

Category:	Patient Care	Policy No:	7006
	General	Date:	08/01/2004
	Patient Care Record	New Update	01/01/2010

PATIENT CARE RECORD (PCR)

I. PURPOSE

To establish requirements for completion, reporting, and submission of approved Patient Care Records.

II. RELATED POLICIES

ALS to BLS Transfer of Care, ATG 4

III. APPROVED PATIENT CARE RECORDS

- A. The **Electronic Patient Care Record (EPCR)** is the permanent electronic record of prehospital patient evaluation, care, and treatment
- B. The **Field Transfer Form (FTF)** is the temporary record of prehospital patient evaluation, care, and treatment
- C. Other PCRs approved by the EMS Agency may be utilized by those agencies without EPCR capability as defined in this policy

IV. POLICY

- A. A prehospital care report will be completed for every patient identified by EMS personnel when a medical assessment is deemed necessary. A patient is someone who meets any one of the following criteria:
 - 1. Has a chief complaint or has made a request for medical assistance
 - 2. Has obvious symptoms or signs of injury or illness
 - 3. Has been involved in an event when mechanism of injury would cause the responder to reasonably believe that an injury may be present
 - 4. Appears to be disoriented or to have impaired psychiatric function
 - 5. Has evidence of suicidal intent
 - 6. Is dead
- B. The EPCR will be used as the reporting mechanism unless circumstances as defined in this policy dictate otherwise.
- C. The EPCR will be filled out in a clear, concise, accurate, and complete manner, reflecting all care provided in the prehospital setting.
- D. The personnel responsible for the patient's disposition are ultimately responsible for the completion of the EPCR. This does not preclude any agency from creating an additional record.
- E. If the request or dispatch for medical assistance is deemed a service request (e.g. back-to-bed or blood pressure check), an evaluation by an EMT level or higher responder must be performed. Such calls may or may not require an EPCR, but must be documented according to provider agency reporting requirements. Documentation shall include that medical assistance and/or transportation to a receiving facility was offered.

Category:	Patient Care	Policy No:	7006
	General	Date:	08/01/2004
	Patient Care Record	New Update	01/01/2010

- F. If a patient is transported to a receiving facility, one copy of the EPCR shall be left with the receiving facility upon transfer of care. In the event that personnel are unable to leave a completed EPCR at the facility, the FTF will be completed and left in its place and a completed EPCR will be delivered within 12 hours of transfer of care. In the event a FTF cannot be completed due to an emergent dispatch, field personnel will confirm that adequate information has been provided to hospital personnel. Documentation will then be provided as specified in this policy.
- G. If no patient transport occurs, the EPCR will be completed as soon as possible, but no later than 12 hours after patient contact.
- H. If personnel are rendering care outside of the county to assist in mutual aid (e.g. fire-line personnel), the FTF will serve as the PCR. The FTF will be created on site and a copy submitted to the provider agency as soon as possible after returning to the county.
- I. For ground transportations out of the county, field personnel shall submit a FTF to the receiving facility. A completed EPCR shall be produced within 12 hours of transfer of care.
- J. For air ambulance transportations, field personnel shall complete an EPCR and fax it to the receiving facility within 12 hours of transfer of care.
- K. Willful omission, misuse, tampering, or falsification of documentation of patient care records is cause for formal investigative action under 1978.200 of the California Health and Safety Code.

V. GENERAL INSTRUCTIONS

- A. The patient care record is part of the patient’s permanent medical record and is used for, but not limited to, the following purposes:
 - 1. Transfer of information to other healthcare providers
 - 2. Medical legal documentation
 - 3. Billing for services
 - 4. Development of aggregate data reports for Continuous Quality Improvement (CQI), including specific quality indicators and identification of educational needs
 - 5. EMS Agency case investigation
- B. Reference to a Marin County EMS Notification Form or similar record should not be included on the patient care record.
- C. If ALS to BLS transfer of care is determined to be appropriate, documentation of assessments and all care rendered must be completed by both the ALS and the BLS units according to policy ATG 4.
- D. Provider agencies are responsible for training their employees in the initiation, completion, distribution of patient care records, and any accompanying forms based on the EMS Agency’s currently approved training curriculum.