR field that cannot be accurately populated for inapplicability of the value to real world circumstances shall be marked “N/A” (not applicable), either by text entry or drop down menu where available. Values that cannot be accurately populated due to the information not being known at the time of authoring shall be marked “UNK” (unknown).

ePCR EDITORIAL ACCOUNTABILITY

5) The dynamic 'validity' calculated by the ePCR platform during authoring, tracks the author's input across the range of required data fields. A satisfactory validity score does not confirm the quality, completeness or relevance of the entered data, and should not be considered proof of a medico-legally comprehensive and reimbursable record of care.

6) As the use of dictation or 'talk-to-text' applications often result in typographical errors, authors using such applications are responsible for proofreading and manually correcting erroneous text.

ePCR CORRECTIONS

7) In cases where EDCEMSA identifies absent documentation or determines a need for revision of a specific ePCR, whether for billing or quality assurance purposes, it shall notify the respective provider agency of:

    a. The incident number (when known)

    b. The date of service, and

    c. The corrective action required.

8) Upon receipt of the correction request, provider agencies shall affect the necessary documentation revision according to applicable agreement or contract timelines, and in light of any relevant penalty schedules therein.

    a. Corrections to <u>non-clinical</u> aspects of the ePCR shall be affected directly in the unlocked document.

    b. Corrections to <u>clinical</u> aspects *other than the narrative* shall be affected directly in the unlocked document and described in an addendum.

    c. Corrections <u>to the narrative</u> will be affected by non-destructive addenda only (ANNEX 6)

    d. When edits are complete, the document shall be marked 'Finished'.

9) The patient care report in either electronic or hard format shall be accurately completed in accordance with these policies and procedures. Willful falsification of a patient care

record or failure to comply with these policies and procedures shall result in formal investigative action per 1798.200 of the California Health and Safety Code.

F. DATA USAGE, DISTRIBUTION AND MANAGEMENT

1) Hard copies of face sheets and other paper records shall be relayed to EDCEMSA office no later than Wednesday of the week following the date of service.

2) EDCEMSA collects ePCR data to align with the National Highway Traffic Safety Administration (NHTSA) Uniform Prehospital Emergency Medical Services Dataset, National Emergency Medical Services Information System (NEMSIS) and in accordance with the reimbursement procedures set forth by the Centers for Medicare and Medicaid Services (CMS). EDCEMSA may alter the terms of this policy to ensure continued alignment with those datasets and procedures as necessary.

3) As submitted documentation constitutes the focal substance of the Continuous Quality Improvement (CQI) process, and since EMS quality measures and analysis methods are subject to change, EDCEMSA may alter documentation processes at its discretion. In such cases, any change in guidance will be communicated to all provider agencies under contract or agreement with EDCEMSA, and will also be communicated to accredited ALS providers via the County approved ePCR platform and public website.

4) PCR data may be provided to:

   a. HIPAA covered entities in accordance with EDCEMSA policy,

   b. Patients or legal representatives thereof through written authorization,

   c. Law enforcement sources in accordance with applicable state and/or federal laws, or

   d. An attorney, notary public, justice of the peace or officer of the court pursuant to a valid subpoena.

5) EDCEMSA is the final authority for determination of aggregate data reports that are to be maintained confidential or distributed. Any EMS service agency may request in writing that EDCEMSA hold a specific aggregate report confidential. The written request must include the specific report topic or topics and detailed rationale for confidentiality. Data reports that may be deemed proprietary, at the EDCEMSA' discretion, will be referred to the potentially affected service agency(s) for feedback prior to public distribution.

G. TRANSPORTS ORIGINATING AT A MEDICAL FACILITY

INTERFACILITY TRANSFERS (IFT) AND RETURNS

1) Interfacility Transfers and post-discharge returns shall be subject to the same documentation standards as layperson-initiated EMS activity and will contain all documentation elements described in Section D, where ascertainable.

    a. In the case of post-discharge returns, the 'Chief Complaint' field shall reference the clinical circumstance prompting the patient's initial hospital visit.

    b. In the case of IFT for continuing care at a receiving facility, the 'Chief Complaint' field shall reference the working diagnosis or condition necessitating the transfer.

    c. Phrases such as *"None", "IFT", "BLS transfer"* or *"Return transfer"* without any supporting clinical context, are not sufficient.

2) A signed Physician's Certification Statement (PCS) shall be obtained from the referring facility. The PCS must clearly indicate why other means of transportation is **medically contraindicated**, and, in cases where a patient is transferred for more advanced care, must clearly indicate the services at the destination facility which are **unavailable at the originating facility**. If this information is not readily apparent on a filled PCS, *the transporting provider shall inquire and request that the detail be added to the form*.

3) In the event of a round-trip IFT, separate ePCRs shall be generated for each leg of the transport, with all fields populated in the same manner as a typical one-way transport. The hospital admissions information sheet and PCS shall be attached to each ePCR in the manner described in Section E (3).

