

# Five Good Reasons for Better EMS Documentation

**Documentation, like any clinical intervention or manual task, is a skill that can be taught, practiced and improved upon**

By Douglas M. Wolfberg, Esq., and Stephen R. Wirth, Esq.

Ask many EMS providers, and they'll tell you documentation is one of the least favorite parts of their job. However, next to patient care, it is one of the most important things we do. Many providers do not appreciate the varied and critical purposes served by their patient care documentation. Some simply see their patient care reports (PCRs) as documents casually tossed aside or ignored at the emergency department, or evidence that "can and will be used against them" in a quality improvement review. A full appreciation for the importance of EMS documentation comes from a deeper understanding of its uses and applications in five critical areas: clinical, operational, legal, financial and compliance.

This article looks at these five purposes of documentation. Not all of these issues apply to every EMS provider. For instance, some providers work in systems that do not bill for their services, so the financial aspect of documentation may not apply. Nevertheless, EMS providers are likely to move between several jobs during their careers. Thorough documentation skills must be "portable," so you can remain marketable in the workplace.

## **Clinical: For the Record**

First and foremost, EMS documentation serves a vital clinical purpose. It is the record of your assessment and care of patients. It becomes part of the patient's medical record, both at the receiving facility and within your EMS organization. EMS PCRs record the role EMS providers played in the continuum of care for that patient. An accurate record of the care provided in the field can play a critical role in the subsequent treatment of patients in an ED, trauma center or other receiving facility. An effective EMS chart informs subsequent caregivers of the patient's presenting signs and symptoms, the caregiver's assessment of the patient's condition, attempted EMS interventions, successful EMS interventions and the patient's response to those interventions.

Because PCRs are primarily clinical documents, it is important that EMS providers furnish their documentation to subsequent caregivers promptly and efficiently. For instance, ambulance crews may benefit from the information contained in the first-responder's PCR. Hospital EDs may benefit from the information in the ambulance PCR. A physical therapist providing subsequent rehabilitation to an injured patient during their recovery may benefit from seeing a complete clinical presentation of the patient's injury, from the time of the incident forward.

While it is not always possible to provide a copy of a completed PCR to the next level of provider at the time of service, information vital to that provider's assumption of care should be communicated. For instance, if a paramedic administers a medication while en route to the hospital, the ED physician needs to know that so as not to inadvertently overdose the patient on more of that medication, or inadvertently administer a drug that could negatively interact with one given in the field. In some states, EMS laws or regulations establish specific time frames,

such as 24 hours, within which an ambulance service must provide a full PCR to the hospital. Check your state law for any such guidelines that apply to you.

EMS providers sometimes assert that their documentation is ignored by the hospital or the ED physician, and cite this as a reason to be less complete, accurate or timely in their documentation. While EMS providers may not always witness their PCRs being carefully reviewed by an emergency physician, they should be aware that their documentation becomes part of the patient's medical record and will be reviewed and scrutinized.

Stark evidence of the importance of EMS documentation in the continuum of care can be found in a 2002 court case where the completeness of an ambulance crew's PCR was the central issue. According to the court's unpublished decision in *DeTarquino vs. the City of Jersey City (NJ)*, a young man was involved in an altercation with police officers, subdued and taken to the police station. The officers subsequently called EMS to the station because of the patient's apparent injuries. During the course of EMS treatment and transport, the patient reportedly vomited. However, this fact was allegedly not documented on the PCR. The receiving facility to which the patient was transported—a community hospital emergency department—evaluated and discharged him. The patient was returned to police custody. At the police station, he subsequently developed a grand mal seizure. EMS was called again, and this time the patient was transported to a trauma center. He was later pronounced brain dead, and the cause of death was determined to be epidural hematoma.

Following the patient's death, his family brought a lawsuit against, among others, the ambulance service and the individual EMS providers. Their legal theory was that the EMS crew was negligent—not in its patient care, but in its documentation. If, they argued, the EMS crew had documented the fact that the patient vomited, as the family claimed, the first hospital might have recognized this as a sign of a potentially serious head injury, and might not have discharged the patient. The state's court of appeals agreed, and held that the state EMS Act immunity provisions did not protect providers from negligent documentation—only from negligence in the actual performance of patient care.

While the *DeTarquino* case is applicable only in New Jersey, it is instructive on the importance of accurate documentation from the clinical perspective. It also emphasizes the importance of writing a complete EMS chart.

In addition to the clinical uses of EMS documentation in the real-time rendering of patient care, documentation also serves another vital clinical purpose: the assessment and improvement of that care in the future. Documentation is central to quality assessment and improvement activities in EMS. It is our ethical imperative (as well as our legal duty in most states) to participate in a QA or QI process so that the effectiveness of our care can be continuously monitored and improved.

### **Legal: CYA**

Of course, EMS documentation serves an important legal purpose. In the event of a lawsuit like the *DeTarquino* case discussed above or any case alleging patient care malpractice by EMS providers, your documentation will invariably be among the first things reviewed. The central issue in a malpractice case will be whether the EMS providers met the applicable standard of care. The EMS PCR will be the best record of that fact. It should also be a contemporaneous record of that fact. This means the PCR should be written at or as close to the time of the incident as possible, thus constituting the most timely record of your care. A contemporaneous

PCR is usually more reliable than a provider's memory when sitting on a witness stand months or years after the fact.

