CGP119

PATIENT CARE DOCUMENTATION AND PATIENT CARE RECORD

POLICY AND PROCEDURE

LINK TO POLICY

LINK TO PROCEDURES & FORMS

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1. POLICY INTRODUCTION

The Patient Care Documentation and Patient Care Record (PCR) Policy and Procedure CGP119 aims to provide clear direction to ensure that safe and quality continuous care is delivered to patients and that best practice is ensured in all patient care documentation. It also ensures that all documentation is confidential and that National Ambulance (NA) complies with all legal and regulatory requirements. Where reference is made to the PCR, this encompasses the paper PCR and ePCR

The PCR /ePCR and all patient related information are legal documents and are part of the patient's health care record. It is essential that all patient care documentation produced by NA is comprehensively completed by all clinical staff after any call out, regardless of whether there has been patient contact.

The PCR contains vital data which is used in Key Performance Indicators, research and highlights trends; the PCR will be audited for completeness and clinical appropriateness.

The paper-based PCR is the default for when the ePCR is unavailable; ePCR allows for increased patient care by facilitating use of decision support tools.

2. SCOPE

This Policy and Procedure applies to all NA staff who make entries in the PCR, revise contents and any forms and review. It also applies to those who transport, store and audit the PCR and other patient documentation.

This Policy and Procedure applies to all documentation including patient care records, information and Communications Centre documentation and to both electronic (ePCR) and hard copy documentation.

The purpose of this policy and procedure is to give comprehensive direction on the completion, evaluation and audit of patient care documentation, including but not limited to PCR by National Ambulance (NA) clinical staff and to ensure availability to other relevant healthcare providers. It also ensures safe and confidential transfer of all patient related documentation and availability for storage and auditing purposes.

3. ROLES AND RESPONSIBILITIES

CAMO /DELEGATE

- The CAMO / Delegate has responsibility to develop, review and revise this Policy and Procedure as well as the content and form of the PCR, other internal patient related documentation and any associated training materials.

- Has responsibility for setting Key Performance Indicators and any metrics to monitor the quality of patient related documentation.
- Has clinical oversight for all assessment and treatment information recorded within the PCR

OPERATIONS DIRECTOR

- Has responsibility for implementation and monitoring of this Policy and Procedure.

CLINICAL GOVERNANCE AND AUDIT OFFICER

- Works under direction from CAMO / Delegate in enabling the implementation of this policy and the monitoring of PCRs is undertaken to ensure quality and accurate completion.
- To ensure PCRS's are managed in accordance to laws and regulations.

CLINICAL EDUCATION MANAGER

- Ensures the adaptation of clinical training programmes and mentorship of clinicians to promote the most accurate and complete documentation
- Ensures that Clinical Education provided to staff enables them to anticipate the required information to be included in the PCR

ORGANISATIONAL MANAGERS

- Must ensure PCRs are completed and reported as required by CAMO / Delegate and policy
- Must ensure that any approved changes to the PCR or other patient care documentation are communicated to all relevant personnel
- Must ensure that paper PCR is securely transported and received in the archiving area.
- Must ensure that any issues relating to breach of this policy are raised to Senior Management
- Have responsibility to ensure that any issues that arise from Patient Care Documentation are managed according to NA Policies

CLINICAL ADMINISTRATIVE ASSISTANT:

- Timely scanning, renaming, filing and archiving of the PCRs (paper PCRs, missing PDFs of ePCR, CAOS and ECG papers or other documents wherever applicable).
- Segregation of UAE national and non-UAE national Patient Care Records (PCR) and relative documents.
- Collating PCRs and ePCRs of MVA's for insurance claims.
- Allocating A3 paper PCRs and missing ePCRs as per clinical Audit criteria.
- Ensure PCR is delivered and archived securely.
- Should ensure keeping the paper PCR in a secure area before leaving his desk area
- Ensure to lock the computer if he need to do another task and should follow "ITP121 clear desk and clear screen policy"
- Ensure that archiving area and its key are secured.

CLINICAL STAFF

- Are authorised to make entries in the PCR and other patient related documentation in accordance with their scope of practice and agreed competencies
- Must read and understand and act in accordance with this policy and complete all mandatory fields and ensure appropriate Patient Care documentation in the PCRs
- Must ensure at least two patient identifiers are clearly documented (can be documented from verbal notification)
    - Patient name (via National ID, passport, verbal)
    - Date of Birth
- Must read and understand all other related Policies, Procedures and Guidelines
- Must complete the training package for Patient Care Record on the NA Learning Management System
- Should ensure keeping the paper PCR /ePCR in a secure area before leaving their work area
- Ensure to lock the computer /MDT if he/she need to do another task and should follow "ITP121 clear desk and clear screen policy"
- Ensure the PCR archiving area are secured and proper handover to logistic.

IT TEAM:

- Investigate and fix technical issues and update the ePCR
- Manage and maintain ePCR platform

4. POLICY

This policy and procedure must be read and understood in conjunction with International Best Practice as well as National Ambulance Policies, Procedures and Guidelines including but not limited to:

- CGP103 Patients' Rights and Responsibilities Policy & Charter
- CGP105 Consent Policy and Procedure
- CGP110 Patient Assessment Clinical Policy and Procedure
- CGP113 Pain Management Policy and Procedure
- CGP148 Clinical Audit Policy and Procedure
- CGG104 Discharge of Care Flow Chart
- CGP212 Glossary of Clinical Terms, Definitions and Abbreviations

This policy is to be used in conjunction with the NA PCR learning resources and any other learning resources that relate to Patient care documentation.

The Policy and Procedure details:

- Who is authorised to make entries in the PCR and other patient related documentation?
- Who can revise the content and form of PCR?
- Who can review and Audit the Patient Care Documentation and PCR?
- How Patient Care Documentation and PCRs are to be completed in accordance with the principles stated below and as per the procedure?