CRITICAL CARE TRANSFERS (CCTs):

4) In the event of a CCT, the attending Registered Nurse (RN) will have Primary Medical Responsibility and will produce the clinical record for the duration of care according to the documentation policy(ies) of their employer (hospital, air-medical provider, etc).

5) The Paramedic(s) shall be responsible for documenting all other applicable dispatch, demographic and concluding elements as described in Section D, as well as clearly documenting the Chief Complaint per Section G.1 (b) and (c); expanded upon to capture:

    a. The services at the destination facility which are unavailable at the point of origin, and;

b. The specific non-paramedic scope intervention(s) or processes which necessitated an RN-staffed CCT.

6) In the event that patient care requires the use medical equipment or consumable supplies from the EMS unit stock, the paramedic will document the usage in the same manner as a typical EMS intervention, and shall communicate with the attending RN to confirm any details needed to properly document the intervention on the transport ePCR.

7) The RN notes described in G(4) above shall be attached to the transport ePCR in the manner described in E(3).

E. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILTY ACT (HIPAA) COMPLIANCE

1) The process of documenting patient care requires provider agencies and their staff to receive, process and compose Protected Health Information (PHI).

2) In accordance with the HIPAA *Standards for Privacy of Individually Identifiable Health Information* (“Privacy Rule”), PHI disclosure is permitted for the following purposes:

    a. **Treatment** in real time, provided the information sharing occurs between healthcare providers directly involved with patient care, with a contemporaneous ‘need to know’. This includes transfer of care.

    b. **Healthcare Operations** to include quality assessment and improvement activities, including case management and care coordination; as well as competency assurance activities, including provider performance evaluation, credentialing, and accreditation.

    c. **Payment** processes, specifically as they relate to reimbursement for services rendered during treatment and transport.

3) Beyond the purposes noted above, no disclosure of any PHI is permissible by any EMS provider in the County of El Dorado at any time.

4) Authoring providers will take all reasonable and proper measures to prevent accidental disclosure or misuse of PHI during the composition and transmission of their ePCR.

5) EDCEMSA and all provider agencies operating either under contract or agreement within the County of El Dorado, shall jointly observe the general provisions of the HIPAA *Security Standards for the Protection of Electronic Protected Health Information* ("Security Rule"), resolving to:

   a. Ensure the confidentiality, integrity, and availability of all PHI they create, receive, maintain or transmit;

   b. Identify and protect against reasonably anticipated threats to the security or integrity of the [protected] information;

   c. Protect against reasonably anticipated, impermissible uses or disclosures; and

   d. Ensure compliance by their workforce.

6) Upon conclusion of patient interaction, and in accordance with Part D of this policy, providers shall supply each patient with the EDCEMSA Notice of Privacy Practices and mark the "Receipt of Notice of Privacy Rights" box on the ePCR. This provision applies in the case of IFT as well as for patients released in the field against medical advice.

7) In the event of an accidental breach of PHI, the provider agency will immediately notify the EDCEMSA Privacy Officer, detailing:

   a. When the breach occurred,

   b. How the breach occurred,

   c. What PHI was breached, and if applicable

   d. How the breached information was recovered.

22 CCR § 100171. Record Keeping
Parts (e)-(h)

(e) The paramedic is responsible for accurately completing, in a timely manner, the electronic health record referenced in Section 100170(a)(6) compliant with the current versions of the National EMS Information System and the California EMS Information System, which shall contain, but not be limited to, the following information when such information is available to the paramedic:

(1) The date and estimated time of incident.
(2) The time of receipt of the call (available through dispatch records).
(3) The time of dispatch to the scene.
(4) The time of arrival at the scene.
(5) The 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; and
(G) Vital signs.

(7) Appropriate physical assessment.
(8) Primary Provider Impression.
(9) The emergency care rendered and the patient's response to such treatment.
(10) Patient disposition.
(11) The time of departure from scene.
(12) The time of arrival at receiving facility (if transported).
(13) Time patient care was transferred to receiving facility.
(14) The name of receiving facility (if transported).
(15) The name(s) and unique identifier number(s) of the paramedics.
(16) Signature(s) of the paramedic(s).

(f) A LEMSA shall establish policies for the collection, utilization, storage and secure transmission of interoperable electronic health records.

(g) The paramedic service provider shall submit electronic health records to the LEMSA according to the LEMSA's policies and procedures.

(h) The LEMSA shall submit the electronic health record data to the Authority within seventy-two (72) hours after completion of the patient encounter, or at longer intervals if established by written agreement between the LEMSA and the Authority.

