Alabama Office of Emergency Medical Services
Patient Care Reporting Guidelines
February 8, 2022

OVERVIEW

Electronic Patient Care Reports serve as mandated, standardized and time-validated permanent records of the responses of EMS crews to the calls for help of ill and injured citizens and the disposition of those cases. They serve many purposes including as sources of investigative and research data, sources of case history for clinicians and insurance payers, and as documentation protective against litigation.

BACKGROUND

"NEMSIS" is an acronym for the National Emergency Medical Services Information System. Alabama has participated in NEMSIS along with all other states and some territories since 2003. States and participating territories are under agreement with the federal government under a memorandum of understanding to require and collect electronic patient care reports and to subsequently transmit a specified portion of each report to the NEMSIS records repository in Utah. Submitted data is used at the federal, state, regional, local and service levels for research purposes.

RESPONSIBILITY

- Emergency Medical Services Personnel are responsible for the completion and submission of an electronic Patient Care Report (e-PCR) to the Emergency Medical Provider Service for who the patient care was provided. (EMS Rules 2020: 420-2-1- .21 (1))
- Emergency Medical Provider Service operators are required to acquire and maintain access to an electronic patient care reporting software (approved by the OEMS Director) to provide a mechanism for their personnel to create and submit e-PCRs. (EMS RULES 2020: 420-2-1- .11 (5) 6., 420-2-1- .21 (2))

TOPIC SECTIONS

☐ INTERPRETATION OF SITUATIONS REQUIRING e-PCR DOCUMENTATION

1. In the operation of Emergency Medical Services, units are either dispatched to the location of a call for help (passive detection) or while traveling, encounter a scene within which a call for help exists (active detection). An EMS unit, in service and ready for call, has a duty to act if passively or actively dispatched to a call for help within normal parameters of service.

2. Initiation of a patient care encounter begins with Incident Recognition and Access of the 9-1-1 System. Direct involvement of a provider begins with Access/Dispatch of that provider. At the time of passive or active detection/dispatch, the Duty to Act of the provider is engaged to the situation. Once the Duty to Act is engaged the case MUST be documented via e-PCR.

3. Possible Dispositions Requiring Documentation:
    - Assist, Agency
    - Assist, Public

- Assist, Unit
- Canceled (Prior to Arrival at Scene)
- Canceled on Scene (No Patient Contact)
- Canceled on Scene (No Patient Found)
- Patient Dead at Scene – No Resuscitation Attempted (With Transport)
- Patient Dead at Scene – No Resuscitation Attempted (Without Transport)
- Patient Dead at Scene – Resuscitation Attempted (With Transport)
- Patient Dead at Scene – Resuscitation Attempted (Without Transport)
- Patient Evaluated, No Treatment/Transportation Required
- Patient Refused Evaluation/Care (With Transport)
- Patient Refused Evaluation/Care (Without Transport)
- Patient Treated, Released (AMA)
- Patient Treated, Released (per protocol)
- Patient Treated, Transferred Care to Another EMS Unit
- Patient Treated, Transported by this EMS Unit
- Patient Treated, Transported by Law Enforcement
- Patient Treated, Transported by Private Vehicle
- Standby-No Services or Support Provided
- Standby-Public Safety, Fire, or EMS Operational Support Provided
- Transport Non-Patient, Organs, etc.

4. Explanations/Examples of Dispositions Requiring Documentation

   NOTE: All dispositions are valid for both emergency or non-emergency responses/situations.

   a. **Assist**, Agency
      i. Dispatched to assist another EMS agency on scene where the reporter was never the Primary Care Provider for any patient.
      ii. Example: Fire non-transport EMS unit arriving second on scene to assist primary responding transport unit.

   b. **Assist**, Public
      i. Dispatched to assist a citizen with an situation that is caused by a medical issue. Unsure of severity of situation.
      ii. Example: Dispatched to a lift assist where the severity of the case is unsure. Lifted the subject from the floor without any true patient assessment steps being performed.
      iii. NOTE: If any patient assessment is performed (rule out injury) and patient is not transported, disposition should be “Patient Evaluated, No Treatment/Transportation Required”.

   c. **Assist**, Unit
      i. Your unit is dispatched to assist another unit within your agency or department. The first responding unit has already accepted or begun patient care responsibility.
      ii. Example: Assisting a fellow shift unit with lifting a heavy patient.

d. **Canceled** (Prior to Arrival at Scene)
    i. While responding (emergency or non-emergency) you are cancelled by your dispatcher. The report documents the fact that the unit was relieved of the responsibility for the call's disposition.
    ii. Examples: Cancelled after responding and prior to arrival due to a change that no longer requires an EMS unit. Cancelled on one call to be dispatched on a second call that is either closer or requires the unit's services (Cancelled on a BLS call to re-direct to an ALS call). NOTE: Cancellation documentation can serve to relieve the unit's crew of liability from complaint regarding the original call.
e. **Canceled on Scene** (No Patient Contact)
    i. After responding to the scene location, you are cancelled prior to any contact with the patient/patients. Usually as a result of first responders "waiving off" the unit indicating that your services are not needed.
    ii. Examples: Police arrive on scene and determine that EMS is not needed but do not have an opportunity to cancel you prior to your arrival. First responding EMS arrives on scene and evaluates patients to find further EMS services are not needed and does not have an opportunity to cancel you prior to your arrival.
f. **Canceled on Scene** (No Patient Found)
    i. After responding to the scene location, you are unable to find any patient. Implies scene command responsibility and correct address/location from dispatch information is ascertained.
    ii. Example: A motorist passing a wrecked vehicle on an isolated road calls 9-1-1 to report a probable motor vehicle accident. The driver of the vehicle has previously left the scene. Upon your arrival and after a reasonable search of the immediate area no patient is found to be present. NOTE: A "reasonable search" is one that any EMS-trained person would be satisfied with. All rational measures were applied to detect a patient, alive or dead, if one existed.
g. **Patient Dead at Scene-No Resuscitation Attempted** (With Transport)
    i. After arrival and a reasonable evaluation of the patient resuscitation efforts are deemed futile and the patient determined to be deceased. Your unit is used to transport the remains to another location. NOTE: Complete documentation of death criteria is vital. See Operational Guidelines 18.03 "Death in the Field" Section *Withholding Resuscitative Efforts*.
    ii. Example: After arrival you evaluate a patient to find injuries incompatible with life. At the request of the coroner your unit is used to transport the remains to the morgue.
h. **Patient Dead at Scene-No Resuscitation Attempted** (Without Transport)
    i. After arrival and a reasonable evaluation of the patient resuscitation efforts are deemed futile and the patient determined to be deceased. Your unit is not involved in the disposition of the remains. NOTE: Complete documentation of