4.1. Confirm Patient Identity prior to completion of the PCR/ePCR

- Staff must confirm the identity of the patient prior to completing any patient documentation by requesting a form of identification, ideally an Emirates ID or passport so that two patient identifiers can be captured (Patient full name and date of birth). If there are 2 or more patients with identical name and date of birth ask for a further variable.
- Staff should ask the patient to give their full identification details through clear questions and not to read these identification details to them for confirmation.
- If the patient does not have the capacity to identify him or herself e.g. not well enough (including all unconscious patient) the identification must be initially confirmed by another person who can identify the patient like family member or other appropriate person.
- **Allergy status** - Once the type of the patient allergy is identified, this should be written and printed clearly in the specified section of PCR/ePCR.
- In the event of the patient's name not being known, then the identification must state: UNKNOWN MALE / FEMALE if possible.
- Custody of patients' belongings should not be accepted by NA staff, including valuables such as electronic devices, wallets, passport, or ID. All belongings should be handed to patient family/Hospital/Police and noted in the last part of the ePCR with the initials of the received person. Name and signature of the receiver with his/her ID and contact number the receiver and specify the list of items handover to the receiver

4.2. Accuracy and Fact

Accuracy is an essential requirement of all documentation. NA operational staff must distinguish between what they observe and what is stated by the patient. For example, a patient may state that he or she had been assaulted by three youths. This should be recorded as "patient stated that he was assaulted by three youths" not "patient assaulted by three youths".

You must not record any patient assessments if you did not complete them, e.g. a minimum of two sets of observations are required, however if you did not carry these out you must write the rationale in the free text box, do not write the outcomes if you did not assess the patient twice. Refer below example:

Observations						
Time	24 hr	06:08	06:18	06:28		
HR	bpm	117	115	110		
RR	bpm	19	20	20		
BP	mmHg	141/89	130/85	131/83		
SpO2	%	100	100	100		
AVPU/GCS	#/15	A/15	A/15	A/15		
Temp	°C	37.9	37.7	37.4		
FLACC Pain Score	#	2	2	2		
BGL	mg/dl	96				
PEFR	LM^{-1}					
EtCO2	mmHg					
Shock Index	SI	0.83	0.88	0.84		
Early Warning Score	EWS	3	3	2		

4.3. Objectivity

Written reports should be objective and should not include opinions or value judgments of the Clinicians. For example, the statement that the patient "appears to be intoxicated" or "under the influence of a substance" should be recorded in the following manner:

- Patient's gait unsteady
- Patient's speech slurred
- Patients breath smells of by-products of EtOH (ethanol)

***Any opinion that is not supported by fact should be avoided.**

If the patient makes any claim, e.g. such as consuming product or being attacked, it must be documented as "patient has stated…."

4.4. Completeness

All pertinent information, including all assessment and treatment given should be included on the PCR or when relevant on other documentation such as the QHSE reporting form. It is advisable, in order to have explicit medical management decisions documented, where possible - the "Mechanism of Injury/History" box is to be completed by one clinician as this provides a comprehensive holistic approach to care and continuity on any care pathway determined necessary. If more space is needed on a written PCR, an additional PCR or continuation sheet should be utilised.

In case the call is cancelled or is a backup call for the same patient, the clinician may fill some of the required information in the PCR. In case the call is for an MCI, the clinician may utilize the MCI triage tags instead of filling the PCR.

For the ePCR

You must complete mandatory fields before you can fully complete the PCR; many fields have drop down boxes to assist you with making swift and accurate choices. You must have knowledge of how to use the decision support tools in the most effective manner.

In the event that NA clinician are working alongside other care providers /teams who are leading on the assessment and management of the patient, NA clinician should ensure that all assessment and management of the patient including vital signs, BGL and pain scores are recorded and documented in accordance with this and other NA clinical and patient care policies and procedures to ensure a comprehensive record.

4.5. Legibility

For PCR/ePCR and other documents, every effort must be made to ensure that the PCR is legible (readable). If necessary, use 'print' writing (writing in capital letters) to help ensure legibility. All hard copy entries must be made in black or blue ballpoint pen pressing firmly to ensure all copies of the form are legible.

4.6. Timeliness

Documentation in the PCR must be contemporaneous. Inappropriate alterations, post-event additions or spurious alterations to the PCR are not ethical and are not permitted. Where a significant record must be made after the event, this should be done on a separate PCR appropriately dated and timed with the clear justification for why this was not contemporaneous. These additions must be brought to the attention of the Manager at the time of addition. The Clinical Governance and Audit Officer is to be informed if concerns are raised. Clinical staff that make such clinical additions that cannot be justified may face formal disciplinary proceedings.

4.7. Use of Abbreviations and Symbols

Only accepted medical terms, abbreviations, or those approved for use by NA, are to be used on the PCR. These terms are detailed in the CGP 212 - Glossary of Clinical Terms, Definitions and Abbreviations.

4.8. Errors

Errors made during the completion of the paper PCR should be corrected as follows:

- Cross through the incorrect entry with one line only.
- Initial the correction and include your employee number.
- Write the correction close to the error or use an arrow to identify what the correction refers to.
- Do not obliterate the error.
- Do not use white out or liquid paper.
- The original mistake must remain legible.

4.9. Signing the Record

Clinician ID numbers are to be included in the PCR both hard copy and electronic versions.
For ePCR scan of National Ambulance ID card/s will generate the staff member details.
Upon completion of the PCR the treating clinician must, where possible sign the PCR and any other patient related documentation and write their name clearly. The Clinical Staff responsible for administering any medication to the patient must ensure that they record their signature in the PCR.

It is the responsibility of the most Senior Clinical Staff in charge to ensure that the PCR is filled with all pertinent information and advisable that only one clinician to complete the Mechanism of Injury / History box.

The DOH-Licensed Temporary clinician under National Ambulance will be able to write / edit the free text section

4.10. Support and Advice from NA ACC Team Leader

For patients who do not appear to have capacity or are refusing to be conveyed, remote advice can be given directly to the patient and/or relative/guardian as per CGG 104 - Discharge of Care Flow Chart. It is imperative for an Emergency Medical Technician (Basic) to contact ACC for advice in cases as described above. Refer below example:

Consent	Yes نعم	No لا	
I have been made aware of the patient rights and responsibilities.			تـم اعلامـي بحقـوق المرضـى وواجبـاتهم
I agree to receiving routine treatment and care relating to my condition/injuries from National Ambulance clinician.			أوافـق علـى أن يتـم علاجـي مـن قبـل طـاقم الاسـعاف الوطـني
I agree to be transported to another healthcare facility.			أوافـق علـى نقلـي لمـزود رعايـه صـحيه آخـر
In Case of refusal for care and/or transport, the risk of refusing care and/or transport have been explained to me and I have decided to accept responsibility for my own care. فـي حـال رفضـي العـلاج و/ أو النقـل بالاسـعاف ، أقـر بأنـه تـم اعلامـي بخطـورة رفضـي وأتحمـل المسـؤوليه تجـاه ذلـك I understand that the information contained in this document may be used for purpose of approved research activity, data analysis and for payment purposes to health insurance companies. I authorize the ambulance clinician to release all or part of my information to other healthcare providers as deemed necessary. أقـر بـأنني أتفهـم بـأن المعلومـات الموجـوده بهـذه الوثيقـه قـد يتـم اسـتخدامها لأغـراض الأبحـاث و التحليـل والمطالبـات الماليـه مـن شـركات التـأمين ، و أخـول طـاقم الاسـعاف الوطـني اعطـاء جـزء أو كـل المعلومـات الـتي تخصـني لأي مـزود رعايـه صـحيه آخـر عنـد الحاجـه لـذلك			
Patient / Guardian sign and print			

Where instructions have been issued please ensure read-back is done from written text where possible

4.11. PCR Transfer

The hard copy PCRs and MCI triage tags are transferred to the Archiving area via secure means and by National Ambulance staff or systems, they must not be externally mailed. This ensures privacy and direct delivery.
Clinician will log of PCR envelop and send to Clinical Services with envelop number to ensure tracking.
Logistics will log the receipt of the envelop delivery for tracking system.
The Electronic PCR will also be secured by use of username, password or electronic access systems. Use of the CAD number +/- gender & date of birth should be used as patient identifier in any communication (e.g. email, asana, incident report forms) PCR's cannot be emailed unless approved by the CAMO / Delegate and with the correct encryption.
Clinical staff should ensure that ePCR / paper PCR is submitted correctly either to the database or sent to the archiving area to minimize the missing patient care record. The area Lead / Manager should ensure that the ePCR local session is clear from any pending e-PCRs before the end of the duty/shift and handover. (Appendix 1 – Steps Clearing ePCR Local Sessions)

4.12. Storage of PCR Records during Treatment

PCR Records of patients being treated in National Ambulance First Aid Posts or Clinics will be held in a folder allocated to the relevant CAD number.

4.13. Storage of PCR Records after Treatment

Once treatment is completed, paper PCR's must be stored securely until they reach the station. At the station they must be stored securely until they are passed to logistics for safe delivery to National Ambulance archiving area for processing and allocating for Clinical Audit. Clinicians and logistics need to –follow the process for PCR Delivery to Head Office as required.

4.14. Auditing

PCRs are subject to be audited by designated clinical Auditor under supervision of the Clinical Governance and Audit Officer. The audit utilises approved Key Performance Indicators and any metrics set by the CAMO / Delegate
In some circumstances, Managers may need to review the PCR/ePCR upon CAMO / Delegate approval.
An encrypted copy of audited PCR which need further action will be sent to the Mentorship Coordinator for further assessment.

Inadequate completion of PCR resulting in insufficient data for audit, will be considered as a noncompliance. Refer CGP148 Clinical Audit Policy and Procedure for audit criteria and parameters.

4.15. COPIES OF THE PCR

For hard copy of the PCR there will be 3 copies:

- White to be retained for NA purposes,
- Pink for receiving clinician at the tertiary care centre
- Blue for the patient or next to kin .

Electronic copies of ePCR will be held on the Z:Drive after submission until they are transferred to the N:Drive for processing and merging with all records for the day, month and year. Refer to CGW106 – Patient Care Record (PCR) Flow Chart

- Any NA staff approved by CAMO / Delegate to have an access to PCR folder either under clinical services or database (Z drive) or any Healthcare Information System and Application should complete and sign "CGF180 - Patient Care Record Folder Confidentiality Agreement" (refer to COP403 – General Confidentiality Policy)
- Any incident of security information or breach of patient confidentiality has to be reported to DOH within 24 hours of initial knowledge of the breach.
- There will be the following formats on the N:Drive
    - ePCR-20180101-0001-Ptn-HHMMSS ('pure' ePCR)
    - ePCR-20180101-0002-Ptn-CODE
    - ePCR-20180101-0004-Ptn-CODE-CODE-CODE
    - 20180101-0010-Ptn
    - 20180101-0013-Ptn-CODE-CODE-CODE

4.16. PATIENT INFORMATION:

Any NA Staff authorized by CAMO / Delegate to exchanges and circulates patient information:

- Must ensure its confidentiality.
- Must not use it for non-health purposes.
- Must not use it without the written consent of the patient, except in the following cases:
    - Data or health information required by the health insurance companies or any provider of health services with respect to the health services received by the patient for purposes of auditing, approving or verifying the financial benefits related to those services.
    - The purposes of scientific and clinical research, provided that the patient's identity is not disclosed and that the ethics and rules of scientific research are followed.
    - The purpose of preventive and curative measures related to public health, or to maintain the health and safety of the patients or any other persons in contact with them.
    - At the request of the judicial authorities.

- At the written request of the patient (UAE national or non-national) not residing in the Emirate of Abu Dhabi and getting non-emergency medical services as a medical tourist in a healthcare facility licenced by Abu Dhabi Department of Health.

At the request of the health authority for the purposes of inspection, supervision and protection of public health. **CODE**	**Meaning**
Ptn	Patient Number for CAD
CONT	Continuation Sheet
ECG	Electro Cardiogram
CA	CAOS
OW	OverWrite
DUP	Duplicate
MVA	Motor Vehicle Accident
MiDB	Missing in Database
MiHC	Missing Hard copy
NE	Northern Emirates
CD	Civil Defence/CCAD
EV	Events
MO	MOPA
PTS	Patient Transfer Service
YAS	YAS Marina Circuit

Example
20181332-0999-2-ECG-CA-OW-MVA
On 32nd day of 13th month of 2018, CAD Incident Number 999, Patient 2 had ECG done, was a cardiac patient needing CAOS to be completed, the ePCR was overwritten after printing database version and it was an MVA

5. DOCUMENTATION PROCEDURE

The procedure when completing Patient Care Documentation including PCR is to follow the designated form/s. Completion of each of the fields should ideally be done in the order shown on the form, however in some cases there may be a deviation from this, for example if a patient's identity or history can't be established moving straight to patient assessment and recording of findings is acceptable
The list below details the main requirement for each section on the PCR.