ANNEX 2

Authoring Responsibility Guidelines

The iterations in this Annex are presented as templates based on standard incident timelines. Providers should implement variations as scene conditions require, whilst ensuring absolute adherence to the General Provisions of the Documentation Policy. *See Fig.1 "Do I have to write a PCR?" for additional.*

Upon Dispatch

1. **Primary Medical Responsibility (PMR)** is vested in the nearest transport-capable ALS unit.
2. All other ALS units en route are deemed **ALS Support**.
3. An EMS Response terminating prior to patient contact will be documented by the PMR unit, whose ePCR shall contain, at a minimum:
   i. All relevant Dispatch Elements (D.1 a-g)
   ii. A record of all other units dispatched
   iii. The basis for response termination (caller cancelled, cancelled by law enforcement, etc.)
   iv. Time back in service.

If the EMS Response is not cancelled, PMR remains with the nearest transport-capable unit up to the point of first patient contact by an ALS provider.

Upon Initial Patient Contact

1. PMR conveys to the ALS provider making initial patient contact, regardless of the type or configuration of the provider's vehicle (engine or medic unit).
2. All other dispatched units not yet on scene are deemed ALS Support.
3. Any unit having PMR at dispatch, which is cancelled prior to arrival, shall produce an ePCR capturing, at a minimum:
   i. All imported CAD data (EMD code, dispatch notes, times, etc.),
   ii. The basis for response termination (i.e. cancelled by unit on scene),
   iii. Time back in service.
4. No ePCR is required from a cancelled unit not previously having PMR.
5. With regard to subsequently arriving units, ALS Support designation will remain for the duration of scene operations; unless there is a mutually agreed transfer of PMR.
6. In instances of PMR transfer after initial patient contact, both crews shall be responsible for documenting the chronological record of care for their period of responsibility.
7. While the receiving provider may document referring crew's actions as Prior to Arrival (PTA), the referring crew will be responsible for documenting their own actions in accordance with Section D, paragraph 6 of the Documentation Policy, and whenever possible, will transfer their ePCR to the receiving crew in accordance with the procedure outlined in ANNEX 3.

ANNEX 2

<table>
<tr><th colspan="2">Upon Conclusion of Scene Operations</th></tr>
<tr><th>Patient Transport</th><th>Non-Transport (AMA)</th></tr>
<tr><td>
1. Provider with PMR shall produce an ePCR capturing, at a minimum:

i. All applicable elements noted Section D, paragraph 1) of the Documentation Policy,

ii. Any other information necessary to produce a coherent, accurate record of care, inclusive of any print-outs or attachable media that support the providers' field impression and/or clinical decisions, and,

iii. Documentation of any ALS Support units cancelled prior to arrival.

2. In instances where an engine-based provider retains PMR and transportation is furnished by a medic unit, the engine-based provider shall complete the described ePCR promptly, and avail it to the transporting crew for attachment/inclusion into the transport ePCR prior to shift's end.

3. Providers furnishing patient transportation in accordance with 2. above, shall produce an ePCR capturing:

i. All imported CAD data (EMD code, dispatch notes, times, etc.),

ii. Patient transport mileage,

iii. The attached ePCR of the PMR crew rendering patient care,

iv. Documentation of their own chronological record of care (when applicable), and,

v. Time back in service.
</td><td>
1. Provider with PMR shall produce an ePCR capturing, at a minimum:

i. All applicable elements noted Section D, paragraph 1) of the Documentation Policy,

ii. Any other information necessary to comply with EDCEMSA Field Policy "REFUSAL OF CARE AND/OR TRANSPORTATION", and

iii. Documentation of any ALS Support units cancelled prior to arrival.

2. In accordance with Section C, paragraph 2) of the Documentation Policy, any ALS Support providers having made patient contact shall either:

i. Validate and sign the ePCR of the provider with PMR, or

ii. Produce a separate ePCR, detailing the actions of all signatories.

Reminders

Per Section A – Definitions:

"Patient" = An individual requesting, or perceived to require, medical assistance proximate to a medical condition, or for whom an EMS response has been initiated. Any <u>person</u> meeting this definition at any point is a <u>patient</u> until otherwise documented by a provider.

Per Section D - Mandatory Documentation Elements, para 1, part g:

In cases where a patient is later deemed a non-patient, the paramedic will document a clear rationale for his/her determination in an ePCR; explicitly confirming the absence of:
a) An acute complaint, or,
b) A present need, deriving in <u>any measure</u> from a chronic medical condition.
</td></tr>
</table>

ANNEX 2

Out-of-County/Non-ImageTrend Providers
In instances of an El Dorado County crew furnishing transportation to a provider agency not using an EDCEMSA approved ePCR platform, the transporting crew shall produce an ePCR capturing: 1. All imported CAD data (EMD code, dispatch notes, times, etc.), 2. Patient transport mileage, 3. Patient name 4. Date of birth 5. Destination 6. Name, department and unit/vehicle ID of attending provider(s), 7. Chronological documentation of any care provided by the El Dorado County crew, and 8. Time back in service.