death criteria is vital. See Operational Guidelines 18.03 "Death in the Field" Section *Withholding Resuscitative Efforts*.

ii. Example: After arrival you evaluate a patient to find injuries incompatible with life. No further service is required of your unit.

i. **Patient Dead at Scene-Resuscitation Attempted** (With Transport)

i. After arrival and determination of cardiac arrest the CPR/ALS process is initiated, and patient comes to meet criteria in Operational Guidelines 18.03 "Death in the Field" Section *Determining Death in Cardiac Medical Arrest*. Thereafter CPR/ALS is terminated. Upon determination and permission of coroner or law enforcement your unit is used to transport remains to another location. NOTE: Complete documentation of CPR/ALS and decision-making criteria are vital.

ii. Example: A patient if found to be in cardiac arrest upon your arrival and with application of judicious effort does not improve after a period of twenty minutes. All criteria are met, and efforts are terminated. After which your unit is required to transport the remains to the morgue.

j. **Patient Dead at Scene-Resuscitation Attempted** (Without Transport)

i. After arrival and determination of cardiac arrest the CPR/ALS process is initiated, and patient comes to meet criteria in Operational Guidelines 18.03 "Death in the Field" Section *Determining Death in Cardiac Medical Arrest*. Thereafter CPR/ALS is terminated. After termination and conference with coroner or law enforcement, no further services are required of your unit. NOTE: Complete documentation of CPR/ALS and decision-making criteria are vital.

ii. Example: A patient if found to be in cardiac arrest upon your arrival and with application of judicious effort does not improve after a period of twenty minutes. All criteria are met, and efforts are terminated. After which your unit is no longer required and freed to return to service.

k. Patient Evaluated, No Treatment/Transport Required

i. After arrival at a scene of a proposed emergency the subject proposed to be ill or injured is of age of consent, sober, conscious, and rational states upon inquiry that they do not require EMS care or transportation. With consent, the patient may be evaluated by physical assessment, including vital signs measurement, to ensure that true homeostasis is intact. NOTE: If the patient's condition is questionable, contact OLMD. All evaluation criteria should be carefully documented. See Operational Guidelines 18.07 "Patient Rights and Refusal of Care".

ii. Example: You arrive on the scene of a single vehicle minor motor vehicle accident to find the driver standing beside the vehicle and talking on her cell phone. You ask, "Are you injured?" and she states that she is not. She has no obvious injuries, disabilities and appears normal. You ask, "Would you like us to check you out?" to which she states "Yes, please." All vital signs are within limits, two sets taken five minutes apart, and no pain can be elicited on the vehicle restrain points. She denies any medical condition or medications. You

ask, “Are you sure you would not like us to take you to the hospital just to be sure?” and she states that she feels she is uninjured. You return to service.

l. **Patient Refused Evaluation/Care** (With Transport)
   i. After arrival at a scene of an obvious emergency the subject appears to be ill or injured is of age of consent, sober, conscious, and rational states upon inquiry that they do not require EMS care or transportation. With consent, the patient may be evaluated by physical assessment, however the patient refuses any evaluation or care by you or your crew. You can convince the patient to allow you to transport them to the hospital without any evaluation or care by you or your crew and do so to ensure that the patient receives care. NOTE: If the patient’s condition is questionable, contact OLMD. All evaluation criteria should be carefully documented. See Operational Guidelines 18.07 “Patient Rights and Refusal of Care”.
   ii. Example: You arrive on the scene of a roll-over motor vehicle crash to find the sole occupant and driver standing in front of the vehicle. The patient is obviously injured. When you begin your evaluation of the patient you find her completely lucid but unwilling to either be evaluated by your or your crew or to be treated. The patient states that she only wishes to be given a ride to the hospital. You explain the dangers of her situation to her and again she refuses to be evaluated or treated, but states that she will allow transport. You consider consulting OLMD and safely transport the patient to an appropriate hospital during which you contact the ED and explain the situation.

m. **Patient Refused Evaluation/Care** (Without Transport)
   i. After arrival at a scene of a proposed emergency the subject appears possibly ill or injured is of age of consent, sober, conscious, and rational states upon inquiry that they do not require EMS care or transportation. With consent, the patient may be evaluated by physical assessment, however the patient refuses any evaluation or care by you or your crew. You are unable convince the patient to allow you to transport them to the hospital without any evaluation or care by you or your crew. NOTE: If the patient’s condition is questionable, contact OLMD. All evaluation criteria should be carefully documented. See Operational Guidelines 18.07 “Patient Rights and Refusal of Care”.
   ii. Example: You arrive on the scene of a moderate motor vehicle accident. The vehicle has all airbags deployed and the patient states they were restrained during the crash. They are not obviously very injured but shaken up. They refuse any evaluation or treatment by you or your crew. You offer your services to transport them without evaluation and they refuse. They are lucid in all respects, and you discharge them from your care. You return to service.

