Title: Patient Care Reports
Policy: 406.00
Purpose: To maintain an accurate record of medical care given by OCEMS personnel in compliance with standard medical records practices and to ensure continuity of care between healthcare professionals.

Policy:
A Patient Care Report (PCR) must be generated for every patient contact and/or incident number issued by the Communications Center.

The PCR will be generated with the current Electronic Patient Care Reporting system.

The patient care record in all instances will accurately describe the services provided to the patient, any and all pertinent scene information, an accurate and complete patient assessment and accurate and complete treatments. All sections of the ambulance run report must be completed in as much detail as possible. Intentional falsification of patient care records is a serious violation of OCEMS policy and will result in disciplinary action up to, and including, termination.

A copy of the PCR form must be left at the receiving facility. If time does not permit completion of the entire report, at a minimum an abbreviated report must be left and the full report forwarded to the receiving facility as soon as practical.

A bar code with be attached to all face sheets, EKG’s, hospital transfer forms, and any other related patient information to be electronically attached to the PCR.

Mileage for PCR’s will be taken from the vehicles trip odometer and documented to the tenth of a mile.

Each patient contact shall document;

1. Incident location & location type
2. Response level to scene
3. Date
4. Call times
5. Patient name
6. Gender
7. DOB
8. Agency
9. Vehicle & crew identification
10. Assessment of patient
    o including vital signs
    o clinical impression
11. Treatment, and response to treatment
12. Disposition of patient, and the date and time the report was distributed* to receiving facility.
13. Barcodes linking forms for; billing, Physician Certification Statement (PCS), Advanced Beneficiary Notice (ABN), or other forms associated with call.
14. Signatures
   - Patients (or power of attorney, legal guardian)
     - If patient is unable to sign receiving facility or primary care provider
   - Receiving facility
     - Full name and credentials of signer
   - Legibility
     - If the patients, or receiving facilities, signature is not legible a witness signature is required (including patient initials).

Responses that result in the crew arriving on scene of a traumatic event and finding no injuries have been sustained by the individual or individuals involved will be handled as a cancellation. The run number will be accounted for with no requirement for patient demographics or PHI being made. The exception will be incidents involving school buses from any jurisdiction. A crew will respond to the scene when requested and complete one patient care report. This report will list the names of all students and the operator of the bus that are on board at the time of the incident. One run number will be issued for this event and a signature will be obtained from the responsible school board representative.

All PCR’s will be completed as soon as practical after the call and prior to the end of the shift. All reports must be completed prior to leaving unless specifically authorized by the Shift Commander or EMS Chief. Unless approved in writing by the Shift Commander or EMS Chief, no employee is authorized to leave the station for end of shift until all of their patient care records and reports have been submitted. If remaining at the station to complete the patient care records/ reports generates overtime, the on-duty Shift Commander must be notified via email justifying the reason. If a patient care record and/or report is returned to the provider for correction and/or clarification, the provider must do so within 72 hours from the date notified.

OCEMS will maintain a copy of the patient care record/report as defined in subsection 64J-1.001(18), F.A.C., for a period of at least 5 years. This copy is considered to be the copy of record, contains an original signature by the lead crew member and is certifiable as a true copy.

Accountability and Compliance:
1. Each day the on duty Shift Training Officer (STO) will research and investigate that all runs assigned to crews were written.
   - Any discrepancies will be sent out via email to the crew assigned to the run and the EMSSuper group email.

2. Each day the on duty Shift Training Officer (STO), Field Training Officer (FTO) or a Field Trainer (FT) will review 100% of all interfacility, designated alert calls (Stroke, Cardiac, Trauma), and cardiac arrest run reports for proper documentation.
   - Any errors found will be addressed, documented and returned to crew for amendments.
   - At the end of each month a review of all errors will be reviewed to look for any patterns and be reported at the monthly senior staff meeting.
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3. Each day the on duty Shift Training Officer (STO), Field Training Officer (FTO) or a Field Trainer (FT) will review 50% of all other run reports for proper documentation.
   o Any errors found will be addressed, documented and returned to crew for amendments.
   o At the end of each month a review of all errors will be reviewed to look for any patterns and be reported at the monthly senior staff meeting.

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