One of the first things that most plaintiffs' attorneys will do when assessing a possible malpractice case is to review the documentation of the potential defendants, including the EMS providers. Most often, this review will occur in consultation with an expert witness, such as an emergency physician retained to help guide the attorney through the clinical appropriateness of the care and documentation. If an EMS chart is thorough, well-documented and reflective of the appropriate standard of care being satisfied, a reputable expert witness may well advise the attorney that there is no viable case to be had against the EMS providers. While it is often unlikely that a good PCR will "scare away" a plaintiff's lawyer, it is a possibility, especially when coupled with the hurdle of legal immunity for acts of ordinary negligence that EMS providers in most states enjoy.

From the legal perspective, EMS documentation should also be thought of as the provider's "substituted memory." In most states, the plaintiff has a fairly long period of time after the incident to initiate a lawsuit. This period is set forth in the statute of limitations. While it varies from state to state, the statute of limitations is most often measured in years (often two years). Memories can fade quickly though, and recollections of patients can blend together-especially after a few hundred calls. A well-written and descriptive PCR that creates a clear picture of the patient can trigger your memory of other important details of the call that are not documented on the chart.

Even if a lawsuit is brought immediately after an incident, it could still be months or years until the case moves into the discovery phase, where the EMS provider is likely to be giving a deposition or sitting on a witness stand. The farther removed we are from the actual event, the harder it becomes to recall the facts and circumstances of that event. When testifying months or years later, and trying to demonstrate that your treatment met the applicable standard of care, your documentation will often be the only thing you can rely on to help you paint that picture for a judge or jury.

Because of the importance of the EMS chart as a legal document, it is vital that the integrity of the PCR be ensured. It is permissible to make late entries or write an addendum to your chart, but this should, whenever possible, be done as soon as possible following the incident. The longer after the incident you make such a change, the more it will look like a self-serving effort to make the chart look like something you wish had happened, not something that actually happened. Over time, we often subconsciously gloss over our mistakes. Documentation recorded long after the fact can raise many troubling issues when you have to defend yourself on a witness stand.

### **Operational: Data Drivers**

Documentation forms the backbone of many operational issues in the delivery of EMS. For instance, times documented on PCRs (and from other sources, such as dispatch records or device time clocks) are necessary to track important performance measurements such as response times, call-to-intervention times, on-scene times, transport times and other such assessments.

EMS PCRs also form the basis of most regional and statewide EMS data collection systems. When aggregated and properly analyzed, field documentation can help drive many important system decisions, such as those regarding ambulance deployment, staffing, peak-demand utilization, disaster response and more. Data based on PCRs is also often used by policy makers

at the regional and state levels to make decisions regarding funding, training and the allocation of resources.

The previously reviewed QA/QI uses of EMS documentation are closely related to another critical operational use: training and continuing education. Ideally, documentation and the resulting data will help determine where an EMS organization needs to concentrate its efforts in personnel training, education and skill evaluation. For instance, if your organization's documentation reveals that a particular paramedic or group of medics hasn't performed an intubation in the past three months (or whatever period of time you happen to use), you may want to offer a practical skills-oriented continuing education or in-service program on airway management. Or perhaps you could arrange for those medics to perform a clinical rotation at a local hospital or spend some time in a simulation lab.

### **Financial: The Bottom Line**

As many providers know, documentation plays a critical role in billing and reimbursement. In fact, it is not an overstatement to say that the PCR is easily the most important document in this process. Even a cursory look at today's healthcare system tells us that billing and reimbursement are critical to the survival of almost any entity that provides medical care, whether it is for-profit, nonprofit or public.

Perhaps the financial realities of healthcare and EMS can best be summed up by the phrase "no margin, no mission." This means if we don't pay attention to our bottom lines, we won't be here to take care of the next person who needs our assistance. It is therefore incumbent upon every EMS provider (at least those who work in organizations that bill for their services) to make sure their documentation is capable of supporting a prompt and accurate billing decision. To be clear, this is not to say it is the responsibility of EMS providers to document in a manner that permits their ambulance service to always get paid. It is, instead, the responsibility of EMS providers to be complete, accurate and timely in their documentation, so that a prompt and compliant billing decision can be made.

Consider, for instance, the Medicare rules regarding medical necessity. Medicare, which is the single largest payer for most ambulance services (comprising 35%-50% of the revenues in most EMS organizations that bill for services), will only pay for ambulance services where other means of transport are contraindicated by the patient's condition. This is an exacting criteria-it means Medicare will not pay for ambulance services unless the patient cannot safely be transported by other means (e.g., car, bus, wheelchair van).

Medical necessity is presumed to be met when the patient experiences an emergency medical condition such as a myocardial infarction, stroke, fracture, hemorrhage or other serious and emergent condition identified by Medicare. These conditions deal with medical necessity. However, the level of Medicare reimbursement for a medically necessary transport is also based upon how the provider was dispatched. If the EMS dispatch meets Medicare's criteria for an "emergency" response, the ambulance service can be paid at a higher emergency rate, even when the patient's condition turns out not to be an emergency. Therefore, documentation of emergency calls should include the nature of dispatch, even if the patient's condition on scene turns out to be different. For instance, "dispatched by 9-1-1 for an ALS emergency for chest pains. Arrived on scene to find patient complaining of nausea x 2 days."

Emergencies are one thing, but it is altogether more challenging to meet Medicare's medical necessity criteria for nonemergency ambulance transports. Such nonemergency calls include the

transport of a patient from a hospital to a nursing home following discharge, or the scheduled transport of a patient from a nursing home to a dialysis clinic.