n. **Patient Treated, Released** (AMA)
   i. After arrival at a scene of a proposed emergency the subject appears obviously ill or injured, is of age of consent, sober, conscious, and rational states upon inquiry that they will allow EMS care/treatment but will not allow transportation. With consent, the patient may be evaluated by physical assessment, and allows physical assessment and treatment. You are unable

convince the patient to allow you to transport them to the hospital after the treatment is given. This sometimes occurs with the patient feeling improved after treatment and then refusing transport. You diligently attempt to convince the patient to allow transport and continued treatment and they refuse after you have explained the danger of their decision. NOTE: If the patient's condition is questionable, contact OLMD. All evaluation criteria should be carefully documented. See Operational Guidelines 18.07 "Patient Rights and Refusal of Care".

ii. Example: Example: You arrive on the scene of a roll-over motor vehicle crash to find the sole occupant and driver standing in front of the vehicle. The patient is obviously injured. When you begin your evaluation of the patient you find them completely lucid and willing to be evaluated by your and your crew and to be treated. The patient states that they only wish to be evaluated and bandaged and are unwilling to be transported to a hospital. You explain the dangers of the situation and again, despite your recommendation to allow transport, they refuse to be transported but are willing to be evaluated and bandaged. You consider consulting OLMD and provide appropriate evaluation and treatment and discharge them from your care. NOTE: You closely document your interaction with the patient and include all evaluations made and treatments given, as well as your attempts to convince them to be transported. Many experienced providers recommend making at least three attempts to convince a patient to be transported which are documented in their narratives.

o. **Patient Treated, Released** (per protocol)

i. After arrival at a scene of a proposed emergency the subject appears minimally ill or injured, is of age of consent, sober, conscious, and rational states upon inquiry that they will allow EMS care/treatment as needed (bandaging small wounds, evaluation of blood glucose, etc.) but that they wish to travel to seek physician's care by private owned vehicle (POV) either immediately or when the opportunity arises (when physician office opens, etc.) or if they personally perceive a need to do so. In your opinion the patient is neither ill nor injured to a degree where ambulance transport is essential. You have assured the patient that you are happy to transport them to the hospital of their choice. NOTE: If the patient's condition is questionable, contact OLMD. All evaluation criteria should be carefully documented. See Operational Guidelines 18.07 "Patient Rights and Refusal of Care".

ii. Example: Your unit is tasked with stand-by duty at a public park during a prearranged family day picnic. As you sit in your unit a citizen approaches you and states that she has accidentally cut her finger while opening a container. You ask if you can check it and they allow you to do so. You see a small shallow laceration which may possibly require a stitch or two. As you bandage the wound your partner asks if vital signs and history can be taken and is allowed. You take two sets of vital signs five minutes apart as you derive history and demographic data. You advise the patient to seek medical care for tetanus shot and sutures. You offer transport options, including your unit. The patient states

they will have a family member transport them to a clinic close by. You ask the patient to sign your procedural waiver of liability and they do so.

p. Patient Treated, Transferred Care to Another EMS Unit

i. You are called to the scene of an emergency and are the first to arrive on scene. While treating the patient, another dispatched EMS unit (with level equal or higher than yours) arrives on scene to transport the patient to an appropriate hospital. A patient and treatment history are exchanged (like that done at transfer of care at the hospital) and the transporting unit assumes care of the patient and transports. Typically used to record a tiered response (i.e., a fire department first responder who cares for a patient until a transport ambulance arrives on scene) or a situation where an EMS helicopter is called to transport a patient more quickly and safely from a scene to an appropriate facility for the patient's condition.

ii. Example: An ALS fire engine is dispatched to the scene of an emergency simultaneously with an ALS transport ambulance. The engine arrives first and begins evaluation and care of the patient after which the ambulance arrives to transport the patient. ***NOTE: If the highest level on the engine (i.e., fire-medic) remains with the patient and is transported with the patient, no matter what level crewmembers are on the ambulance, patient care responsibility remains with the first responding provider. In such cases, care is not transferred to the transporting EMS unit. This was nationally recognized as difficult to document using the NEMSIS elements prior to Version 3.5. Version 3.5's NEMSIS elements divide the element eDisposition.12 into five elements (eDisposition.27 through eDisposition.31) which facilitate the documentation of first responder retention of patient care responsibility.***

q. Patient Treated, Transported by this EMS Unit

i. You arrive on the scene of an emergency and are either first responders or assume care from the first responders. After evaluation and treatment on the scene you transport the patient to an appropriate hospital.

ii. Example: You answer a patient on scene, treat per protocols and transport the patient to the most appropriate facility. Appropriate facility may be hospital, clinic, doctor's office, skilled nursing facility, etc.

r. Patient Treated, Transported by Law Enforcement

i. You arrive on the scene of a proposed emergency and evaluate / begin treatment of a patient. The patient is ultimately transported to a facility and/or taken into custody by a Law Enforcement unit.

ii. Examples: (1) You arrive on the scene at a jail facility to evaluate an inmate. After evaluation the corrections personnel deem it safer to transport the patient to the corrections wing of the local hospital in a secured vehicle. (2) You arrive on the scene of a residence where an assault has taken place. You evaluate a person under arrest. Injuries appear minor and the Law Enforcement personnel transport the patient to jail for booking and observation. (3) On the scene of a multiple injury accident the number of patients is disproportional to the number of available transport units even with mutual aid. After evaluating a patient

with moderate injuries and bandaging the wounds a Law Enforcement unit agrees to transport the patient to an appropriate hospital facility, so all ambulance units are free to care for more severely injured patients.

s. Patient Treated, Transported by Private Vehicle

i. You are called to the scene of a proposed emergency. Upon arrival you find a patient with a minor illness or injury who you evaluate and treat as needed. The patient wishes to be seen by a physician and wishes to be transported by a family member in a privately owned vehicle (POV). You discharge the patient from your care with the understanding that they will travel immediately by POV to the facility of their choice.

ii. Example: You are dispatched to the home of a patient with general illness. After evaluation you find all vitals within normal limits, including blood glucose and pulse oximetry. You measure the vital signs (other than BG) twice at five-minute intervals and record them. The patient asks if you think that traveling to the doctor's office by POV is appropriate in this case. You agree and discharge the patient to travel to their physician's office.