Fig. 1 *"Do I have to write a PCR?"*

Medical determination per CAD?

no → No **PCR** needed

yes → Made pt contact?

no → PMR at dispatch?

no → No **PCR** needed

yes → **PCR**
Dispatch elements (Section D.1, a-g) and time back in service, at minimum.

yes → ALS Support only / PMR at contact *(or after)*

ALS Support only → Provide transport?

yes → **PCR**
Dispatch, Demographic and Concluding elements, as well as your own patient care, if not verifiably documented elsewhere.
AND
Download the ePCR of the primary crew.

no → Either **A** or **B**

B → Ensure that your actions are properly captured on another PCR* ***and*** sign that PCR.**

PMR at contact *(or after)* / **A** → **PCR**
Capturing all mandatory elements noted in Section D.1 of the Documentation Policy, at minimum.

Primary Medical Responsibility (PMR) defaults to the closest transport unit at the time of dispatch and is assumed by whichever ALS unit makes first pt contact. *(Can be transferred on scene by attending crews)*

ALS Support describes all other ALS units on scene which were neither first to make pt contact, nor assumed PMR later.

* You are responsible for confirming proper documentation of your actions.

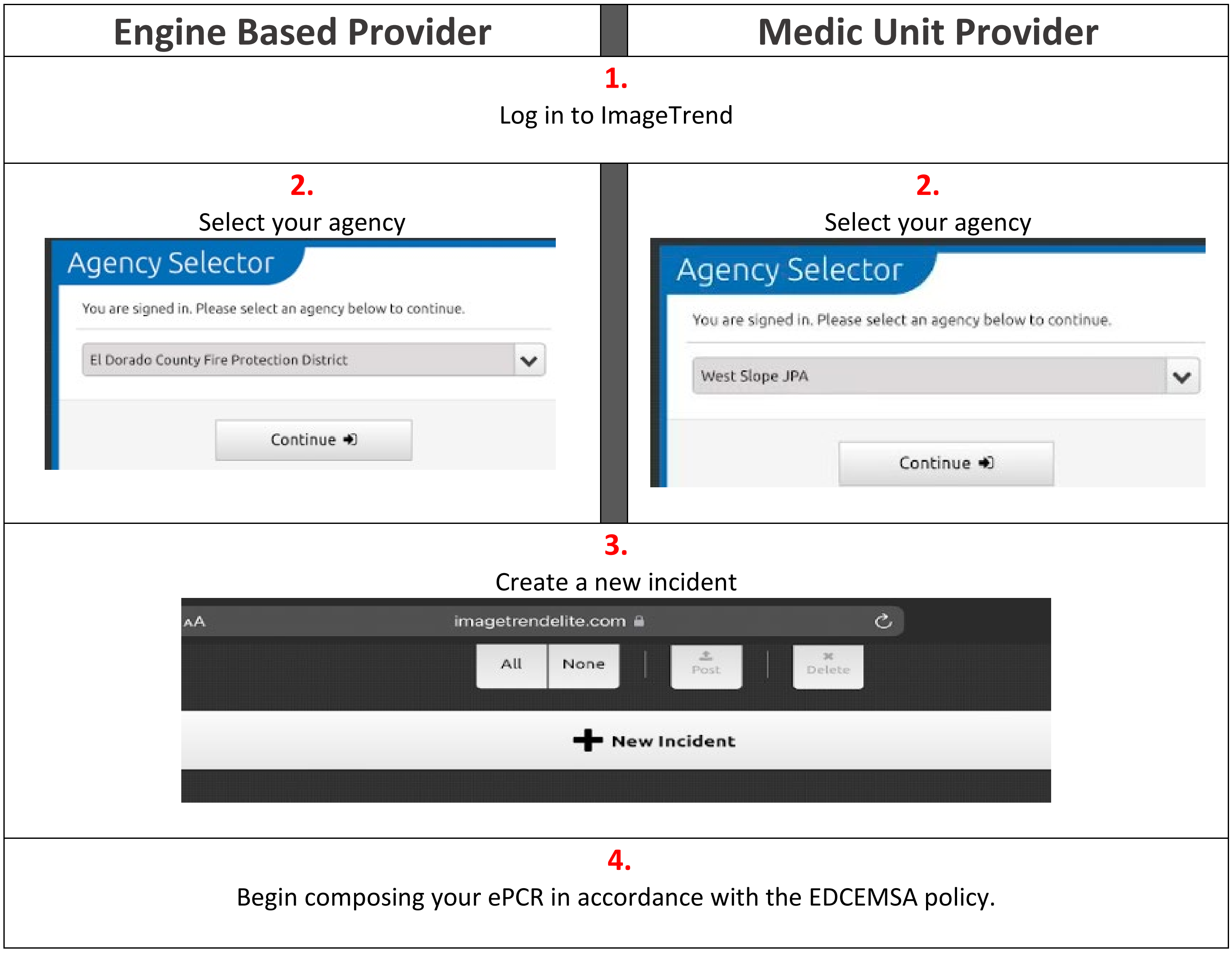
** Only if concludable before end of shift.