- Date
- Staff ID number/s

- Number of Patients
- Triage Categories – Critical, Moderate, Minor, Deceased
- Incident Number (generated by the CAD system)
- Receiving Hospital
- Receiving Hospital Department (if applicable)
- Location of incident
- Contract/Event – e.g. CICPA, HEMS, N. Emirates
- Triage tag no. – if relevant
- Patient Property Bag No.Base
- Call sign
- Time received, tasking urgency, time of lift (HEMS)
- **Patient details** including:
  - Emirates ID
  - Phone number
  - Family name
  - First name (given name)
  - Date of birth (DOB)
  - Nationality
  - Sex – Male or Female
  - Resident Type
  - Address (Street, City, Emirates and PO Box No).
  - Next of Kin, Relationship and phone number
  - Insurance company and number, as a UAE National, resident or visitor
- **Call details** including date and times for**:**
  - Call origin
  - Responding
  - On scene
  - At patient
  - Transporting
  - Pre-alert
  - Arrival at receiving hospital
  - Clear Patient And/or Departure for receiving hospital
  - Arrival back at base /or at next call
- **Patient Medical History including:**
  - Allergies or tick box for NKDA (No Known drug allergies)
  - Past Medical History
  - Regular medications
  - Last Oral Intake
  - Tetanus Status
  - Actual/estimated weight – if known (especially for paediatric cases)
- **Mechanism of Injury/History including**
  - MVA , Plate Type, Plate Source, Code, Plate #

- Chief complaint/presenting complaint
- Injuries/information
- Patient Type
- Exact time of incident/onset/injury (date, Time, Emirates)
- Subjective (History of Present Complaint)
- Objective (Findings)
- Assessment (Observation & Examination)
- Management Plan
- Tick box if further details are written on the continuation sheet
- If Cardiac arrest complete CAOS form

- **Injuries/examination including**
  - Population of body map
  - BEFAST test performed
  - Burn Percentage (Anterior)
  - Burn Percentage (Posterior)
  - Onset Time
- **Observations**
  - Including all observation recording times (HR, RR, BP, SpO2, AVPU/GCS, Temp, Pain Score, BGL, EtCO2, Shock Index, Early Warning Score)
  - Glasgow coma scale (See reverse for scale in paper PCR)
  - Minimum of 2 sets of observations including pain scores
  - For pain scores 1-10, Wong Baker and FLACC must be used (See reverse for tools in paper PCR)
- **Medications and Fluid Administration including the following:**
  - Route
  - Time commenced and discontinued (for oxygen and Entonox administration)
  - Type of drug or fluid
  - Dosage
  - Rate (for IV Fluids)
  - Units
  - Responsible person including signature and staff ID no.
- **Management including:**
  - Airway (manual, OP/NP, LMA iGel, ET Intbn, ET Size, ET length, SurCric)
  - Chest (Ventilated, BVM, ICC, L/R, Thoracostomy, Thoracotomy)
  - Circulation including IV siting, size and number of cannulation attempts, IV line success, IV line flushed
  - ECG and findings
  - Immobilisation including, C collar, spinal board, Vacmal, splints
  - Transport (Chair, Stretcher, Walk)
  - Transport Securely (Seat/Stretcher Belt, Spider Strap)
  - Other including Naso-gastric and oro gastric tubes, ultrasound (If available)
  - ISTAT-Laboratory test outcomes (HEMS only)
- **Hospital Handover including:**
  - Hospital
  - Name,

  - designation
  - signature/time of receiving clinician
  - Specific clinical details of correctly identified patient
  - Time of Handover
- **Adverse Event including:**
  - If sentinel event
  - Death and timing (occurrence prior to team arrival, in care, after arrival at receiving hospital)
  - Who is affected, Patient, passenger, crew, equipment
  - Reported to QHSE
  - Any prolonged scene time
- **Complaint and source**
  - Any comment
- Patient Hospital Identifier or sticker if appropriate
- Working Diagnosis (See codes on reverse of paper PCR)
- Escort Details/Other Relevant Information
- Clinical Waste – disposal at hospital or warehouse
- **Consent**
  - I have been made aware of the patient rights and responsibilities. (Yes/No)
  - I agree to receiving routine treatment and care relating to my condition/injuries from National Ambulance clinician. (Yes/No)
  - I agree to be transported to another healthcare facility. (Yes/No)
  - In Case of refusal for care and/or transport, the risk of refusing care and/or transport have been explained to me and I have decided to accept responsibility for my own care.
  - I understand that the information contained in this document may be used for purpose of approved research activity, data analysis and for payment purposes to health insurance companies. I authorize the ambulance clinician to release all or part of my information to other healthcare providers as deemed necessary.
  - Patient / Guardian sign and print
- Does the Patient / Guardian have Capacity (Yes/No)
- Is the Patient a high fall risk (Yes/No) & Score.
- Does the Patient Require Transport (Yes/No)
- Was the Patient Transported (Yes/No)
- Language Barriers? (Yes or No and Language spoken)
- Cultural issues (Yes/No)
- Patient Over 120kg (Yes/No)
- Prolonged Handover Time (Facility issue) (Yes/No)
- Further advice Details, (this is for patients refusing or not receiving transportation and including mode of advice (face to face or remote))
  - Advice From
  - Summarise Advice Given
  - Note: for remote advice or if any issues arise contact ACC
  - Clinician signature

- **Official Use**
  - Billing Completed / Referred
  - Clinical review required

Reverse side of the form (Only in Paper PCR)

- Cardiac Arrest Outcomes Study (CAOS)
- Diagnosis codes
- FLACC and Wong Baker pain scoring tools for pain assessment and management
- Glasgow Coma Scale tool for observations
- Pre-departure checklist including:
  - Documentation
  - Equipment
  - Access to specific equipment and drugs

Continuation page - If required with header for Basic details and Patient Details

5.1 Retrieval of PCR data

PCR's are retained and stored as per COP402 Document Retention Policy and are retrievable for information of assessment and treatment in line of continuum of care. If the patient did not receive a copy of the PCR upon completion of the transfer or refusal of transport, a copy can be requested from NA through CGF 137 Patient Care Records Form by providing the necessary proof of documents. PCR information can be requested by legal guardian or a legally authorised representative provided they submit the relevant documentation. All external PCR requests should be addressed to feedback@nationalambulance.ae

KEY POINTS

- The PCR and all patient related information can be used for legal purposes
- Patient related documents must be completed clearly and concisely after any call out
- Do not record any patient assessments or care if they were not carried out
- Use only accepted medical terms, abbreviations approved for use by NA
- Staff ID numbers are to be recorded in the PCR both hard copy and electronic versions
- If the patient appears to not have capacity, refuses transport or insists on transport when it may not be needed, staff should call the NA Ambulance Communication Centre (ACC) to get further clinical opinion and authorisation when it is needed on how to proceed. This must be clearly documented in the PCR.
- Completion of each of the fields should ideally be done in the order shown on the form
- No one except the CAMO / Delegate has the right to alter or edit the Patient Care Record Form.

