

McHenry Western Lake County EMS System
Continuing Education Quiz
Documentation and Release Forms
December 2018

This month we will be looking at the medical report that we generate as well as the release forms that we use when documenting a patient refusal of care. Documentation on a medical report serves many purposes. Some of the reasons for documentation include:

- Preserves basic patient information for your department
- Records any changes noted in the patient condition
- Supports the treatment that you provided
- Allows continuity of patient care
- Satisfies national regulatory requirements for creating medical records
- Provides data for Quality Improvement and Quality Assurance

Good documentation also helps to protect the EMS personnel when it comes to litigation. Having a solid medical report to review and refresh your memory in the event of you being deposed or even having to testify will make you look much more credible when all of your care has been documented. It reflects on the fact that you provided good patient care. An accurate, complete medical record implies organized assessment and management of your patient. Characteristics of a good medical record are:

- Accurate
- Complete
- Legible
- Free of extraneous information

Accurate means that we are only documenting the facts and noting all of our observations. Do not speculate about the patient or the incident itself in your reports. Make sure after you have information in your document that you are double checking items like numerical entries for accuracy and you have not documented a wrong total for something. Always recheck your spelling of the patient's name, the location of the incident and be very cautious with medical terminology and the spelling of those words.

Complete implies that all of the required and requested information has been placed in the document. If information that is requested is not applicable or does not apply, then make sure to note "not applicable" or "N/A". Include at least two sets of vital signs on every patient you encounter. Failure to document something implies to the person looking at your record that you failed to consider it. If you look for something and you note that it is not there, document it's absence in the record. An example would be "there is swelling and deformity at the L ankle, but no crepitation was noted while splinting" Remember that if it is not documented...it was not done!

Legible means that if you cannot make sense of your report, you also may be unable to determine what happened when you are asked to interpret it by someone else. Documents that are subpoenaed or brought into court usually speak for themselves. You will be much more credible on the stand or to attorneys if what you wrote makes sense. If your document does not make sense, a jury has the right to ignore it altogether.

Free of extraneous information implies that you will avoid using phrases that will label your patients as being “drunk” or maybe “psych patient”. You will only want to describe the observations you made while you had contact with your patient. You also want to add a preface to any comments that had been made by the patient as “per the patient” or “patient stated” before what had been said. An example of this would be “patient stated that they had two beers today”. Only use quote marks if it is accurate as a statement which is word for word. You will only document hearsay if it is applicable to the patient at this time. Do not record it as factual information. Avoid interjecting any humor into the report. The public does not regard EMS as any kind of a humorous business.

A copy of your medical record is required to be filled out and either left at the ED or faxed to them after it is completed back in your station. A green sheet, which is the information form that you fill out at the scene and throughout your call, will need to be copied and left at the ED until the actual medical report has been produced. The person that is in back with the patient during the transport should be the individual that completed the medical document. All personnel that were involved and participated in the care of the patient should review the report before actually signing off on it. Here is a copy of the green sheet for your review of the information on that document.

McHenry Western Lake County EMS System- EMS Run Form

DEPARTMENT	SCENE LOCATION	Date	/ /
DISPATCHED AS		Dispatched	
PATIENT		EnRoute	
Name	Age	Arrive Scene	
Address	Male / Female	Arrive Patient	
DOB		Leave Scene	
Phone	Weight	Arrive Dest.	
Family Doctor	kg	Available	
Chief Complaint	Onset	Destination	
Secondary Complaint	Onset	Starting Mileage	
		Ending Mileage	

History	Medications	Allergies
HTN DM MII CHF CVA COPD CA		
Other:		

ASSESSMENT

MVC	A&Ox	Skin	Breathing	Lung Sounds	Pupils
1-2-3-4	Temp	Color	Moisture		
Person	Warm	Pink	Dry	Normal	Clear
Place	Cool	Pale	Clammy	Labored	Diminished
Time	Events	Cold	Cyanotic	Normal	absent
			Diaphoretic	Agonal	L R
				Wheezes	L R
				Rales	L R
				rhonchi	L R