ANNEX 3

ePCR Transfer for Unified Reports

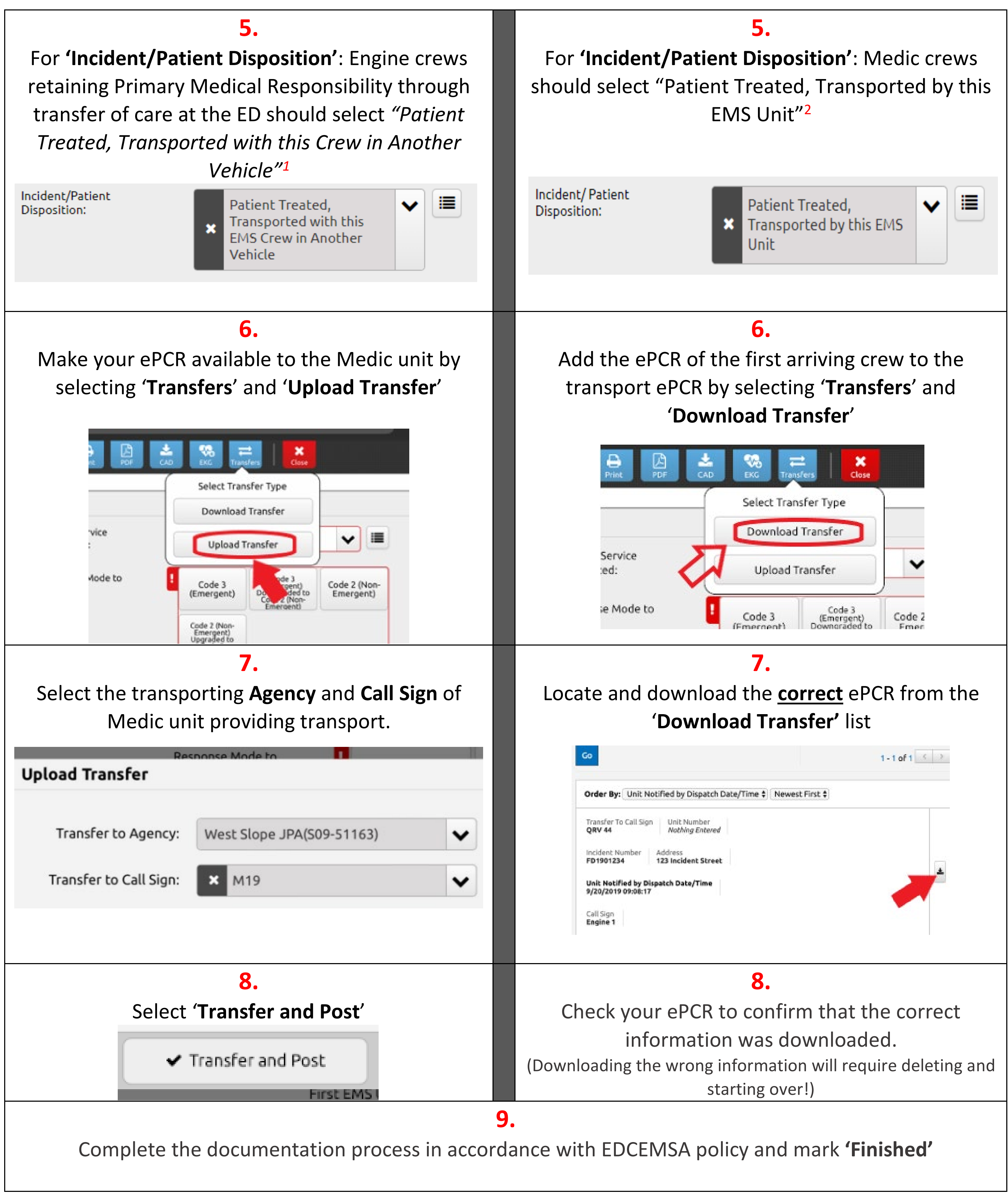
The Centers for Medicare and Medicaid Services (CMS) define the terms for reimbursement of EMS services nationwide. CMS has determined that 'transport' is *(in most cases)* the only billable service that EMS providers perform. The transport ePCR is therefore the central mechanism for recovering the costs of the EMS system overall.

The chart below is provided to outline a complimentary documentation process for both engine and medic based providers, with the aim of composing a unified ePCR from both sources. The processes are equally useful whether the first arriving unit transfers medical responsibility on scene, or retains responsibility through transport.



Engine Based Provider	Medic Unit Provider
1. Log in to ImageTrend	
2. Select your agency	**2.** Select your agency
3. Create a new incident	
4. Begin composing your ePCR in accordance with the EDCEMSA policy.	