6. RELEVANT LEGISLATION

Code, Name of Legislation	Jurisdiction
JCI Accreditation Standards for Medical Transport Organizations, 2nd Edition, (MOI.4)	July 2015
DOH Medical Documentation Checklist	
Abu Dhabi – HealthCare Information and Cyper Security Standard	February 2019
DOH Standard on Patient Healthcare Data Privacy	September 2020

7. RELATED POLICIES AND FORMS

Policy & Procedure /Form
CGP103 Patients' Rights and Responsibilities Policy & Charter
CGP105 Consent Policy and Procedure
CGP110 Patient Assessment Clinical Policy and Procedure
CGP113 Pain Management Policy and Procedure
CGP148 Clinical Audit Policy and Procedure
CGG104 Discharge of Care Flow Chart
CGP212 Glossary of Clinical Terms, Definitions and Abbreviations
COP402 Document Retention Policy and Procedure
COP403 General Confidentiality Policy
ITP125 IT Operation Policy

8. FEEDBACK

Any feedback or suggestions for improvement to this Policy, Processes or Procedures can be submitted to ghse@nationalambulance.ae

9. DOCUMENT CONFIGURATIONS CONTROL DATEOF CHANGES RELEASE APPROVAL

A review and update of this document will take place as necessary, when changes occur that identify the need to revise this Policy such as changes in roles and responsibilities, release of new legislative or technical guidance, or identification of a new policy area.

This document ownership for editing is identified as:
CAMO/ Delegate

Change Brief

Version No.	Date	Changes
1	08.01.14	New Document will supersede Patient Care Record Documentation and Tracking SOP003
2	19.02.14	Revision to ensure that all patient assessment and management takes place and is recorded in accordance with NA Policies and Procedures even where responsibility and accountability lies with other partner care providers
3	10 11.14	Full revision of PCR form and process
4	May 2015	Clarity and additions to ensure that patient assessment information is accurate and addition of times for oxygen and Entonox and rates and times for IV fluid administration Addition of a key points section
5	February 2016	Wording added to ensure contingency for event of unavailability of e-PCR.
6	November 2016	Inclusion of terminology Revision to ensure appropriate and adequate completion of PCRs to facilitate audit Alignment with HAAD Consent Guidelines V1 January 2016 Alignment with HAAD Ambulatory Care standards First Edition 2008
7	March 2017	Terminology Requirement for objective statements Inclusion of “Do Not Use List” for abbreviations (as per JCI requirement)
8	August 2017	Scope of document to include ePCR Inclusion of Senior Medical Officer (SMO) Role of Clinical Governance Manager Role of Clinical Education Manager Guidance on completion of “Mechanism of Injury/History” box by a single clinician MCI Triage tags to be brought to the HQ No PCR can be emailed unless approved by the CMA/SMO and with the correct encryption Removal of CSD reference Reference to CGG104 Discharge of Care Flow Chart made
9	March 2018	Strengthen policy in terms of storage and archive Ensure patient confidentiality during internal communications List nomenclature of electronic files storage With strike-through error insert Employee number with initials Add paediatric weight if known or estimated weight Remove reference to tertiary care and replace with generic transfer
10	24 June 2019	Medical Director Terminology Clinical Governance and Audit Officer Terminology Add Administrative Assistant to roles and responsibilities Update Patient Identification Change word staff with clinician

		Delete "Do Not Use" Abbreviation list Add new "Consent" section Change Warehouse/Head Quarter to Archiving Area Update section 5.14 "Auditing" Update the CODES in PCR naming Update the PCR content
11	11 November 2019	Delete Directors & Supervisor from the "Roles & Responsibilities" Update the Manger roles Replace QHP105 with CGP212 Replace BSL with BGL Update the screenshot of the vital signs Update section "**5.13 Storage of PCR Records after Treatment"** Update section 6 according to new ePCR version Add "Relevant Legislation"
12	January 2020	Move the purpose to Scope Add in 4. 4 Completeness "In case the call is cancelled or is a backup call for the same patient, the clinician may fill some of the required information in the PCR. In case the call is for a MCI, the clinician may utilize the MCI triage tags instead of filling the PCR"
13	September 2020	*Update the title & the roles & responsibilities of the clinical administrative assistant* *Update the roles & responsibilities of the clinical staff* *Add IT Team roles & responsibilities* *Add one point to section 4.9* • *"The DOH-Licensed Temporary clinician under National Ambulance will be able to write / edit the free text section"* *Add two points to section 4.11* • *Clinician will log of PCR envelop and send to Clinical Services with envelop number to ensure tracking.* • *Logistics will log the receipt of the envelop delivery for tracking system.* *Rephrase one sentence under section 4.13 to be* • *Clinicians and logistics need to follow the process for PCR Delivery to Head Office as required.* *Add one point to section 4.15* • *Any NA staff approved by MD to have an access to PCR folder either under clinical services or database (Z drive) or any Healthcare Information System and Application should complete and sign "CGF180 - Patient Care Record Folder Confidentiality Agreement") (refer to COP403 – General Confidentiality Policy"*
14	March 2021	- Requirement for DOH Standard on Patient Healthcare Data Privacy • CGW106 – Patient Care Record (PCR) Flow Chart • Update 4.15 by adding "Any incident of security information or breach of patient confidentiality has to be reported to DOH within 24 hours of initial knowledge of the breach" • Add new point 4.16 Patient Information as per ADHICS Standard - Update the code and their meaning - Update section 5