t. Standby-No Services or Support Provided

i. You are tasked to standby at a special event or fire scene. No services are needed by anyone during the time you are there.

ii. Examples: (1) Your unit is scheduled to standby at the local high school Friday night game. No illnesses or injuries occurred, and your services were not needed during your standby. (2) You are dispatched to a fire scene but are not required to assist in the operations and no one becomes ill or injured.

u. Standby-Public Safety, Fire, or EMS Operational Support Provided

i. You are dispatched to a scene where you are standby providers. You provide support to the public safety, fire, or EMS operations on the scene. NOTE: You submit a separate e-PCR for each patient you treat and/or evaluate. The "Standby-Public Safety, Fire or EMS Operational Support Provided" covers your time on standby. If no support was necessary, you would have filed "Standby-No Services or Support Provided". If you pulled hose at a fire, helped carry SCBA tanks, or looked for injured in the area (without finding anyone or providing any patient care) you file "Standby-Public Safety, Fire, or EMS Operational Support Provided".

ii. Examples: (1) You are dispatched to a fireground standby. After arrival you are positioned by the Scene Commander and remain available throughout the fire operations process. When asked you provide water for well, uninjured firefighters. (2) You are dispatched to a "fun-run". During your time on standby, you treat and transfer care of two patients to another EMS unit. At the end of your standby, you submit three separate e-PCRs outlining your actions.

v. Transport Non-Patient, Organs, etc.

i. You are called upon to transport in your ambulance items such as organs for transplant, medications or equipment between locations, bodies to a funeral home or morgue, or other items or personnel not considered patient care.

ii. Example: Your unit is called to a hospital to transport a body to a funeral home. ***NOTE: If the corpse is on a scene (you answered and determined death or were present with death was determined) the "Patient Dead On Scene-No Resuscitation Attempted (with transport)" designation is used. If you are sent to a residence by a funeral home specifically to transport a body the "Transport Non-Patient, Organs, etc." designation is used.***

5. Documentation of Refusals, Etc.

- ***a.*** Documentation cannot be overemphasized in cases where patient care is applied and/or suspended by patient request.
- ***b.*** Refusals and suspensions by request absolutely require the patient to sign a waiver of liability, or for a witness to sign witnessing the patient's signature and/or decision to refuse or suspend.
- ***c.*** Witnesses to look for are family members, police officers, fire officials (not your department) or unbiased bystanders.
- ***d.*** An old rule of EMS is "If you didn't write it down, you didn't do it." Meaning you cannot prove in court that you did (or did not do) an action that was not documented.

☐ NEW ELEMENTS FOR EMSA AND VERSION 3.5

Beginning June 1, 2022, e-PCRs submitted to the Schematron for Alabama's Electronic Patient Care Report Repository which do not have the EMSA custom elements in place will fail validation. The e-PCR software vendors performing sales and service to our state's Emergency Medical Provider Services (EMS Services and Departments) were made aware on 11/8/2021 of the addition of these custom elements through the NEMSIS website. It is their responsibility to their clients to implement the EMSA elements.

1. EMSA (Emergency Medical Stroke Assessment) Elements

On March 1, 2022, Alabama will enable and facilitate, in the State's RESCUE software platform, 11 custom stroke evaluation elements. The elements are unique to Alabama and are integrated into the Alabama Stroke System. All Alabama EMS personnel should have been trained regarding the use of the EMSA elements for stroke evaluation. EMSA is required to be utilized on every patient care report upon which patient assessment was recorded and is recorded only once (not serially) during the patient care process. EMSA evaluation should be used in conjunction with, and not as a replacement of, other stroke scales, such as the Cincinnati Stroke Scale or FAST Stroke Scale. All NEMSIS software platforms used in Alabama should include the EMSA elements by, or shortly after, March 1, 2022. As stated above, the deadline for implementation is June 1, 2022.

- emsa.SuspectedOccurrence-EMSA-Suspected Acute (New Onset) Stroke/CVA Occurrence
  "Do you suspect an acute (new onset) stroke/cva occurred? CHOICES: Yes, No, Unknown

IF ABOVE ELEMENT IS ANSWERED "YES"

- emsa.TimeFactor-EMSA-Time Factor Date/Time
  "The approximate date/time that the complaint was noticed."

ANS: Date/Time

- emsa.Onset-EMSA-Onset
  "Was the onset of this complaint acute/rapid or gradual/slow?"
  CHOICES: Acute/rapid, Gradual/slow

- emsa.Pain-EMSA-Pain
  "Does the patient experience head pain with this complaint?"
  CHOICES: Yes, No

- emsa.AlabamaStrokeSystemEntry-EMSA-Alabama Stroke System Entry
  "Did you enter this patient into the Alabama Stroke System?"
  CHOICES: Yes, No

- emsa.E1-EMSA-Horizontal Gaze
  "Patient Horizontal Gaze. Ask patient to keep their head still and follow your finger left to right with their eyes."
  CHOICES: Normal-Equivalent Movement, Abnormal-Patient is unable to follow as well in one direction compared to the other.

- emsa.M2-EMSA-Facial Weakness
  "Facial Weakness. Ask patient to show their teeth or smile."
  CHOICES: Normal-Bilaterally equivalent smile (both sides), Abnormal-Unilateral facial droop (one side does not move as well as the other).

- emsa.M3=EMSA-Arm Weakness
  "Arm Weakness. Ask patient to hold out both arms, palms up, for 10 seconds with eyes closed."
  CHOICES: Normal-Both arms behave the same and do not drift away or down from position start, Abnormal-One arm does not move or drifts downward compared to the other.

- emsa.M4-EMSA-Leg Weakness
  "Leg Weakness. Ask patient to lift up one leg and then the other, hold 5 seconds each."
  CHOICES: Normal-Both legs behave the same and do not drift down during 5 second lift, Abnormal-One leg does not move or drifts down compared to the other

- emsa.SA5-EMSA-Naming
  "Naming. Ask the patient to name your watch and pen ("What is the name of this object?")"
  CHOICES: Normal-Patient clearly says "watch" or "pen" or gives brand name, Abnormal-Patient slurs words, says the wrong words (either one) or is unable to speak.