ANNEX 3



5. For **'Incident/Patient Disposition'**: Engine crews retaining Primary Medical Responsibility through transfer of care at the ED should select *"Patient Treated, Transported with this Crew in Another Vehicle"*[1]	**5.** For **'Incident/Patient Disposition'**: Medic crews should select "Patient Treated, Transported by this EMS Unit"[2]
6. Make your ePCR available to the Medic unit by selecting '**Transfers**' and '**Upload Transfer**'	**6.** Add the ePCR of the first arriving crew to the transport ePCR by selecting '**Transfers**' and '**Download Transfer**'
7. Select the transporting **Agency** and **Call Sign** of Medic unit providing transport.	**7.** Locate and download the **correct** ePCR from the '**Download Transfer**' list
8. Select '**Transfer and Post**'	**8.** Check your ePCR to confirm that the correct information was downloaded. (Downloading the wrong information will require deleting and starting over!)

9. Complete the documentation process in accordance with EDCEMSA policy and mark **'Finished'**

1. This disposition should only be used if the engine crew retains patient care during transport. If care is transferred, use 'Patient treated, transferred Care to Another EMS Unit'

2. This is the appropriate disposition regardless of the agency affiliation of those providing care during transport.

ANNEX 4

Narrative Mnemonic Acronyms

SOAP (T)

S: SUBJECTIVE – The Patient's Story

a) Patient description.
b) Chief complaint.
c) History of the Present Event: What happened? When did it happen? Where did it happen? Who was involved? How did it happen? How long did it occur? What was done to improve or change things?
d) Allergies, current medications, past medical history (pertinent), and last oral intake.

O: OBJECTIVE INFORMATION – The EMS Provider's Story

a) The rescuer's initial impression: Description of the scene. What was your first impression of the scene and patient?
b) Vital signs.
c) Physical Exam findings.
d) General observations: Other noteworthy information such as environmental conditions, patient location upon arrival, patient behavior, etc.

A: ASSESSMENT – The EMS Provider's Impression

a) Conclusions made based on chief complaint and physical exam findings.
b) Often, this is the "narrowed-down" version of the differential diagnosis.

P: PLAN – The EMS Provider's Plan of Therapy (Treatment)

a) What was done for the patient. This should include treatment provided prior to your arrival as well as what you did for the patient.
b) Describe what you did with the patient – Disposition. This could be "patient loaded and prepared for transport", "patient handed off to flight crew", or
c) "patient signed refusal of transport and is left home with family."

T: TRANSPORT – Re-Assessment (Patient Trending)

a) Information regarding therapies provided during transport as well as changes in the patient's condition during transport.
b) It may also include pertinent events surrounding the transfer of the patient at the hospital.

CHART

C: Complaint –

Basic description of the problem the patient is reporting, or where a third party seeks EMS on behalf of a patient, the potential problem as perceived by that third party.

> *"The Pt is a 67 y/o male complaining of substernal chest pain and nausea. The pain is described as a heavy pressure mid-sternum with radiation to the left shoulder." Or…*
>
> *"Dispatched to the parking lot of Save Mart, 1270 Broadway, Placerville for an unconscious subject in a car"*

H: History –

The **SAMPLE** acronym may be helpful.

c) Current **S**ymptoms
d) **A**llergies
e) **M**edications
f) **P**ast Medical History
g) **L**ast oral Intake
h) **E**vents leading up to the illness or injury

A: Assessment –

A *superior* to *inferior* approach, followed by a summary of machine diagnostic findings and provider impression (*differential*) may be helpful.

a) **HEENT** (noting airway patency, pupil response, etc.)
b) **Chest** (noting breath sounds, heart tones, consistency with palpated pulse, etc.)
c) **Abdomen** (noting softness, tenderness, discoloration or pulsatile masses, etc.)
d) **Back** (noting pain or deformity, etc.)
e) **Pelvis** (noting stability, etc.)
f) **Extremities** (noting reflexes, pulse, motor and sensation, edema, deformity, etc.)
g) **Diagnostics:** (ECG interpretation, BGL, SpO2, ETCO2, etc.)
h) **Field Impression:** (Rule out CVA, STEMI, active labor, etc.)

Rx: (Treatment) –

Any therapies, medications or other interventions performed. In the case of non-transport due to AMA, the 'advice' given may be captured under this heading.

T: Transport –

Describes the outcome as it pertains to transportation, as well as an overview of any changes experienced en route and the conduct of patient handover at the receiving facility.

