Documentation in the ESO EHR

CHAPTER:	2000	Number:	2080	APRROVED:	11.19.2018
REPLACES:	Clinical Documentation Standards(SOAP)				
Last Revised:			REVIEW:		
APPROVED:			Joe Hoffman, Medical Program Director		
APPROVED:			Scott Weninger, Chair		

I. Purpose

To provide a standardized electronic records software for Emergency Medical Services providers in Kitsap County as determined by the Council.

II. Policy:

It is the policy of Kitsap County Emergency Medical Services and Trauma Care Council that ALL EMS field providers of agencies using MPD services shall adhere to the following requirements for patient care documentation. A surcharge may be imposed after 7/1/19 on agencies that opt for electronic records software outside of the designated standard or paper-based reporting.

III. Procedure:

An Electronic Health Report (EHR) shall be completed for all patients who receive an evaluation and/or treatment from a provider as specified in WAC 246-976-330. A patient is defined as a person who has contact with EMS providers under an incident number. Limited patient contacts such as " lift assists " and "citizen assists " may be recorded in a brief and limited EHR format as approved by the MPD.

A. Flowchart

1. The flowchart section shall be used to document all procedures and treatments performed.

2. As required by the ESO program, all treatments and procedures shall include documentation of the following:
   a. The provider/ proceduralists name,
   b. Tthe size of any equipment used,
   c. The dosage and route of any medications administered,
   d. Any complications encountered and the patient's response to treatment.

3. STEMI, Stroke, Trauma and Sepsis Alerts shall be time stamped in the flowchart section with the time the notification was made to the receiving ED. (This can be easily retrieved later using the time of the call from the cell phone.)

Assessment Tool

The assessment tab shall be used to document the objective findings of the patient's physical exam. The comments area within each section of the Assessment tab shall be used to further describe details that the "+" and "- "check boxes do not clearly explain. (Example: a note in the Mental Status comment box stating " Patient is oriented to person and place, but lethargic and slow to respond.")

The anatomical models may be used to detail specific locations of injuries or findings. This is highly recommended to create a specific and clear picture of injuries identified.

B. Primary Impression

The primary impression field shall be populated with the most life-threatening medical problem identified by the pre-hospital provider. (Example: if the patient was initially seen for a STEM! but deteriorated to cardiac arrest, the Primary Impression selected within the EHR would be "Cardiac Arrest" and the Secondary Impression would be " STEMI". Primary is worst, not first.)

C. ECG and Monitor Imports

1. If vitals are imported from the patient monitor, the provider shall confirm the accuracy of those vitals and remove erroneous values. (i.e. a heart rate of240 recorded due to artifact on the monitor durng transport would be deleted).

2. 12 lead ECGs performed and pertinent ECG tracings shall be uploaded and attached to the EHR. At least one of the 12 lead ECGs (the one with the most relevant clinical information) shall be detailed in the ESO EHR vitals/ECG section.

3. Any subsequent 12 lead ECG with significant changes is to be documented there as well.

D. Personnel

All personnel within the provider's agency who were involved with patient care shall be listed in the personnel section of the EHR.

E. Completion

1. For transported patients, the provider shall enter the destination transported to in the EHR prior to departure from the Emergency Department. (Note: Once Wi-Fi is available, ESO will then transmit a draft version of the information collected up to that point to the Hospital Patient Tracker software.) Within 60 minutes of arrival of the Emergency Department, a draft report shall include at least the following information:
   a. Patient First and Last Name,
   b. Approximate age or Birth date,
   c. Chief Complaint,
   d. Vital Signs,
   e. Medications Administered,
   f. Treatments performed and
   g. **Last known well when applicable to treatment for presumed STEM!, CVA, or Sepsis patients.**
2. Per the requirements of WAC 246-976-330(2)(b) all EHRs must be completed (locked) and available at the Emergency Department within 24 hours of patient arrival, but the goal should be completion of documentation before the patient is likely to leave the Emergency Department.

F. Narrative:

The Narrative section is intended to tie together all the aspects of the EHR and provides a clear depiction of the patient encounter. The Narrative section shall include the following information:\

G. Note

Providers may elect to document a complete traditional SOAP format in the narrative but shall still comply with all the other aspects of this policy and ensure the patient record does not contradict itself.

1. **S = Subjective**: What is told to you
   a. What where you dispatched to? Include any updates, changes, delays, staging, or anything out of the ordinary that happened while in route to the scene if applicable.
   b. What the Patient and/or witnesses state led to/happened just prior to this incident.
   c. What was the Patient's chief complaint? Detail the Patient's and/or witnesses' description of chief complaint in their words as much as possible.
   d. Consider using mnemonics' such as O.P.Q.R.S.T. Document pertinent negatives related to the chief complaint.

2. **0 = Objective**: What you find
   a. Detail the behavior and general appearance of the patient on initial assessment. Describe any and all other pertinent findings related to the patient's environment and the patient's position on EMS arrival.

b. The majority of the objective exam is detailed in the Assessment Tab but you can also use the objective portion of the narrative to describe anything else noted to ensure the clear depiction of the patient assessment.

3. P = Plan: Actions performed during patient care

a. The Plan portion of the Narrative shall include a less detailed chronology of the treatments and procedures performed. The intent of this additional narrative is to provide a reader with the general picture of what was done for the patient recognizing the specifics of those treatments and procedures are detailed in the flowchart section.
b. This section shall also document any discussions with medical control and direction given if applicable.

H. AMA/Refusals

1. In the event a patient refuses treatment or transport consistent with Kitsap County Policy, the signature obtained from the patient or guardian shall be on the the electronic version of the Kitsap County
2. Patient Refusal Information Sheet, located on the signatures page of the EHR. An unsigned paper copy shall be available to leave with the patient if requested. The provider shall also ensure the criteria on the second page of the form are met and documented.

I. Additional Forms

All required specialty forms, as determined by the MPD, shall be completed prior to locking the record, including the Child Injury supplemental report if applicable.

J. ALS Evaluations

1. **When** an ALS provider has evaluated the patient and determined it is appropriate to downgrade the patient to BLS care and transport **a brief note from the ALS provider shall be completed within the EHR.**

2. This must include an evaluation and rationale for such downgrade to BLS status and **MUST** include a statement as to why ALS level of care and transport is not warranted. It may be expanded to include the elements of a full SOAP note.

3. In these circumstances, the BLS provider shall add "ALS Assessment" from the Critical Care tab in the flowchart section, designating the provider that performed the ALS assessment and the time performed.

4. The ALS provider shall document the brief note mentioned above either in the comments section of the ALS Assessment field prior to the record being locked or as an addendum to the narrative after the record has been locked. This directive is also met by the ALS provider completing a separate EHR as will be the case when providers are from separate agencies. 12-lead ECG and rhythm strips will be attached the EHR regardless of its origin.

K. Documentation of Independent BLS Care

Independent care by BLS providers prior to arrival of ALS providers will documented within the EHR It may be expanded to include the elements of a full SOAP note. This directive is also met by the BLS provider completing a separate EHR in the case when the providers are from a separate agency

L. Controlled Substances

In the event a controlled substance is used or wasted during patient treatment, the Controlled Substances form on the EHR signatures page shall be filled out with a witness. (Witnesses must be a Washington State credentialed healthcare professional.)