For nonemergency transports, Medicare requires either that the patient be bed-confined or that the patient's medical condition prevents safe transport by other means. To be bed-confined under the Medicare criteria means the patient is unable to get out of bed without assistance, ambulate and sit in a chair or wheelchair. From a documentation perspective, it is imperative that the EMS provider document things like where and how the patient was found and how the patient got to the ambulance stretcher. For instance, if the patient was found seated in a chair in her room at a nursing facility, then walked with assistance to the stretcher, these important facts should be documented. It is simply not enough to document merely that the "patient was placed on our stretcher and transported." The PCR must document how the patient was moved or otherwise conveyed to the stretcher.

Some ambulance service managers have suggested that if a patient was observed to be sitting or ambulating, their EMS providers should omit these facts from their PCRs, since they would not support a finding of medical necessity and would thus make it more difficult to bill for the transport. While it is true that a patient who was sitting or ambulating would not meet the bed-confined criteria, there may still be other reasons that transport by ambulance is required. It is the responsibility of the EMS provider to document these reasons. For instance, if a patient was ambulatory to the stretcher but required upper airway suctioning and oxygen en route to the facility, these facts would likely support medical necessity. Other reasons could as well.

If the patient does not meet the bed-confinement criteria or any other criteria for medical necessity, it is important that EMS field providers honestly and accurately document these facts. The willful failure to document findings that fail to support medical necessity could be just as illegal as the outright falsification of a chart to dishonestly make a particular transport billable. If the patient is ambulatory, the PCR should say so. If the patient did not require oxygen or airway management or pain control or cardiac monitoring or IV medications or any other therapy, the PCR should accurately reflect it. If, in the final analysis, the PCR does not meet the criteria to bill Medicare, at least a prompt decision can be made in the billing office. In such cases, the bill can be sent to the patient or the patient's financially responsible party. At least the billing office staff is not placed in a position of having to guess or assume that medical necessity was met, and the ambulance service is not faced with a delay in its cash flow while it attempts to track down enough information to fill in the gaps on an incomplete PCR.

From the financial perspective, EMS documentation must include everything necessary to making proper billing determinations. For instance, the patient's signature, or that of an authorized signer on the patient's behalf (such as the patient's legal guardian or whoever holds their healthcare power of attorney), in order to assign the patient's benefits directly to the provider of healthcare services. It could take the billing office days or even weeks to track down a signature that could have been obtained in mere moments in the field at the time of service. If a patient cannot sign because of their condition, the crew should document why the patient is unable to sign, not merely that they are.

### **Compliance: Following the Law**

Finally, EMS documentation serves an important role in the overall compliance of the organization. Compliance in this context essentially means that the organization is operating in adherence with all applicable contracts and local, state or federal laws, such as response time standards or other performance requirements. At the state level, there are typically minimum

staffing and personnel requirements, and compliance with these can be readily ascertained with reference to your EMS documentation.

At the federal level, myriad laws and regulations pertain to EMS and ambulance services, and field documentation is often the best proof of compliance with them. For instance, OSHA requires the availability and use of personal protective equipment to prevent exposure to bloodborne pathogens. HIPAA requires we give most patients privacy notices and make good-faith efforts to obtain their signed acknowledgment that they received them.

Additionally, because Medicare and Medicaid benefits, as well as those paid through certain other government programs, are public funds, there are a host of federal laws and regulations that apply to billing for them, and then to keeping the money once your organization receives it. Medicare audits are fairly common and usually involve a Medicare carrier or other government contractor (sometimes a specialized fraud investigator) retrospectively reviewing an ambulance service's charts, invoices and other records to ensure that payment was appropriate. These audits and investigations often compare the EMS documentation to the documentation from other providers in an attempt to ascertain a more complete picture of the patient's condition.

It is not, for example, uncommon for an audit to uncover evidence from a nursing home chart showing that a patient was ambulatory immediately prior to being picked up by the ambulance, even though the ambulance crew may only have observed the patient in bed the entire time. Even though the standard for reimbursement is bed confinement at the time of transport, Medicare may use this information from the nursing home chart to retrospectively deny payment to the ambulance service, requiring that the organization repay any amounts it received for those services. For this reason, field documentation should be supplemented with thorough and effective call intake documentation. Specially trained call intake personnel should obtain detailed information for nonemergency transport requests prior to the time of service so that a complete picture of medical necessity can be documented.

### **Conclusion**

By understanding the five most critical uses of EMS documentation, EMS providers can gain a fuller appreciation for the importance of their PCRs. Hopefully this appreciation will translate into more complete, accurate and timely charting by EMS providers in both emergency and nonemergency situations.

# **El Dorado County EMS Agency Accreditation Required Reading: Article 1**

## **Tips from an Expert Witness**

By Robert G. Nixon, BA, EMT-P

There may come a time in your career when a call does not go quite right. Maybe someone will forget to do something, or someone will make a treatment mistake that jeopardizes the life of a patient. Maybe, despite everyone's best efforts, the patient succumbs anyway.

It's not unheard of that surviving family members file a lawsuit against the crew and the department, seeking redress for perceived wrongdoings. The plaintiff's attorney may well hire a consultant to testify against the EMS crew, and the defense attorney may employ an expert of its own to defend the crew's actions. On either side, the expert witness will examine all the information and give an opinion about the case.

But who is this person, and how can an EMT or paramedic lessen the risk of being challenged by him? Having served as an expert witness in many cases, both for and against EMS professionals, I can provide an understanding of what experts do and offer tips on how to avoid excess and sometimes unnerving scrutiny at their hands.