ANNEX 5

EDCEMSA Approved Abbreviation List

Abbreviation	Definition
A-fib	atrial fibrillation
AAA	abdominal aortic aneurysm
ACLS	advanced cardiac life support
Abd	abdomen, abdominal
AC	antecubital
ALS	advanced life support
a.m.	morning
AMA	against medical advice
A&O	alert and oriented
AOS	arrived on scene
ALOC	altered level of consciousness
BLS	basic life support
BP	blood pressure
BPM	beats per minute
BGL	blood glucose level
BSH	base station hospital
BVM	bag valve mask
C2	code 2
C3	code 3
CABG	coronary artery bypass graft
C/C	chief complaint
CHF	congestive heart failure

CHP	California Hwy Patrol
CNS	central nervous system
c/o	complains of
CO	carbon monoxide
CO2	carbon dioxide
COPD	chronic obstructive pulmonary disease
CPAP	continuous positive airway pressure
CPR	cardiopulmonary resuscitation
CPSS	Cincinnati prehospital stroke screen
CSM	circulation sensation movement
C-spine	cervical spine
DKA	diabetic ketoacidosis
DNR	do not resuscitate
DO	doctor of osteopathy (Physician)
DVT	deep vein thrombosis
D5W	5% dextrose in water
ECG	electrocardiogram
ENT	ear, nose, throat
EMT	emergency medical technician
Epi	epinephrine
ER	emergency room
ET	endotracheal
ETA	estimated time of arrival
$EtCO_2$	end tidal CO2
ETOH	alcohol/ethanol

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GCS	Glascow Coma Score
GI	gastrointestinal
gm	gram
HCTZ	hydroclorothiazide
HTN	hypertension
Hx	historical exam
ICU	intensive care unit
IM	intramuscular
IO	intraosseous
IV	intravenous
IVP	IV push
J	joule
JVD	jugular vein distention
kg	kilogram
TKO	to keep vein open
L	liter
LOC	loss of consciousness
LPM	liter per minute
LR	lactated ringers
L/S	lung sounds
LVAD	left ventricular assist device
LUQ	left upper quadrant
MAD	mucosal atomization device
MCI	mass casualty incident
MD	medical doctor (Physician)

mEq	milliequivalent
mg	milligram
MI	myocardial infarction
mL	milliliter
mm	millimeter
MOI	mechanism of injury
N/A	not applicable
NC	nasal cannula
NCD	needle chest decompression
NG	nasogastric
NKA/NKDA	no known allergies/ no known drug allergies
NPA	nasal pharyngeal airway
NS	normal saline
NSAID	nonsteroidal anti-inflammatory
NSR	normal sinus rhythm
N/V	nausea/vomiting
O2	oxygen
OB	obstetrics
OD	overdose
OPA	oropharyngeal airway
OR	operating room
OTC	over the counter
PAC	premature atrial contractions
PCN	penicillin
PD	police department

ANNEX 5

PEA	pulseless electrical activity
PERRL	pupils, equal, round, reactive to light
PJC	premature junctional contraction
PT	patient
PTA	prior to arrival
PVC	premature ventricular contractions
RLQ	right lower quadrant
RN	registered nurse
R/O	rule out
ROSC	return of spontaneous circulation
RR	respiratory rate
RPM	respirations per minute
RUQ	right upper quadrant
Rx	prescription
SIDS	sudden infant death syndrome
S.O.	sheriff’s office
SOB	shortness of breath
s/s	signs and symptoms
STID	sexually transmitted infectiondisease
STEMI	ST elevation myocardial infarction
SVT	supraventricular tachycardia
TB	tuberculosis
TIA	transient ischemic attack
Tib-fib	tibia/fibula
TKO	to keep vein open

Tx	treatment
TXA	tranexamic acid
UTI	urinary tract infection
UNK	unknown
V-fib/VF	ventricular fibrillation
Via	by the way of
VS	vital signs
w/	with
w/o	with out
Yrs	years
yo	years old

Facility Abbreviations

S.A.F.H. / A.F.E.R.	Auburn Faith Hospital / Emergency Room
B.M.H. / B.M.E.R.	Barton Memorial Hospital / Emergency Room
C.T.H. / C.T.H.E.R.	Carson Tahoe Hospital / Emergency Room
C.V.M.C. / C.V.M.C.E.R.	Carson Valley Medical Center / Emergency Room
El.C.H.	El Dorado Convalescent Hospital
G.C.C.H.	Gold Country Convalescent Hospital
M.F.H. / M.F.E.R.	Mercy Folsom Hospital / Emergency Room
M.G.H. / M.G.E.R.	Mercy General Hospital / Emergency Room

