SASKATCHEWAN COLLEGE OF PARAMEDICS

Documentation Guidelines

This guideline outlines the expectation of patient care documentation for Emergency Medical Responders (EMR) and all Paramedics. Your documentation provides a key form of communication between other health care providers. It communicates the evidence to support the decision making and care provided to the patient. In cases of investigation or legal or disciplinary hearings, the documentation is a primary piece of evidence in determining that appropriate care was provided given the circumstances[1].

All Emergency Medical Services (EMS) use the same provincial form. However, paramedics working outside an EMS service may have different forms to use. Documentation guidelines remain the same regardless of the form used. The term patient care record will be used throughout these guidelines as a single term and is not meant to reference a single type of document. Employers may have additional documentation requirements and should develop their own policies regarding documentation.

The patient care record (PCR) is a legal document which describes all assessment findings (may be either present or absent findings, i.e. pertinent negatives) as well as the treatments offered and provided by the EMR or Paramedic, or those that are refused by the patient. If you are unsure about whether something should be noted within the documentation, write it down. It is always better to have more information than not enough. Remember: if it isn't documented, it didn't happen. The supplemental PCRs should be used whenever necessary to capture all appropriate patient information.

All patient care records should be maintained in accordance with the applicable privacy legislation. For more information on privacy please refer to the Office of the Saskatchewan Information and Privacy Commissioner at www.oipc.sk.ca.

The term patient care record, or PCR, is used frequently throughout this document. This should be accepted as a broad term regarding documentation of any patient care activities whether in EMS, in facility or elsewhere.

A good test to evaluate whether the documentation is well written is to answer the question: if another practitioner (e.g. nurse or physician) had to step in and take over the care of this patient, does the record provide sufficient information for the seamless delivery of safe and competent care? [1]

Do not generalize in your documentation. Phrases such as "stable", "status unchanged", or "small amount" are vague and should be avoided.

Do not document unfounded conclusions. For example, unless you witnessed the patient fall it should be documented as found patient on the floor or Paramedics were told by bystander that the patient fell

[1] Healthcare Insurance Reciprocal of Canada (HIROC). (August 2017). *Strategies for Improving Documentation Lessons from Medical-Legal Claims. A guide for healthcare providers and administrators*. Retrieved from https://www.hiroc.com/getmedia/9b3d1ed1-b2e1-45fc-ae18-bfc998177d15/Documentation-Guide-2017.pdf.aspx

from a standing position. Instead of writing patient was drunk, document what you directly observed. For example, noted a smell of alcohol on patient's breath and their speech was slurred.

Do include direct quotes when appropriate. These must be indicated using quotation marks. The speaker should be identified using by-stander, patient's daughter or similar descriptors.

Do write in ink (black or blue).

Do ensure it is legible.

Do complete your patient care documentation as soon as possible following the patient interaction.

Do use the 24-hour clock when documenting time.

A separate documentation form must be used for each patient encountered by the EMR or Paramedic, even when multiple patients are assessed and/or cared for during the same call for service.

As part of the permanent patient record, a copy of the document (ex. PCR) must be left at the receiving facility, or if the EMS crew is called out before completing the PCR, as soon as possible after.

Abbreviations should be used cautiously. Ensure you are using approved abbreviations for your organization. The Institute for Safe Medication Practices (www.ismp.org) has a list of abbreviations that should not be used. This may not be a complete list; ensure you follow your organization's recommendations.

PCRs should never be thrown out or shredded. Errors should be crossed out with a single line drawn through it and initialed by the writer. The correct information should be written in the next available line with the writer's initials, date and time recorded with it. If for some reason a new PCR must be started, a line should be drawn through the initial PCR and VOID written across the PCR in block letters. This PCR should be attached to, and kept with, the second PCR.

Late entries, items that are entered at a time outside of chronological order, should be recorded as such with the time and date of the entry and the date and time that the assessment, treatment or other item was done (approximations of time should be identified). Ensure you initial the late entry.

The EMR or Paramedic attending to the patient during the call is responsible for completing the PCR. The second attendant must sign the PCR themselves once the PCR is completed. This indicates that they agree to the information contained within the PCR. No one else should sign a PCR on behalf of either attendant(s). Students or other health care providers who may have been involved in the care of the patient (i.e. and RN who accompanies the paramedics on an interfacility transfer) should print and sign their name on the PCR.

In summary, from the Canadian Medical Protective Association's Good Practices Guide[2]:

Key Concepts

Medical records are legal documents.
Medical records are used to show the thought process leading to a diagnosis and plan of care.
Medical records are a means to communicate with other caregivers, whether concurrent or subsequent.
Patients have the right to see the content of their medical record, subject to certain exceptions.

Good Practices

Take care to document every patient encounter.
Record the interaction as soon as reasonably possible.
Include all relevant information.
Indicate your reasoning and intentions.
Write legibly.
Use only accepted abbreviations.
State the facts using clear and simple language.
Consider what a patient would think if reading your notes.
When making corrections, be sure to date them and indicate the reason for the correction.
Never erase an original entry.
Don't alter a medical record after receiving a complaint, threat of legal action, or legal action

[2] Canadian Medical Protective Association. (n.d.). *Key concepts and good practices. CMPA Good Practices Guide*. Retrieved from https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/key_concepts/pdf/key_concepts_and_good_practices-e.pdf

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