- emsa.SA6-EMSA-Repetition
  "Repetition. Ask the patient to repeat "They heard him speak on the radio last night" after you."
  CHOICES: Normal-Patient remembers and clearly says the phrase when requested, Abnormal-Patient slurs words, says the wrong words, or is unable to speak.

NOTES:

**If you answer "YES" to the suspected occurrence question (Do you suspect a new onset stroke/cva has occurred) then you will have to answer the other questions and the patient should be put into the Alabama Stroke System.

**If you are on a call and are cancelled, or other situations where there IS NOT PATIENT CONTACT, you should answer the suspected occurrence question (Do you suspect a new onset stroke/cva has occurred) with either "NO" or "UNKNOWN". YOU MUST ANSWER THIS QUESTION FOR THE e-PCR to pass validation.

The EMSA Score is a number between 0 and 6. For every question answered "abnormal" the patient given 1 point. Completely normal is 0 points and any score greater than 4 is suspected of large vessel occlusion (LVO) and may require thrombectomy. The scorable questions are contained in the EMSA card included below. The reporter is responsible for including the EMSA score of an applicable patient into the body of the narrative. The TCC operator will begin requesting the EMSA Score of a patient placed into the Statewide Stroke System on April 29, 2022.

EMSA (Emergency Medical Stroke Assessment) was developed by the UAB Department of Neurology. A video can be accessed in the following link: http://www.kaltura.com/tiny/xr3fh

2. NEMSIS Version 3.5

Alabama will begin receiving (and submitting to NEMSIS) NEMSIS Version 3.5 data on March 1, 2022. The state provided free e-PCR software, RESCUE, will have the new 3.5 elements within it also by that date. An explanation of the new elements follows.

Items 4 (a through V) above are actually the choices of disposition found in the old element eDisposition.12 replaced in Version 3.5. As we discussed above, documentation of ride-in of First Responder, etc., was difficult under the 3.4 version. eDisposition.12 was replaced by the following:

- eDisposition.27 – Unit Disposition
    - Patient Contact Made
    - Cancelled on Scene
    - Cancelled Prior to Arrival at Scene
    - No Patient Contact
    - No Patient Found
    - Non-Patient Incident (Not Otherwise Listed)
- eDisposition.28 – Patient Evaluation/Care
    - Patient Evaluated and Care Provided
    - Patient Evaluated and Refused Care
    - Patient Evaluated, No Care Required
    - Patient Refused Evaluation/Care
    - Patient Support Services Provided
- eDisposition.29 – Crew Disposition
    - Initiated and Continued Primary Care
    - Initiated Primary Care and Transferred to Another EMS Crew

- Provided Care Supporting Primary EMS Crew
- Assumed Primary Care from Another EMS Crew
- Incident Support Services Provided (Including Standby)
- Back in Service, No Care/Support Services Required
- Back in Service, Care/Support Services Refused

- eDisposition.30 – Transport Disposition
  - Transported by This EMS Unit (This Crew Only)
  - Transported by This EMS Unit, with a Member of Another Crew
  - Transport by Another EMS Unit
  - Transport by Another EMS Unit, with a Member of This Crew
  - Patient Refused Transport
  - Non-Patient Transport (Not Otherwise Listed)
  - No Transport
- eDisposition.31 – Reason for Refusal/Release
  - Against Medical Advice
  - Patient/Guardian Indicates Ambulance Transport is Not Necessary
  - Released Following Protocol Guidelines
  - Released to Law Enforcement
  - Patient/Guardian States Intent to Transport by Other Means
  - DNR
  - Medical/Physician Orders for Life Sustaining Treatment
  - Other, Not Listed

☐ ACUTE HEALTH SYSTEMS DOCUMENTATION

1. Alabama Trauma and Health System (ATHS)

Alabama is the only state in the United States with the capability to constantly monitor the status of every trauma hospital and route the trauma patient to the most appropriate hospital every time. The system was developed to reduce the societal burden of trauma and to save lives. The system itself collects data initiated by prehospital EMS and entered by participating hospitals. Review of prehospital EMS data is often done to perform quality assurance and quality improvement (QA/QI) for the Alabama Trauma System. Participating hospitals are granted a designated as a Level 1, 2 or 3 Trauma Hospital based upon available physicians and services. Level 1 Trauma Centers are the most capable to treat severe trauma.

The purpose of the ATHS is to maximize care for trauma patients with "The Golden Hour" of the case. Patients who meet Alabama Trauma and Health System inclusion criteria should be "put into the system" by the prehospital EMS team initiating care at the scene by calling the ATHS Central Operator at 1-800-359-0123. The operator will then advise the most appropriate destination to treat the patient's condition at the time of entry. Inclusion criteria and entry instructions are listed in the Acute Health Systems/Trauma System protocol on pages 14-16 of the 10th Edition of the Alabama EMS Patient Care Protocols available online at the Alabama OEMS website.

Documentation concerns for Trauma System entry are as follows:

The e-PCR has two elements that should be filled when the TCC operator is called, and a trauma number is given; eOutcome.03 (External Report ID/Number Type) should be selected as "Trauma Registry" and eOutcome.04 (External Report ID/Number) should be the number given by the ATCC operator (will be 6-7 digits long). The e-PCR also has element eInjury.03 which should be a dropdown box with the criteria for transport to a trauma center. This field should be populated with criteria requiring entry into the Trauma System.

2. Alabama Statewide Stroke System

The Alabama Statewide Stroke System was activated on October 30, 2017. The system works similarly to the Trauma System, with the goal to be routing of the patient to the most appropriate facility for the patient's condition and early recognition of large vessel obstruction which may require surgical intervention. Participating hospitals are designated as Level 1, 2, or 3 depending upon stroke treatment capabilities (physicians and services available).