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M.M.H. / M.M.H.E.R.	Mercy Methodist Hospital / Emergency Room
M.M.C.	Marshall Medical Center
M.S.J / M.S.J.E.R.	Mercy San Juan Hospital / Emergency Room
K.N.H. / K.N.E.R.	Kaiser North Hospital / Emergency Room
K.S.H. / K.S.E.R.	Kaiser South Hospital / Emergency Room
K.R.H. / K.R.E.R.	Kaiser Roseville Hospital / Emergency Room
N.N.R.	Northern Nevada Rehab
P.P.C.H.	Placerville Pines Convalescent Hospital
R.M.C. / R.M.C.E.R.	Renown Medical Center / Emergency Room
S.A.H. / S.A.E.R.	Sutter Amador Hospital / Emergency Room
S.T.M. / S.T.M.E.R.	Saint Mary's Hospital / Emergency Room
S.M.H. / S.M.E.R.	Sutter Memorial Hospital / Emergency Room
T.F.H. / T.F.H.E.R.	Tahoe Forest Hospital / Emergency Room
U.C.D.M.C / U.C.D.E.R.	UC Davis Medical Center / Emergency Room

ANNEX 6

ePCR Post-Submission Corrections

A. Editing non-narrative sections

When making changes to:

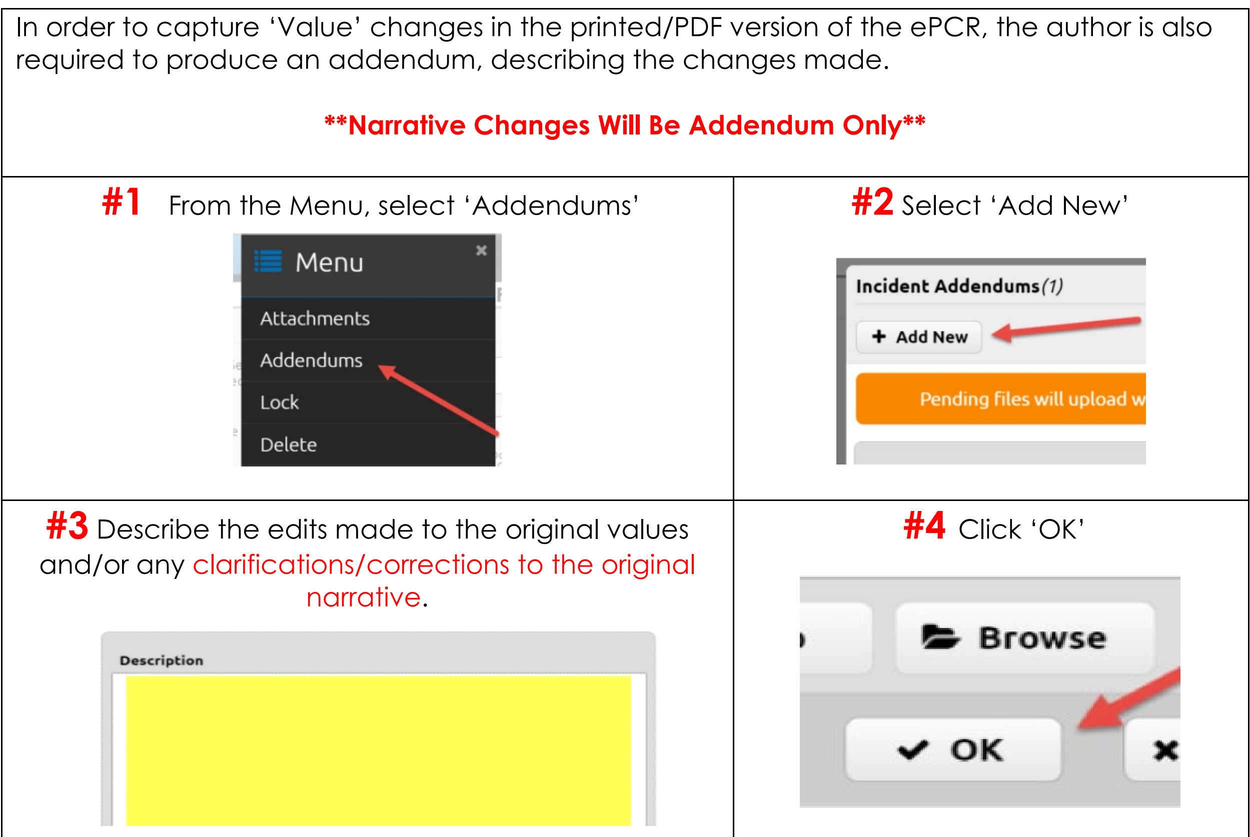
- Times,
- Demographics,
- Disposition, and
- Procedures/interventions,

…the author shall first edit the necessary fields.

Both the original value and new value will be captured in the incident history.

****Do Not Alter Narratives In This Manner****

B. Creating an addendum *(this step is not required for non-clinical edits)*



In order to capture 'Value' changes in the printed/PDF version of the ePCR, the author is also required to produce an addendum, describing the changes made.

****Narrative Changes Will Be Addendum Only****

#1 From the Menu, select 'Addendums'

#2 Select 'Add New'

#3 Describe the edits made to the original values and/or any clarifications/corrections to the original narrative.

#4 Click 'OK'