### **The Expert Witness**

An expert witness is, by one definition, a person with knowledge on a topic that the average person does not possess.<sup>1</sup> A better definition is a person with special training or experience in a technical field who is called on to state an opinion on those technical matters, even though the witness was not present at the event. This contrasts with the role of a nonexpert witness, who is permitted to testify only to observed facts.<sup>2</sup>

The expert who, early in the process, is provided with documents relevant to the case doesn't just testify in depositions or at trial. He often acts as an advisor throughout the entire lawsuit, suggesting questions that his employer should ask other witnesses.

### **Triggering Scrutiny**

Certain things trigger closer scrutiny by an expert witness, and some of the questions that result can be blunt, disconcerting, or even embarrassing. Here are several ways you can avoid follow-up questions and critique.

1. The patient care report must be an accurate reflection of what happened while you were with the patient. The report is a detailed account from the time EMS arrives on the scene until the patient is turned over to an emergency department or another responding agency. Documentation must include where the patient was found; the patient's surroundings, if appropriate; and any assessments, treatments, and responses to treatments.

2. Incomplete or unchecked boxes invite questions. Fully complete any patient care document. Do not leave pertinent boxes or findings omitted or blank. As an example, a patient care report on a patient with a potentially serious head injury did not have all components of the Glasgow Coma Scale checked. The patient, who was inebriated, had fallen, sustaining a laceration to the back of his head. Paramedics treated the patient according to his intoxication and transported him to a receiving hospital that had no trauma facilities. The patient had sustained epidural and subdural hematomas that herniated the brain stem, causing the man's death. Questions that arose concerned the level of assessment the patient had been afforded.

3. If you don't write it down, you didn't do it or it didn't get done. This is an old adage passed along by instructors to nearly every EMT or paramedic. Believe it. If a patient is critically injured and the patient care report says nothing about taking spinal precautions, then such precautions were not taken. An EMS crew may religiously put trauma victims on a backboard, but the one time that it's not documented, it is inferred that the treatment was not performed.

4. If I don't write it down, they can't get me. This corollary to the above statement is a fallacy that too many people believe. Not documenting something because it might look bad provides a false sense of security. During document review, the expert witness will look for incongruities and start posing a lot of disturbing questions based on them.

5. Poor spelling doesn't count, but poor handwriting can pose problems. Not everyone is good at spelling, especially with medical terminology. A few misspelled words are of little consequence. If the report is nearly illegible or disorganized, however, the person evaluating it may question the care given.

6. When in doubt, use national standards. Deviation from local protocol or standing orders should be based on nationally accepted standards. Be able to justify patient care decisions based on the EMT and paramedic textbooks used in training programs or on local policies covering scope of practice. Don't base them on a recent journal article or anecdotal information. When deviating from



protocols, do so in the best interest of patient care, and document everything. There will be questions about it.

7. One set of vital signs cannot tell you that a patient is stable. A 40-year-old man was driving to work when he was involved in a motor vehicle accident in which his car was struck on the driver's side. On initial questioning, the man complained of left chest, abdominal, pelvic, and thigh pain. His initial vital signs were BP: 118/98, P: 90, R: 22. A paramedic on-scene declared the patient "stable." Not exactly. The pulse pressure (systolic minus diastolic) is less than 30 mm Hg (normal is 30 to 40 mm Hg), indicating vasoconstriction and, perhaps, hypovolemia and stage 2 of shock.<sup>3,4,5</sup> Although pulse pressure by itself is not conclusive, it suggests that follow-up assessments are needed. Subsequent vital signs were BP: 90/68, P: 110, and R: 24. At the hospital, the admitting diagnosis was left hemothorax, ruptured spleen, ruptured bowel, fractured pelvis, and fractured femur. In another example, a 40-year-old woman was driving when her car collided with another vehicle. The paramedics on-scene provided a radio report: Patient is complaining of left shoulder pain with no obvious trauma and full range of motion. Slight abdominal tenderness. Vital signs are BP: 128/90, P: 88, R: 20. The woman was transported to the emergency department and placed in a triage room to await X-ray and rule out shoulder injury. Forty-five minutes later, she was found in cardiac arrest and could not be resuscitated. Cause of death was hemorrhage from a ruptured spleen. One question among many that arose later was if the paramedic was familiar with referred pain to the left shoulder secondary to blood irritating the diaphragm after splenic injury. Tips from an Expert Witness By Robert G. Nixon, BA, EMT-P There may come a time in your career when a call does not go quite right. Maybe someone will forget to do something, or someone will make a treatment mistake that jeopardizes the life of a patient. Maybe, despite everyone's best efforts, the patient succumbs anyway.<sup>6</sup>

8. A blood pressure by palpation provides incomplete information. A palpated blood pressure is occasionally permissible during repeat assessments; however, reporting only the systolic blood pressure does not give a full picture of the patient's perfusion status.

9. Repeat vital signs are rarely the same. On many patient care reports, vital signs are always the same. One report documenting a patient with a significant head injury had the following recorded vital signs:

BP: 124/88 R:16

BP: 124/88 R:16

BP: 124/80 R:16

Vital signs taken several minutes apart are rarely the same. A blood pressure and pulse that do not change invite scrutiny and the suspicion that the assessments were actually not made.

10. The narrative must make sense. A 38-year-old woman called 911 after unsuccessfully treating her asthma with five albuterol treatments. After a sixth treatment on the scene, she was placed into the ambulance and transported to the hospital. During the trip, the woman went into respiratory arrest. The paramedic intubated the patient in a moving vehicle and declared the patient had clear breath sounds bilaterally. No pulse oximetry, esophageal detection device, or capnography was used to verify tube placement. Unfortunately, the intubation attempt resulted in esophageal tube placement that was not recognized until arrival at the emergency department. Some of the critical questions that might be posed afterward include the following:

- How can you hear clear breath sounds in a status asthmaticus patient?
- How were you able to detect breath sounds in a moving ambulance, especially one using its sirens?
- Did you use any means other than auscultation to determine tube placement?