Eye Opening	4-Spontaneous	3-Voice	2-Pain	1-None		
Verbal Response	5-Oriented	4-Confused	3-Inappropriate Words	2-Non-Specific Sounds	1-None	
Motor Response	6-Obeys Commands	5-Localization	4-Withdrawal	3-Flexion	2-Extension	1-None
TOTAL GCS:	influenced by interventions: <input type="checkbox"/> NO <input type="checkbox"/> Sedated <input type="checkbox"/> Intubated					

Time	Procedure / Medication					
Airway:	Open	Oral	Nasal	ETT	King	
O2-- Rate:	NC	NRB	BVM	Neb		
IV-- Size:	Site:	Fluid:	Rate:			
Medication:	Dose:	Route:				
Medication:	Dose:	Route:				

Vital Signs							
Time	BP	Pulse	Resp	SpO2%	BGL	EKG	Pain
/	/	/	/	/	/	/	/10
/	/	/	/	/	/	/	/10
/	/	/	/	/	/	/	/10
/	/	/	/	/	/	/	/10
/	/	/	/	/	/	/	/10

McHenry Western Lake County EMS System- EMS Run Form

PEDIATRIC GLASGOW COMA SCORE

Eye Opening	> 5 years	Best Verbal Response	< 2 years	Best Motor Response
Spontaneously	4	Appropriate words/phrases	5	5
To speech	3	Inappropriate words	4	4
To pain	2	None	1	1
None	1	None	1	1

APGAR Assessment

0	1	2	
Appearance (color)	Blue or pale	Blue hands or feet	Entirely pink
Pulse (heart rate)	Absent	< 100	≥ 100
Grimace (reflex irritability)	Absent	Grimace	Cough or sneeze
Activity (muscle tone)	Limp	Some extremity flexion	Active motion
Respirations (effort)	Absent	Weak cry, <40	Strong cry

Crew Members:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Additional Notes:

Another form that is used by several agencies is the patient information sheet. This form was used for a smooth patient handoff to Flight For Life for years, but we have now used it for registering the patients when they come in to the ED as well.

**McHENRY WESTERN LAKE COUNTY EMS
PATIENT INFORMATION SHEET**



PATIENT NAME _____ DATE _____
STREET ADDRESS _____
CITY, STATE, ZIP _____
GENDER M F DATE OF BIRTH _____
CHIEF COMPLAINT _____
EMS AGENCY _____

C7756001 07-15

If something needs to be corrected in the medical record, correct it. The sooner the error is corrected the more credible and reliable the change is. Remember that every time you enter the medical record, you basically leave a finger print that says you were in there and why. Use an addendum form in the document to make any and all changes. This will be saved with the original medical document with the date and time of the change.

Don't hesitate to write a long report on your patient. It is always better to document findings now, than to try and recall the events later. Avoid stating diagnostic impressions. Report facts and observations and if you must state a diagnostic impression, do so within the scope of your training. You want to include the observations that led you to that impression. If your training includes 12 lead ECG's, you may include why you feel the patient may be having an Inferior Wall MI because of the elevation noted in II, II and AVF.

Avoid using "possible" or even "?" when you do your observations if they would be very obvious to anyone. If the patient fell off their bike and has an open fracture to the R wrist and you put in that the patient has a "possible" fracture to the R wrist after bone ends have been noted, that would be an obvious finding. If your patient complains of pain in an area, state what you found when you examined that area. Failure to actually record your observations implies that you did not investigate it.

Now we are going to discuss some certain things that you will want to document on specific types of calls. These are things that should be placed in your narrative as well as conveyed to the ED when you call as well as during your patient hand off time.

MVC's you need to report:

- Type of collision (head on, rollover, lateral impact, etc)
- Degree of damage to the vehicle
- Location of patients
- Use of seatbelts
- Was there air bag deployment?