The Emergency Medical Stroke Evaluation (EMSA) elements were integrated into the Alabama e-PCR as custom elements (as described above) to facilitate patient entry into the Stroke System. If the first element, Suspected Occurrence of Acute Strove, is recorded as "yes" then the patient care provider is expected to have called the Central Operator at 1-800-359-0123 and entered the patient into the Stroke System and to have received a number. The operator will route the ambulance to the most appropriate destination hospital, call for helicopter EMS to transport if necessary, and alert the destination hospital as done with severe trauma patients. Inclusion criteria and entry instructions are listed in the Acute Health Systems/Stroke System protocol on pages 17-18 of the 10th Edition of the Alabama EMS Patient Care Protocols available online at the Alabama OEMS website.

The e-PCR has two elements that should be filled when the ATCC operator is called, and a stroke number is given; eOutcome.03 (External Report ID/Number Type) should be selected as "Stroke Registry" and eOutcome.04 (External Report ID/Number) should be the number given by the ATCC operator (will be 6-7 digits long). This is in addition to the completion of the EMSA elements as described above. The EMSA score (0-6) should be recorded within the narrative as being the "EMSA Score = "if the patient is suspected of having an acute stroke.

3. The Alabama Statewide Cardiac/STEMI System

CARES
The Alabama Department of Public Health (ADPH) and the Office of Emergency Medical Services (OEMS) have partnered with Cardiac Arrest Registry to Enhance Survival (CARES) to measure and improve outcomes statewide from out of hospital cardiac arrest. Extra documentation is not required for the CARES system to work.

STEMI System
A system like the Trauma and Stroke Systems is projected and under development to maximize treatment of ST-elevation myocardial infarction cases encountered in the prehospital environment. Prehospital care providers would utilize 12-lead electrocardiography and contact the ATCC operator to be routed to the most appropriate facility to treat the patient's condition. The drop-down box for eOutcome.03 (External Report ID/Number Type) can possibly contain a

choice “STEMI Registry” but it is not yet used statewide as the Statewide STEMI System is not yet operational. The Birmingham Regional EMS System (BREMSS) currently has a region-specific STEMI system that may and should use those elements.

- ☐ BEST PRACTICES NARRATIVE DOCUMENTATION

Narrative documentation is neither straightforward or standardized in either EMS training or quality assurance and improvement programs within most Alabama EMS services who submit e-PCRs. The following is an overview of functions that the narrative section of e-PCR performs and various preferred approaches to write narratives.

1. Function of the Narrative Section

Elements of an e-PCR record and timestamp assessments, procedures, medication administrations and record the response of the patient to each procedure and medication. Each procedure and administration are recorded under its own unique identification number. The elements are primarily used to count and categorize actions, for example, the number of naloxone administrations in a period for a certain area. Compliance requires that all assessments, procedures, and administrations be recorded in the appropriate elements.

The narrative section of an e-PCR tells the complete story of a scene response and patient care situation. It is likely the least understood part of the e-PCR. The e-PCR elements can tell a reader what was done and when it was done, but they cannot convey “why” it was done. Any patient care intervention must be done secondary to an “indication” (reason) for that intervention. Every EMS Provider makes dozens of complex decisions on every call, based upon personal scope of practice, training, and experience. Appropriate decisions are frequently made which cannot be validated by information in a drop-down menu. A wise EMS Provider gives rationale for decisions made to enact treatment and transport of a patient. The best use of the narrative is the following:

THIS IS WHAT I OBSERVED <-> THIS IS WHAT I DID <-> THIS IS WHY I DID IT
OBJECTIVITY IS THE KEY TO GOOD DOCUMENTATION

As the Patient Care Report serves as a prehospital medical record, treatment criteria must be carefully documented to validate billing for services provided. Similarly Patient Care Reports serve as a legal record for events that occurred on the call and may be used in legal processes to validate the legality and necessity of actions of EMS providers on the scene. Least obviously, Patient Care Reports are used in Quality Assurance and Quality Improvement processes at the individual, service, city, county, region, state, and federal levels.

2. Approaches to Writing the Narrative

A professional narrative should be thorough. It should contain specific information pertaining to the observation of situation, signs, symptoms, histories, and complaints; as well as any precautions taken, and any interventions or treatments administered. Many e-PCR platforms will assist the reporter by placing data into the narrative. Many experienced reporters just use an acronym to chart their own written thoughts in a concise flowing manner. Many use a combination of the two methods cut save time while maximizing recorded information. Whether or not an automated feature is utilized the narrative should be reviewed thoroughly and edited to ensure that the

language is accurate, is readable and is EXACTLY what the reporter wants on the report to provide facts that are accurate, defendable, and objective. Always remember that your professional capacities and reputation are represented by what you write and approve for submission.

1. Common Acronyms Used in Narratives

   Generally, all aspects of a narrative should be accomplished in complete sentences with appropriate punctuation. Remember, if you write like you are unprofessional you will look unprofessional while you are defending your actions in court. Also, any narrative format should start with the "who, what, where, when and why" of the dispatch process as well as a description of what was found upon scene arrival, EVEN in cases of being cancelled on a scene.

   - S.O.A.P. NARRATIVE (Some variations exist.)
     - Subjective – History of the incident. Why you were called. What you are told. How the patient described their symptoms. Dispatch information and your perception of the scene.
     - Objective – Comments are added in including your assessment findings, vehicle damage or other observations, patient positioning, viral signs (at least, initial vital signs) EKG findings and other non-opinionated facts.
     - Assessment – Your differential diagnosis (what you believe you are treating and what you believe you are ruling out).
     - Plan – What you did to treat your patient (interventions, IVs, medications) include what (if any) was done prior to your arrival, what was done on scene and what was done in transport.