## **Importance of Documentation**

It is difficult to remember all of the nuances of patient care, and something is bound to go wrong during a call. When lawsuits are filed and expert witnesses are called in, patient care reports and other documents come under intense scrutiny. Attorneys can pose challenging questions that invite EMS professionals to doubt their abilities.

Even though the care they provided was above reproach, EMTs and paramedics frequently make mistakes in documentation, which in turn invite close evaluation and questioning. Proper and thorough documentation of what happened while in contact with the patient may help defend against litigation.

## **How to testify**

- Review your report before coming to court.
- Bring your report to court to refresh your recollection, if needed, on the stand.
- Wear a suit when possible. Otherwise, your uniform will suffice.
- Show up one half-hour early.
- Once in the courthouse, know that jurors are everywhere, watching everything, listening to everything. You are being evaluated by them even when you are in the hallway. Do not discuss the case.
- Speak with a loud and booming voice from the stand.

- Be confident.
- You may look at the attorneys asking you questions, and you may look at the jury to emphasize particular points, but be yourself while speaking.
- Listen to the question.
- Answer only the question asked.
- Don't add information that is not asked.
- Don't fill in awkward silences with testimony that is not called for by the question.
- You may state that you don't understand a question when you don't understand it.
- You may state that you didn't hear a question when you didn't hear it.
- Show respect to the attorneys from both sides, even if the other side is trying to provoke you.
- Don't give equivocal answers, whenever possible.
- Be definite when you are definite.
- Don't say, "to the best of my recollection U."
- If an objection is sustained, you may not answer a question. If an objection is overruled, you must answer a question.
- You are not the police or district attorney investigator in this case. Your observations are limited to treatment of a patient or to some other aspect of being a first responder; therefore, you are not responsible for taking complete statements or observations from a crime scene

## Critical thinking

The expert witness forms opinions using what is known as critical thinking. Critical thinking is not using thoughts to merely criticize; it is a way of interpreting, analyzing, and evaluating information in such a way as to form impressions, explanations, or inferences. Peter Facione of Santa Clara University explains these components as follows:

**Interpreting** Understanding and expressing, without bias, the meaning of events, situations, and data.

**Analyzing** Examining ideas and concepts behind experience, information, statements, and data.

**Evaluating** Assessing the credibility of statements made or actions taken in a given situation.<sup>1</sup>

The opinions or explanations derived from critical thinking form the basis of the expert witness' testimony.

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# **El Dorado County EMS Agency Accreditation Required Reading: Article 2**

## **If You Didn't Write It, You Didn't Do It**

By Drew Fried

EMS professionals—both paid and volunteer—will agree that the hardest part of their job is the paperwork. What most of them do not understand is that proper documentation is for their protection. EMS documentation is a vital part of being a prehospital care provider. Good documentation is one of the best tools to protect you from successful lawsuits. You might be the best EMT in the world, but it means nothing if you cannot prepare the required documentation.

A Patient Care Report (PCR) is a legal document. It serves as the record of care you and your crew provide to the patient. The PCR becomes part of the patient's hospital record, describing your assessment of the patient and the care you or any bystander may have provided.

PCR formats differ throughout the country. Most states require the use of a standard format. Others leave the monitoring of documentation to the local department of health or even the local agency. With the growing use of computer technology, some PCRs are entered directly into laptop computers or PDAs, and others are prepared using a Number 2 pencil on a Scantron-type report. The pitfall of electronic PCRs is that they are not prepared in your own handwriting and therefore do not provide you a sense of ownership. Also, a Scantron-type report does not give you as the care provider an opportunity to write in your own factual comments. You must rely on the check boxes on the PCR to cover all of your assessment and treatment.

The most commonly used PCR is a written report that combines the check-off boxes and an area where you can add your assessment findings and record of treatment. This type of report gives you the most protection.

### **Who Will Read Your Report?**

In the course of business, your PCR will be reviewed by a number of people. The first will be the hospital staff, which might review the PCR to check your patient's status at the scene and during transport. The staff will also need to see what treatment you provided. If your supervisor responds to the scene, he might need to see the report to determine if the proper care was provided.

Depending on your state's regulations, your squad might be required to conduct quality assurance (QA) reviews of members' PCRs. To conduct the review, the QA coordinator needs to read your PCRs to make sure that there are no errors.

If necessary, your agency's lawyer might need to review the PCR. This could be in preparation to defend you in a court or as evidence related to a crime. During the course of the trial, the plaintiff's lawyer will have access to your PCR, too.

## **PCR Preparation**

The most common error on a PCR is one of omission. It is important that PCRs are filled out clearly, completely, and carefully. Take your time preparing the report. Make sure you have completed all of it before you submit it to the hospital staff. Remember: The run is not done until the paperwork is complete.

In preparing your report, make sure to include only the facts. In the narrative sections, include any significant findings and important observations about the patient and the scene. Remember that objective information is information that is verifiable and supported by fact. When you do record subjective information, be careful to record only pertinent information about the medical circumstances of the call.

Your opinions or feelings should not be included in the report at any time. Your PCR is not the place to present your own conclusions about the incident. Your report should include normal everyday language and should not include radio codes. Since lay people could read your report, use only standard abbreviations. Spell words correctly, especially medical terms. Above all, fill in the form completely.

## **Falsification Issues**

Prehospital care providers frequently make grave mistakes when filling out PCRs. Some of these errors could cost you your job, your certification, and even your freedom.