Falls you need to report:

- Where the patient fell from
- How far the patient fell
- The surface the patient fell onto
- The reason the patient may have fallen

Head injuries you will report:

- Level of consciousness (alert, verbal, painful or unresponsive)
- Pupil reaction to light
- *Note the presence or absence of:*
- Discharge from the nose or the ears
- Cervical pain, muscle spasms, tenderness or any deformity
- Altered PMS (pulses, movement or sensation)

Chest injuries you will need to report:

- Position of the trachea
- Status of the neck veins (are they distended or not)
- Breath sounds
- Heart sounds
- *Note the presence or absence of:*
- Crepitus
- Subcutaneous air
- Paradoxical movement of the chest wall

Extremity injuries you will need to report:

- Distal skin color and temperature
- *Note the presence or absence of:*
- Distal pulses
- Motor function
- Sensory function

Always remember that good documentation is NOT C.Y.A, good documentation is a reflection of good patient care!

Now let's discuss patient refusals. We all have been on calls where we need to document the fact that the patient or individual is refusing care. Providers should always do the following when a patient is refusing treatment.

- Assess the patient as completely as possible
- Inform the patient of the findings
- Offer the patient treatment and transport to the hospital
- Identify the negative aspects of the patient not seeking medical attention.

If after doing the above, the patient still decides that they do not wish to have medical treatment:

- Contact OLMC with all the findings including the patient’s refusal both in writing and on the recorded EMS landline at the hospital PRIOR to the patient leaving the scene.
- Require the patient signs the appropriate medical release
- Have the signature witnessed by family members, friends or police officers.
- Advise the patient and witnesses of the potential risk of not seeking medical treatment.
- Advise the patient of signs and symptoms to be aware of, advising that should any of these occur, that they need to seek medical attention.
- Document in your narrative that all of this was completed
- Use the appropriate Patient Instructions forms to assist with the documentation.

The following are the forms that should be filled out and attached to your medical document to show that these instructions were given to the patient and were given to them. As you can see there is a specific form for the head injured patient which indicates the warning signs of a head injury as well as what to do at home. The next document is for several different types of refusals and allows you to choose a specific category such as Wound Care, Post MVC, Sprain/Fracture, High B/P, Low or High Blood Sugar. These boxes can just be checked, instructions given to the patient and the patient/guardian will sign as well as the witness.

MCHENRY WESTERN LAKE COUNTY EMS SYSTEM
HEAD INJURY INSTRUCTIONS

The patient has suffered a suspected head injury or concussion. Both injuries may get worse, and you must be evaluated by a health care provider if you have any worsening signs or symptoms. The patient must not be left alone and should stay with a reliable friend or relative for at least the first 24 hours.

Warning Signs to Seek Immediate Help (Call 911, go to the nearest Emergency Department):

- Repeated vomiting
- Headache that gets worse or does not go away
- Loss of consciousness or unable to stay awake during times you would normally be awake
- Getting more confused, restless, agitated or any personality change
- Lasting or recurring dizziness
- Convulsions or seizures
- Difficulty walking or difficulty with balance
- Weakness or numbness
- Difficulty with vision, or change in speech patterns
- **Most of all, if you have any symptom that concerns you, your family members, or friends, don't delay, seek medical attention right away**

Home Care

- **Rest your Body:** Avoid activities involving exertion or any activity that make your symptoms worse until symptoms subside. Athletes should not return to play or vigorous activity until symptoms are resolved and cleared by a health care provider.
- **Rest your Brain:** Avoid any activity which increases symptoms. Until symptoms are fully resolved, you may need to modify school/work attendance/activities, avoid text messaging, videogames, reading, prolonged time in front of a computer or television.
- Acetaminophen (Tylenol) is the preferred medicine for pain after the injury.
- Eat a light, well-balanced diet that is nutritious in both quality and quantity.
- Do not drink alcoholic beverages, take illicit drugs, sleeping pills, or other substances that change your thinking and/or might worsen your symptoms
- Do not drive until cleared to do so.
- Arouse the patient every 2 – 3 hours for the next 24. Ask a few questions to make sure they are oriented.

I have read and understand the above instructions and understand that these are guidelines since I have opted not to be transported for evaluation, and they do not take the place of a medical evaluation by a physician or advanced health care practitioner.