		- Update section 6 – Relevant Legislation *After Policy Review committee additional changes* *Add to any staff "authorized by the Medical Director"* *Add ITP125 Policy as reference.* *Add the Escalation Matrix to the IT policy.* *QHSE to send an alert to all staff to report immediately if there is any security information breach.* *For the Flowchart,* *add* *below:* *- Printed copy will be given to the hospital* *- ePCR data will be autoencrypted and transmitted to application service.* *- Envelopes should have "restricted" label*
15	May 2022	Changes in section 4.1 and 4.11 **After Policy Review Committee** As per CAMO, add below statement in Section 4.1: "The receiver's name, signature, ID, and contact number should be mentioned in the PCR and specify the list of items received." Name and signature of the receiver with his/her ID and contact number the receiver and specify the list of items handover to the receiver. Review the process of clearing the Local Sessions. Access to clear/delete any ePCR in the local session should be given only to the Area Lead and Operations Manager **Maisan Comment** Roles and Responsible – change to CAMO / Delegate – COO to change to DOO Clinical Administrative assistant – still valid 4.8 PCR error – added word paper MD – to be changed to CAMO / Delegate 4.15 copy of the pcr? – added the word " or next to kin" Ownership: changed from MD to change to CAMO / Delegate

Review & Approval:

_____ Date _____

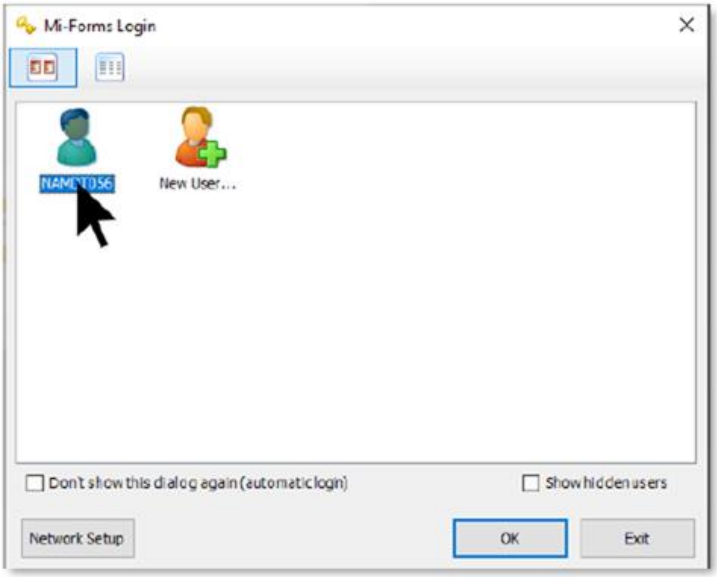
CAMO / Delegate

APPENDIX 1 – STEPS CLEARING EPCR LOCAL SESSIONS

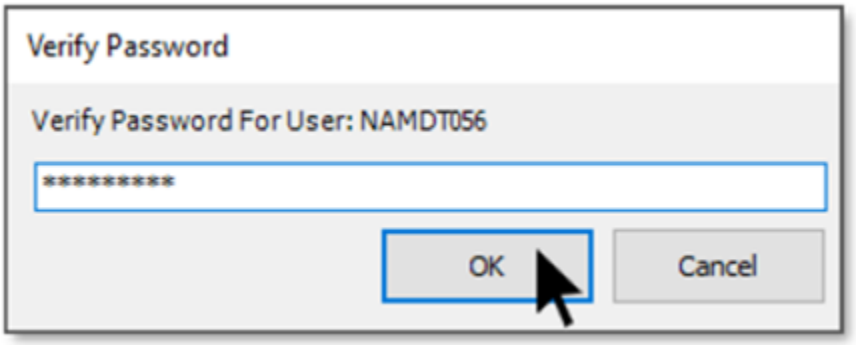
Clinical staff are required to follow the below steps to ensure that the e-PCR "Local Session" is clear from any pending e-PCRs before they complete their duty/shift and handover to the next shift.