   - C.H.A.R.T. NARRATIVE (Some variations exist.)
     - Complaint – Chief complaint (If patient's own words, use "quote-unquote" format – use quotation marks).
     - History – History of the present illness. Patient's recent medical history. Patient's chronic medical history. Any pertinent history is outlined.
     - Assessment - Your differential diagnosis (what you believe you are treating and what you believe you are ruling out).
     - Rx – The patient's prescriptions are listed.
     - Treatment - What you did to treat your patient (interventions, IVs, medications) include what (if any) was done prior to your arrival, what was done on scene and what was done in transport.

   - D.R.A.A.T.T. NARRATIVE (method advocated by Page, Wolfberg and Wirth – National EMS Law Firm and used herein with permission.)
     - Dispatch – Dispatch information given. Your location when response began.
     - Response – Mode of response. Notations of response process (obstructions, etc.).
     - Arrival – Arrived on scene to find. Notations of arrival and observations.
     - Assessment – Observations, differential diagnosis, etc.
     - Treatment – What you did to treat your patient (interventions, IVs, medications) include what (if any) was done prior to your arrival, what was done on scene.

        - Transport – Documentation of aspects of transport to facility, including treatments, observations, and issues.

    - (Assessment Mnemonic) M.U.R.D.E.R.S.I.N.C. Systems Review Assessment
      A review of each body system can be used under the "Assessment" of any mnemonic to indicate either normal or abnormal findings for each body system. Normal findings can be listed as "normal" or "unremarkable". Use of this approach documents that each specific system was considered in assessment.
        - Muscular System –
        - Urinary System –
        - Reproductive System –
        - Digestive System –
        - Endocrine System –
        - Respiratory System –
        - Skeletal System –
        - Integumentary System (skin) –
        - Neurological System –
        - Circulatory System –

      The Systems Review Assessment is also useful for reminding the reporter to ask questions regarding the system. For example, for Musculoskeletal System the assessor would note the development of the muscles. Are they equivalent on either side or is there hypertrophy from exercise or is there atrophy from lack or inability of use? Similarly, for the Urinary System review, if the chief complaint is not urinary pain or other obvious issue, the examiner can ask about changes in urine output including volume, color, smell, or discomfort during urination. A review of the Reproductive System asks a male about any reproductive issues, such as erectile dysfunction and whether any medication is used for that (very important if the patient is experiencing chest pain or symptoms of M.I.). The same for a female asks about the possibility of pregnancy, any history of pathology or surgeries, how many pregnancies have occurred, how many miscarriages and how many live births have occurred.

2. Common Problems with Narrative Documentation

    - Narrative Conflicts with An Element
        - Reporters sometime report something in the narrative that directly disputes the indicated data of an element. For example, the elements that report the Glasgow Coma Score (GCS) are eVitals.19 through eVitals23 are defaulted at "normal" and the reported GCS = 15. The reporter describes the patient's level of consciousness as "responsive to pain". The data conflicts.
        - The result of conflicting data in a court will depend upon what the basis of the hearing is. The presence of conflicting data is like the presence of conflicting statements given in testimony in court. The conflicting information can bring the reliability, quality, and judgement of the reporter into question. This inference can affect the case of the litigating parties and may weaken the case of an EMS professional answering to defend their own actions in the field.

- The e-PCR reporter can avoid conflicting statements by carefully reviewing all elements used and all verbiage in the narrative for correctness and appropriate content prior to submitting the e-PCR.

- The Automated Narrative Feature "Muddies" the Narrative
  - Automated narrative devices used within e-PCR platforms are designed to place data from e-PCR elements into the narrative to assist in writing the story of the patient care process. Their use ranges from very helpful to detrimental to the narrative.
  - Proper use of automated narrative features requires a careful review of the narrative section of an e-PCR prior to submission into the EMS Data Repository. Any extraneous text that may be generated into the narrative field should be edited out prior to submission.
  - EXAMPLE OF COMPLETE DATA AND RESULT:
    - eVitals.19 (Glasgow Coma Score-Eye) = No Eye Movement = 1
    - eVitals.20 (Glasgow Coma Score-Verbal) = No Response = 1
    - eVitals.21 (Glasgow Coma Score-Motor) = No Response = 1
    - eVitals.23 (Total Glasgow Coma Score) = 3
    - Possible Narrative Generation: "The patient exhibited NO eye movement, NO verbal response and NO motor response. Total Glasgow Coma Score = 3."
  - EXAMPLE OF INCOMPLETE DATA AND RESULT:
    - eVitals.19 (Glasgow Coma Score-Eye) = (UNFILLED)
    - eVitals.20 (Glasgow Coma Score-Verbal) = (UNFILLED)
    - eVitals.21 (Glasgow Coma Score-Motor) = (UNFILLED)
    - eVitals.23 (Total Glasgow Coma Score) = (UNFILLED)
    - Possible Narrative Generation: "The patient exhibited Total Glasgow Coma Score = ."
  - Automated narrative inserts are specific for individual e-PCR platform software and are often generated by selection of a "button" by the reporter. The actual range of inserted content can usually be preprogrammed. If they are available to the reporter and especially if they are chosen to be used by the reporter, the text should be reviewed, and any nonsensical text removed prior to "final saving" the report and submitting it to the EMS Repository.

- Terse (short/too short) Narratives
  - Narratives are meant to be descriptive, easily reviewable summaries of the unit's response, approach to and completion of patient care.
  - Statements within narratives should describe the who, what, when, where and why of the EMS response. Statements that are too short are not beneficial for the crew involved, for the clinicians or investigators reviewing the record or the patient. The e-PCR is the State's legal record of the crew's call to action, duty to act, and disposition of the patient.
  - Criteria describing the patient's condition, assessment findings, observations, treatments, and results should be indicated by the elements of the e-PCR and then summarized within the narrative for quick evaluation

by a reviewer of the record. Reviewers may include clinicians, investigators, and attorneys.
- Descriptions should be in complete sentences with appropriate grammar. Abbreviations were previously accepted on hand-written narratives because of space constraints. Electronic narratives typically do not have a maximum character count; thus, abbreviations are neither necessary nor acceptable.