The first thing to remember is that if you forget to write something down, the procedure to add it after you submit the report can be somewhat involved. The additions on the agency's copy should be in different color ink and in the same person's handwriting. You then must make sure that a copy of the revised report makes it into the patient's hospital record.

It's a good idea to send a notarized letter along with the revised report, requesting that the revised report be placed in the hospital record. Advise the hospital not to discard the original record; you want to establish that there was an omission you corrected.

Should you realize that you made a mistake before you submit the report, the procedure is a lot easier. First, do not try to cover up the error with correction fluid or by erasing it. Put one line through the error, so your mistake can still be seen. Write the corrections next to the error, along with your initials, so it looks like this:

The patient was complaining of pain in his ~~left~~<sup>DF</sup> right hand.

The worst thing you can do on a PCR is lie. All of your entries must be truthful, including vital signs. Record only vital signs you actually take. Never indicate any treatment that did not take place or untruthful assessment findings.

## **Refusal of Care**

Many times, EMTs arrive at the scene only to find that the patient does not want to be treated or transported to the hospital. Before leaving the scene, try to persuade the patient to go to the hospital. You will need to inform the patient why he should go to the hospital and what may happen if he chooses not to go. Make sure to document any assessment findings and all emergency care you provided. Document that you have explained the consequences of failing to go to the hospital and exactly what you told the patient. If appropriate, offer alternative methods of getting care. Make sure the patient reads and signs the medical release (RMA), and have a family member, police officer, or bystander as a witness. Remember, your partner cannot be the only witness.

## **When To Use a PCR**

A PCR should be used for every patient on every call to which an EMT or paramedic responds. It will be the EMT's only record of care given at the scene. The PCR not only protects the prehospital care provider but also gives the hospital access to information about the patient at the scene and during transportation. The information recorded by the prehospital care provider documents whether the provided treatment helped the patient and what additional assessment findings were made during transport. A PCR also provides a standard format for documenting the care given.

## **Special Documentation**

When assisting with the administration of both preprescribed or agency-carrying medications, the prehospital care provider should note the name of the medication and the dose taken by the patient prior to the arrival of EMS. It is important to note the time and dosage of medications administered to or taken by the patient. Any time a patient receives medication, any changes in the patient's condition should be documented.

## Treatment Documentation

One of the most important things to document clearly is the treatment of the patient. When documenting treatment, include all of the treatments provided. Some PCR forms do not leave enough room for treatment documentation but provide check boxes next to standard treatments. EMTs need to document treatment in greater detail than these check-off boxes allow. By checking "airway maintenance," EMTs are not released from having to document the response to the airway management. It is important for EMTs to get into the habit of writing a narrative describing the care given.

## Good PCR Is a Tool

Remember that your PCR is your only proof of the patient's condition or the treatment you gave. It sometimes takes years for a civil case to go to court, so your PCR will be the only thing that will refresh your memory. A good PCR is a tool for you; an improperly completed one is a weapon against you. Your PCR is a reflection of you, so remember that spelling, grammar, and penmanship count. Write a clear, complete, and careful report.

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## MVA sample narrative

**"On arrival at the scene of an MVA,** manual stabilization of the neck was held from the front of the patient. A second crew member entered the vehicle and positioned himself directly behind the patient and took over stabilization of the head and neck. Pulse, motion, and sensitivity (PMS) checked in all four extremities. A stiff neck collar, size regular, was applied. KED applied to the patient. Pulse, motor, and sensitivity checked in all four extremities. Removed from the vehicle on a long trauma board."

**If you were only to check off the box** indicating "spinal immobilization," you would not have indicated anywhere that you applied a cervical collar, checked for PMS, or removed the patient on a long trauma board. You could try to defend that you applied the collar, but the ground rule is, "If you didn't write it down, you did not do it."



**Documentation includes all significant** positive and negative assessment findings. If the patient's condition changes, write it down. The hospital needs this information. This would include the patient's denying pain, difficulty in breathing, or a loss of consciousness.

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## **El Dorado County EMS Agency Accreditation Required Reading: Article 2**

### **Proof of Life**

Why we must make every possible effort, even when patients 'look' dead

By David Erdman, EMT-P

In the "Lazarus Phenomenon," patients show signs of life after being declared dead; however, this "recovery" sometimes represents providers' failure to properly assess an apparently dead patient and can have disastrous results.

Erica Smith, 23, was riding in a friend's car when a vehicle coming in the opposite direction crossed the lanes of a San Antonio highway and hit the car carrying Smith head-on. The horrific crash occurred at 3:50 a.m. on a cold morning in December 2007.

San Antonio and South Texas Fire-Rescue crews triaged the scene and declared Smith dead after noting that her brain was partially exposed from an open head wound and brain matter was on the dashboard of the vehicle. She was covered with a tarp and left sitting upright, still trapped in the mangled wreckage that was once her friend's car, while the providers turned their attention to the other victims. The drivers of both cars and the remaining passengers were treated for their injuries and quickly transported to the hospital.

More than an hour after the fateful crash, a medical examiner's investigator arrived at the scene and, to his surprise, found Smith still breathing. He asked police to recall the fire department. The investigator repeated what he'd seen to the arriving fire rescue personnel. After calling their supervisor, the fire-rescue personnel agreed to "check the victim out" and told the investigator who summoned them they would free Smith from the car, "but if at any time during the process, she stopped breathing, they would halt the process."