1) Open Mi-Forms Client

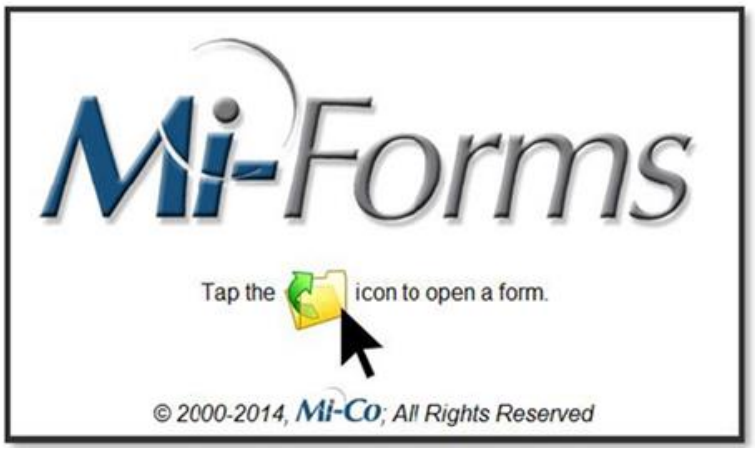
2) Select your user to Login



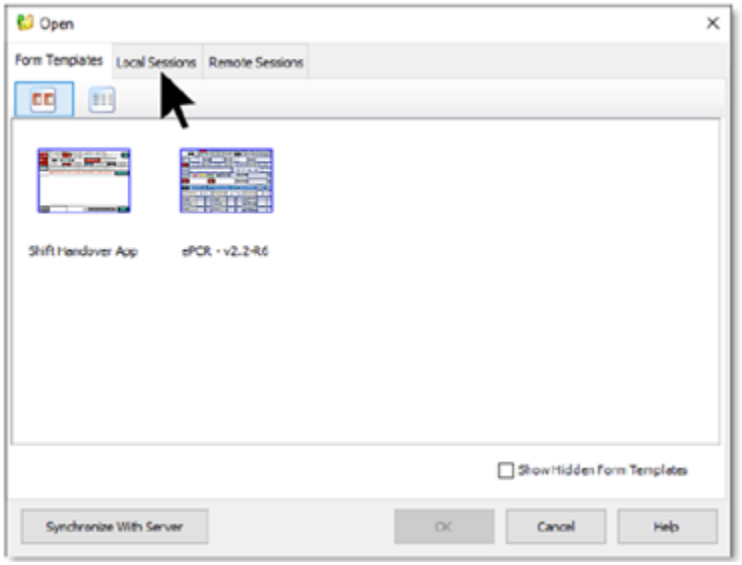
3) Enter correct password and click OK



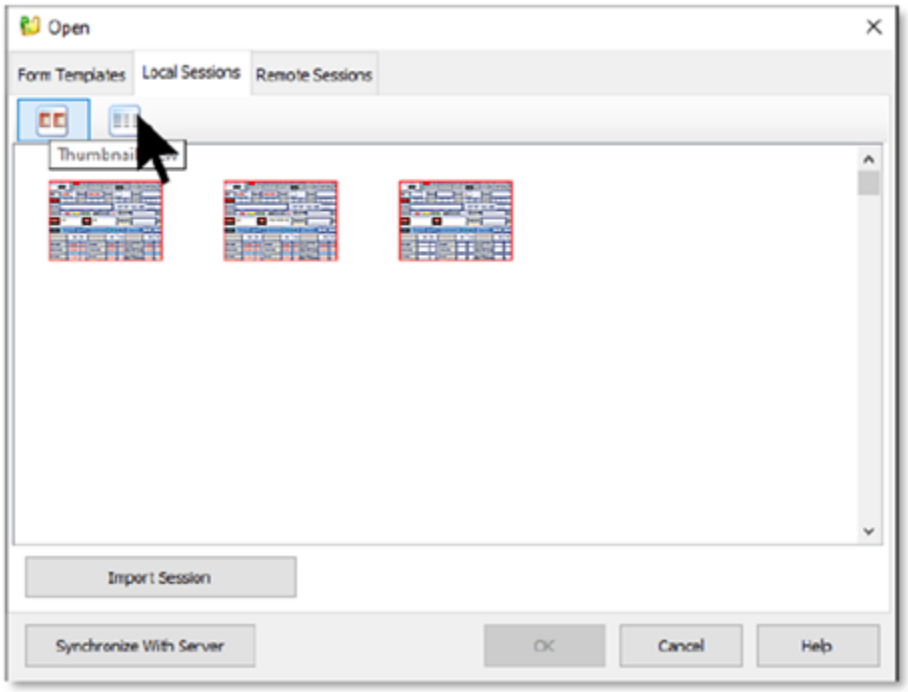
4) Click on the yellow folder icon in the welcome screen



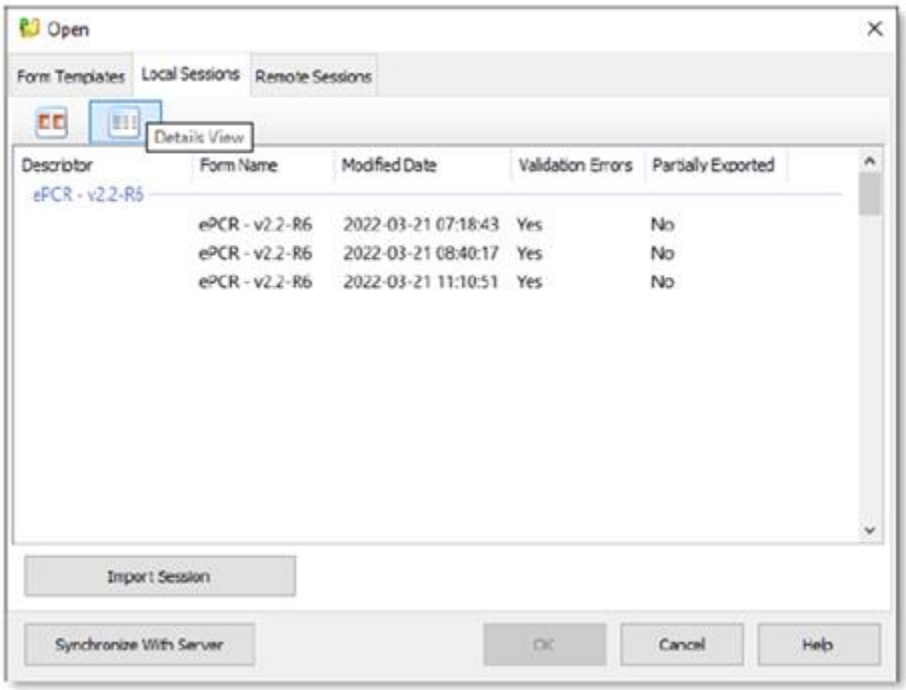
"Open" dialog box will pop up with the "Form Templates" tab selected. Click on "Local Sessions" tab



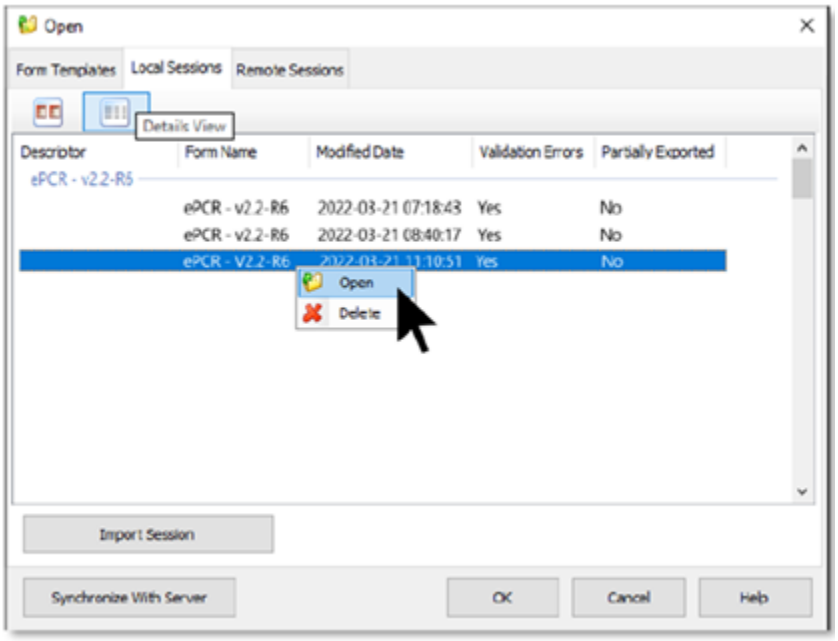
5) If the “Local Sessions” tab opens with “Thumbnails View” mode, change the mode to “Details View”