Signature: Patient or Guardian Date Witness
WHITE: PATIENT COPY YELLOW: DEPARTMENT COPY

MCHENRY WESTERN LAKE COUNTY EMS SYSTEM
Patient Instructions
Checked items apply to your situation

<input type="checkbox"/> Wound Care Instructions Keep the wound DRY for 24 hours and covered with a CLEAN DRESSING. If your wound is becoming RED, SWOLLEN, more PAINFUL, or is DRAINING PUS or there are RED STREAKS from it, then see your doctor immediately or return to the Emergency Department.	<input type="checkbox"/> Post Motor Vehicle Crash Instructions Muscle soreness/stiffness may increase during the first 48 hours. Contact your physician if pain cannot be managed by Acetaminophen or Ibuprofen Contact your physician if symptoms worsen or new symptoms appear.
<input type="checkbox"/> Sprain/Fracture Instructions Apply ice to affected area. Wrap ice in a cloth—do not apply directly to the skin Try not to move the affected area Keep the swollen joint above the level of the heart Rest the affected area for several days Contact your physician if symptoms do not improve or worsen.	<input type="checkbox"/> High Blood Pressure Your blood pressure was elevated during your evaluation. _____ High blood pressure can lead to life threatening disease such as heart disease, stroke or kidney failure We recommend that you have your blood pressure checked again as soon as possible.
<input type="checkbox"/> Low Blood Sugar Your blood sugar was _____ when checked by EMS. Your hypoglycemic episode was treated by: ___ No treatment ___ Oral glucose ___ Other _____ After treatment your blood sugar was _____ Eat a full meal now Contact your physician of this event before you take your next insulin dose. Check your blood sugar frequently for the next several hours. DO NOT stay alone or drive/operate dangerous machinery for the next 6 hours Call 911 if your symptoms worsen.	<input type="checkbox"/> High Blood Sugar Your blood sugar was _____ when checked by EMS. Without proper treatment, high blood sugar can lead to heart disease, kidney disease, and nerve damage. There are effective ways to manage high blood sugar. You need to discuss this with a doctor. We recommend that you contact a doctor to have your blood sugar level checked again as soon as possible. Call 911 if your symptoms worsen.

I have read and understand the above instructions and understand that these are guidelines since I have opted not to be transported for evaluation, and they do not take the place of a medical evaluation by a physician or advanced health care practitioner.

Signature: Patient or Guardian Date Witness
WHITE: PATIENT COPY YELLOW: DEPARTMENT COPY

Ref: Temple College CE program on documentation.

**McHenry Western Lake County EMS System
Continuing Education Quiz
Documentation and Release Forms
Post Test**

NAME: _____ DEPT: _____ DATE: _____

(PRINT CLEARLY)

Circle one: EMT-P PHRN

- 1) After treating a patient with low blood sugar, the patient expresses that they do not wish to be transported to the hospital. Describe what should you do?

- 2) What are the important assessment findings that should be documented in the assessment of a patient with a chest injury?
 - a. _____
 - b. _____
 - c. _____

- 3) Which form that can be used to register your patient at the ED? _____

- 4) What are the characteristics of a good documentation in the medical record?
 - a. _____
 - b. _____
 - c. _____
 - d. _____

- 5) When documenting a refusal, you must call _____ prior to the patient leaving the scene.

- 6) What should be documented regarding a patient that has been involved in an MVC?
 - a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____

7) Good documentation should not be viewed as C.Y.A. It is a reflection of?

8) MWLCEMS indicates that you are only required to have one set of vitals in your medical report.

- a. True
- b. False

9) What documentation is indicated in describing your treatment of a fall victim?

- a. _____
- b. _____
- c. _____
- d. _____

10) The document that can be left at the ED until your medical record is completed and faxed to the hospital is the? _____

IF YOU ARE A MEMBER OF OUR EMS SYSTEM, YOUR CREDIT WILL BE ADDED TO YOUR IMAGE TREND RECORD. PLEASE REFER TO IMAGE TREND TO SEE YOUR LIST OF CONTINUING EDUCATION CREDITS. ANY QUESTIONS REGARDING THIS CAN BE ADDRESSED TO CINDY TABERT AT 224-654-0160. PLEASE FAX YOUR QUIZ TO CINDY TABERT AT 224-654-0165.