Smith was extricated, treated and airlifted to Brooke Army Medical Center nearly two and a half hours after the crash that ultimately claimed her life. The case received national media attention and resulted in the individual responders being disciplined by the fire department. The Texas Department of State Health Services notified five of the responders of intent to pursue disciplinary measures. Erica's mother reportedly said, "Erica would have had a better chance of survival if treated right away." But we'll never know.

### **Back from the Dead**

It's commonly called the "Lazarus Phenomenon." It sounds like a bad tabloid

headline, but it's actually a term generally applied to people who surprisingly "return to life" after being declared dead in the field by EMS providers, either after resuscitative efforts have ended or after responders have decided not to undertake them. In the latter scenario, a split-second decision can leave a potentially viable patient abandoned, EMS providers in jeopardy, and an organization scrambling for answers while fending off litigation, bad press, compromised public confidence and state EMS inquiries.

The cases presented in this article, including the introductory case, are but a sampling of incidents, going back to 1982, concerning this phenomenon. Although some cases draw national media exposure, the majority of "Lazarus" cases generally don't get significant media attention.

The terms "Lazarus Phenomenon" and "Lazarus Syndrome" are derived from the story of Lazarus in the Bible. Lazarus dies and is "brought back to life" by Jesus several days later in front of a crowd full of mourners. Resurrection after dying was quite a crowd pleaser some 2,000 years ago, but the "resurrection" of a declared dead patient by EMS in modern times is not likely to produce letters of commendation or any other meaningful accolades.

A Google search on "mistakenly declared dead" or "declared dead by paramedics" (or similar terms) will turn up an abundance of articles. After sifting through a few pages, you'll understand that this situation is not specific to EMS. Hospitals, nursing homes and other health-care facilities have made the same mistake.

In fact, much has been written about the subject in various medical journals. A 2001 *Anesthesia & Analgesia* article discusses the case of a 66-year-old man who suffered a cardiac arrest while undergoing surgery to repair a leaking abdominal aortic aneurysm and experienced a return of spontaneous circulation a full seven minutes after the aggressive resuscitation effort ended. Surprisingly, the patient survived the event and, after a five-week follow-up exam, he appeared to have fully recovered and has since resumed his normal lifestyle.

## **Case #2**

In October 2005, 51-year-old Louis Golson was declared dead by EMS.

His sister asked her husband to check on Golson, who lived downstairs in a basement bedroom. He found Golson unresponsive. The couple called 9-1-1.

After reaching the residence, EMS personnel emerged from the basement a short time later and told the family that Golson was dead. They explained to family members that Golson "had died in his bed and that rigor mortis had begun to set in." It's not clear what criteria, observations or equipment were used to make this determination.

Another sister arrived on scene and descended the stairs into the basement just in time to see her brother before his body was removed from the scene. She reportedly saw Golson open his eyes and move his arm. Police officers arrived at the scene and examined the victim only to find that he was, in fact, alive. Golson was finally rushed to an area hospital, where he was treated for a condition related to his diabetes.

According to news reports, the EMS crew members were investigated by their employer to determine if disciplinary action was warranted.

### **Case #3**

On Jan. 24, 2005, 27-year-old Larry Green stepped onto a highway in Franklin, N.C., one dark night and was struck by a passing car.

The head-on impact propelled Green 100 ft. in the air. He landed in a ditch and, according to published accounts, suffered extensive head and leg injuries. He lay motionless in the trash-strewn ditch with a pool of blood surrounding his head that was estimated to be a foot in diameter.

At 8:53 p.m., units from Franklin County EMS, Epsom Fire Department (EFD) and Louisburg Rescue were dispatched to the scene. The first emergency personnel arrived on the scene approximately one minute later.

One of the three EFD members, who was also employed as a paramedic with Franklin County EMS, examined Green. The paramedic found no carotid pulse, absent breath sounds, no chest movement and "massive head injuries" before declaring Green dead at the scene. The second unit on the scene from Franklin County EMS was carrying two more first responders. They met with the paramedic who initially examined Green, and it was determined that they did not need to examine him further. They covered his body with a sheet.

At 9 p.m., two personnel aboard the Louisburg Rescue unit arrived and met with the other responders on the scene, who told them that the victim sustained severe head injuries and was pronounced dead. Based on this information, the Louisburg responders elected not to examine the victim.

The Franklin County medical examiner, a licensed physician, arrived at the scene approximately 37 minutes after the initial crews were dispatched to the scene. He surveyed the scene and noted the victim's location in relation to his shoes, socks and pants. He examined other evidence at the scene, including the damage sustained to the car that hit Green. He then examined the victim while the initial first responders, joined by other members of the EFD, held up a tarp to shield the examination of the body from bystanders.

It was at this point, after seeing the victim's chest and abdomen move, an EFD member asked if Green was breathing. According to a report by the Franklin

County Attorney's Office, the medical examiner told the firefighters that the movement was the result of air escaping the body after being turned over during examination. The victim's broken leg was twisted upon examination and first responders state the medical examiner placed his finger in the wound on Green's head.

When questioned later, one first responder stated that they did not respond to possible chest movement, because they relied on the explanation of events provided by the medical examiner. Franklin County EMS policy states that resuscitation efforts should be undertaken immediately "if doubts exist."

Surrounded by paramedics, firefighters and a physician, all trained to save his life, Green was placed in a body bag, which was then sealed for transport. The victim was loaded into one of the rescue units that responded to the scene and transported to the medical examiner's office. The medical examiner began a second exam of Green, and it was during this exam that one of the paramedics present noticed the victim's right eye twitch several times. When she questioned the physician performing the exam, he reportedly replied that this was a muscle spasm "like a frog leg jumping in a frying pan."