3. Overview of Uses for the Narrative

- Quick Reference for Clinicians
  - Upon completion and submission of the e-PCR the destination hospital has access to the electronic record through the RESCUE EXCHANGE system (if the appropriate facility ID code was included on the e-PCR). The record then becomes available for the physician team to review to determine what findings and interventions occurred during the treatment and transport process.
  - Physicians throughout the state have requested that some written form of record be made available at the time of transfer of patient. Use of a written note sheet is completely acceptable for this purpose and many ambulance services already use such note sheets. The OEMS is in the process of developing a note sheet for this purpose for distribution. ANY WRITTEN NOTE SHEET WILL NOT REPLACE THE PROCEDURAL USE OF AN E-PCR ON EVERY RESPONSE.
  - The narrative provides a summarized statement of treatments performed and observations made that many clinicians use to guide their in-hospital treatments of patients.

- Quick Reference for Insurance Payors
  - The basis of successfully filing for insurance payment for EMS services is the accurate reporting of indications, interventions, and responses on EMS reporting documents.
  - Mandatory refiling and review processes are often associated with insufficient and vague charting of rationale and services provided to insurance clients. Repetitive processes serve to slow down payment flow and to increase the costs of filing with avoidable repetition.
  - Insurance adjusters and investigators often center their documentation review of patient care performed on the narrative section of the e-PCR. The necessary documentation may exist in the elements section of the report but may be inadvertently missed by reviewers resulting in an extended or repeated review process for the individual call.

- Quick Reference for Medico-Legal and Investigators
  - In a legal review, if the reporter did not write an action down its completion will remain in question. ("If you didn't write it down you didn't do it.")
  - Observations of EMS personnel are often important in determining safety of a scene. Those observations should be recorded in situations where probable crime investigations will occur. Such situations include, but are not limited to, murders, suicides, assaults, accidents, etc.

- Any observation made that affects decisions, or may reasonably be questioned later, should be recorded.
- Generally, it is preferable to have recorded an observation unnecessarily than to have omitted an observation that should have been recorded.

☐ BEST PRACTICES FOR ELECTRONIC SUBMISSION

1. Contracted e-PCR platforms are responsible (per NEMSIS) for provision of a feature that validates/indicates that a written e-PCR will pass Alabama's (or, nationwide, the state of operation) Schematron. Technically an e-PCR should not be allowed to submit unless it will pass the state's Schematron.
2. Services have the option to set their submissions for either immediate submission by the reporter or delayed submission pending supervisor review. No matter which method is used the Emergency Medical Provider Service is responsible for assuring that an electronic patient care report is submitted to the Alabama EMS Repository for any response their service performs, and that the e-PCR is submitted within the required time period.
3. Alabama OEMS provides several free platforms which can be used by Emergency Medical Provider Service supervisory staff to monitor the e-PCR submissions and to explore the dynamics of the data recorded by their Service.
    - Submission Summary Email
        - May be requested by any Alabama licensed Emergency Medical Provider Service.
        - Receives automated email on Monday mornings at 07:00 with number of unique e-PCRs received in previous seven days (previous Monday at 00:00 to Sunday night at 23:59). Should be compared to run logs for same time period.
        - May designate two recipients per EMPS.
    - Alabama NEMSIS V3 Submission Website
        - May access and download State-form copies of e-PCRs.
        - May lookup e-PCRs by Dispatch Notified Date, Incident Address, Incident #, PCR # or submission times.
        - May search for e-PCRs by Crew Member ID (License Number), Recorded Disposition, Incident Number, ATCC Number, Date of Incident (Range) Incident Street Address, Incident City, Incident County, Patient Data (SSN, Date of Birth, Age, First Name, Middle Name, Last Name, Destination Code and Dispatch Complaint).
        - May review submission groups (submitted e-PCRs by groups submitted).
        - May review submission statistics (report counts, passes and fails).
    - NEMSIS Data Portal (Dashboard)
        - Has preset tools set up to review and count Incident Data, Medication Data, Procedure Data and Report Submission Data.
        - May download counts and statistics in EXCEL sheets.
        - May download graphs in differing formats.
        - Has preset graphs that may be copied and pasted into performance reports.
        - IS DESIGNED TO AID IN WRITING REPORTS FOR REVIEWS, QA, QI, ETC.

☐ SUMMARY

1. The electronic patient care report (e-PCR) is the legally required record of a unit's response to a call for help. Each records the disposition of the service and individual-level duty to act and the patient/patients involved.
2. An e-PCR must be written and submitted for all EMS responses.
3. It is the legal responsibility of the unit's crew to complete an appropriate e-PCR for any response upon which they are dispatched or answer.
4. It is the legal responsibility of the Emergency Medical Provider Service (EMPS) to provide a platform for the purpose of e-PCR completion and submission for their member's employment-related and assigned responses. It is further the responsibility of the EMPS to assure that all employment-related e-PCRs are completed and submitted within the time limits of the EMS rules.
5. The elements of the e-PCR are designed to quickly record data that are descriptive of the parameters of the response, which can be used to categorize findings and create an individual record for a procedure/medication administration, and which do not require verbiage to explain.
6. The narrative of the e-PCR is designed to "tell the story" of the response and disposition of the response and describe the responder's rationale for decisions made and actions taken. It summarizes the call in a way that can be reviewed by clinicians, insurance personnel, law enforcement personnel or attorneys to explain the steps taken by responders to best care for a patient's interests and to meet the requirements of the standard of care for the situation. The narrative is considered the most important aspect of the e-PCR. It is a text box and can contain a virtually unlimited amount of text, making it far superior to previous hand-written reports. <u>The quality of narrative is often used to judge the competence and ability of the crew.</u>
7. Several free-access electronic tools are made available to Alabama-licensed Emergency Medical Provider Services upon request to enhance EMPS surveillance of its electronic reporting and to aid with quantification of data for the purpose of QA, QI and response reporting.