Although the paramedic who witnessed the victim's eye twitch later stated that she was uncomfortable with the situation and related her feelings to other responders present at the medical examiners' office during the second exam, no one took the opportunity to look for other signs of life. After the second exam, Green's supposedly lifeless body was placed in a drawer and secured in the portable morgue.

At 11:23 p.m., the victim was removed from the drawer at the behest of state troopers for a third exam to determine from which direction the vehicle struck the car carrying Green. The medical examiner opened the body bag and saw Larry's abdomen move. He quickly called for EMS, who arrived and placed an ECG monitor on Green and discovered a rhythm. He was taken to Franklin Regional Medical Center by local EMS approximately two and a half hours after he stepped onto the road.

As a result of the Green case, five paramedics were immediately suspended by the county; two were eventually fired and stripped of their paramedic certification by the state. Other responders at the scene were placed under investigation.

Today, Green lives in a nursing facility. He's alive but permanently disabled. Green's parents filed a lawsuit on his behalf. Franklin County's medical examiner, Franklin County EMS, and Louisburg Rescue and EMS were named in the suit, which has garnered national media attention.

### **Avoid Snap Judgment**

There are some troubling similarities in the scenarios described. As my medical

director likes to say, "No one comes to work with the intent of doing the wrong thing." However, good EMTs and paramedics can make critical mistakes due to experience-based assumptions, misleading radio communications and bad information from other responders on scene. Moving forward and changing the way we deal with the "determination of death" may be as simple as changing the collective mindset to determining "proof of life."

An experienced EMT, paramedic or firefighter will see more dead victims in the span of their career than they care to recall. The dead come in a variety of conditions that can cause the most stoic EMS veteran to wince.

Can we count the number of bodies we've encountered that have begun the process of decomposition, testing the limits of our visual and olfactory senses? Can you remember the last five or 10 elderly victims you pronounced dead after their spouse woke up to find them cold and unresponsive? Do these images and experiences, etched deeply in our minds, become a permanent reference for later use in decision-making? Do we make quick judgments on whether a person is dead based on a graphic visual presentation and our past experiences with other dead victims? Have we become so accustomed to seeing dead people, many of whom are horribly injured and disfigured, that we're forever prejudiced in our clinical decision-making? Is there a bias, built up over years of dedicated service in prehospital medicine? In the cases described, the answer may be yes.

Even the most experienced and trusted medical directors appear concerned about the phenomenon. Laurie Romig, MD, the medical director for Pinellas County (Fla.) EMS, outlined concerns she had with regard to declaring patients deceased at crime scenes in a memo written in December 2007. Her memo, titled "Crime scene declaration of death," carried a warning to all her EMS providers. "I realize that there are some types of patients who, for practical purposes, can potentially be declared dead without following the requirements for applying the cardiac monitor and checking for pulse and respirations (decapitation, decomposition, etc.). I cannot authorize deviation from existing protocol ..." She goes on to say, "Stories about patients who have been declared dead and later found to actually be alive come across my desk at least several times a year. Fortunately, the stories haven't been from Pinellas County; we'd like to keep it that way." Good advice.

Ventura County (Calif.) EMS actually references "Patients Who Appear to be Dead" in its medical protocols authorized in December 2008. Its protocols outline a series of actions that must occur in logical progression before declaring someone dead.

### **Proof-of-Life Paradigm**

We can't change the past, but we can acknowledge the need for increased vigilance and make substantive changes for the future. To do that, it's essential to change our mindset from trying to determine death to uncovering proof of life.

EMS professionals can collectively change their approach by following some rules to eliminate the visual bias that may affect judgment and force reliance on our diagnostic skills and cutting-edge equipment to make these critical decisions. Consider adopting these proof-of-life guidelines:

- A BLS unit without the ability to interpret or monitor a heart rhythm unit should not determine death. Exceptions for obvious death can be found in many local protocols and may include decapitation, gross decomposition, massive crush injury that would include destruction of the heart, lung and/or brain, and gross dismemberment of the trunk. All other victims are examined by ALS personnel.
- Check for a pulse in more than one site.
- Listen for heart sounds with a stethoscope.
- Take a minute and look, listen and feel for breathing.
- No one is dead, until they're "wired and dead." The use of a cardiac monitor to check for a viable rhythm should be a mandatory step in looking for proof of life. Most protocols around the nation recommend that the patient be monitored for a full minute and a recording made of the entire process.
- Consider the various medical conditions, including diabetes, overdose, hypothermia and other factors that can cause a person to appear dead when they're actually alive yet unable to express that to you.
- Put a fail-safe plan into effect: The patient is initially examined by an ALS provider, then by a second provider (your partner or another similarly qualified responder on the scene), nearly concurrently, using the same proof-of-life guidelines, and both must agree with the determination of death. If there's any disagreement, resuscitation is immediately initiated.
- Take great care when pronouncing a patient dead after aggressively attempting resuscitation, especially when multiple medications have been administered. Many of the articles written about the Lazarus phenomenon occurring in the hospital setting seem to occur after resuscitative efforts have ceased. One article in particular may provide good advice for prehospital providers when recommending continuous ECG monitoring for 10 minutes after pronouncing death to ensure the patient remains deceased.

### **Conclusion**

It's our duty and obligation to ensure that if an opportunity exists for a patient to survive, we use our skills, tools and experience to give them a fighting chance at life. Acknowledge that there's a distinct difference between "looking dead" and "being dead." Don't let the victim's appearance or distractions on scene, no matter how overpowering, dissuade you from doing all you can to establish that the patient may be viable. You're the patient's last and best hope. Don't let them down when they need you most.

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