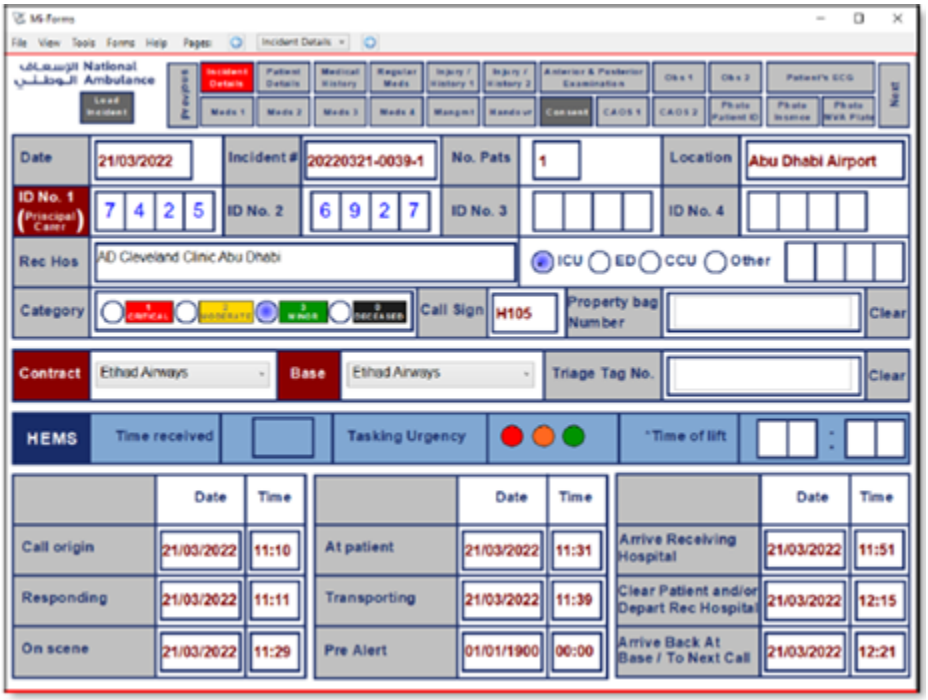
“Details View” mode will look like the below image



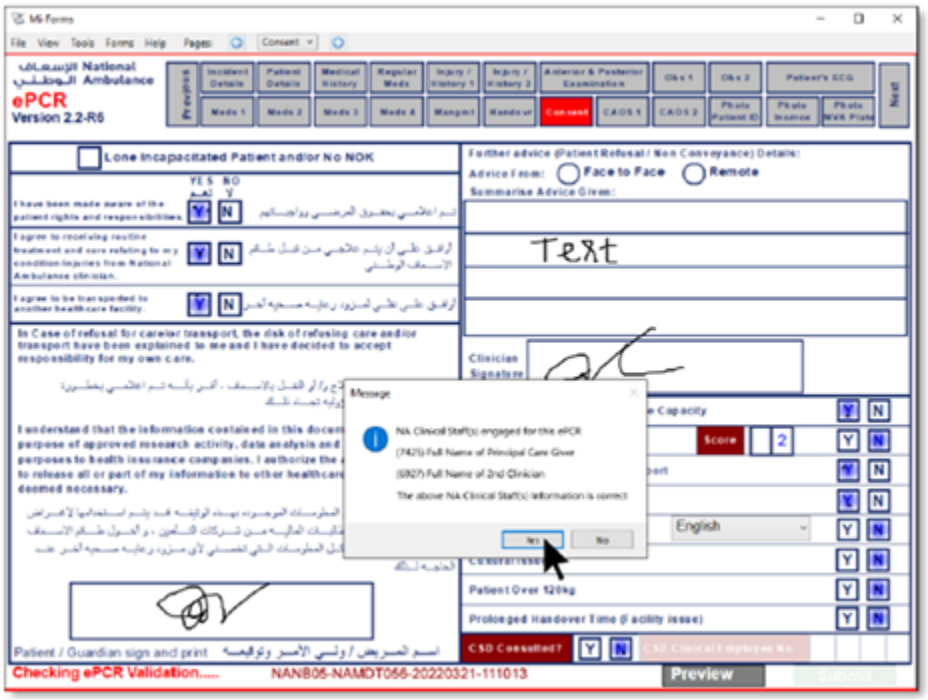
6) Open every single local ePCR session one by one to look for “Unsubmitted ePCR”



After opening an ePCR from “Local Sessions”, check at least “Patient information”, ”observation” and “Consent” tab

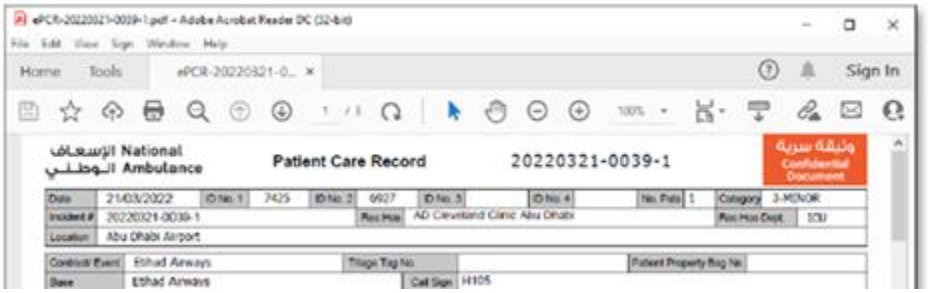


7) If identified as “Unsubmitted Valid ePCR”, click on “Preview” button in the “Consent” tab

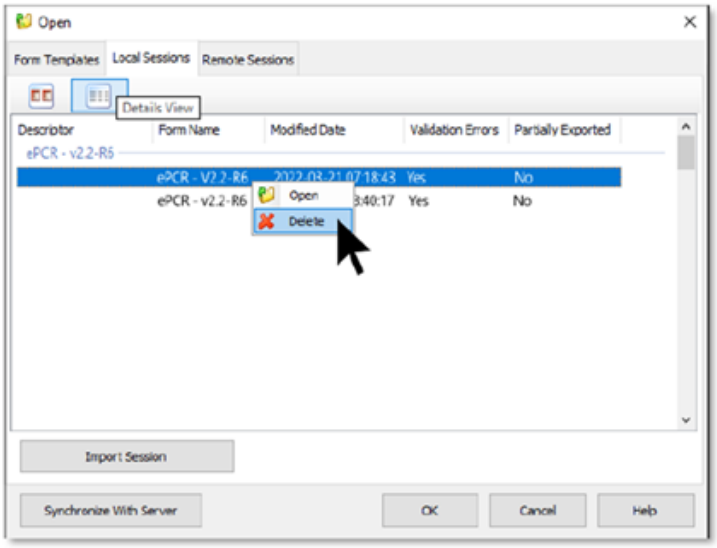


Click on “Submit” button to finish submission

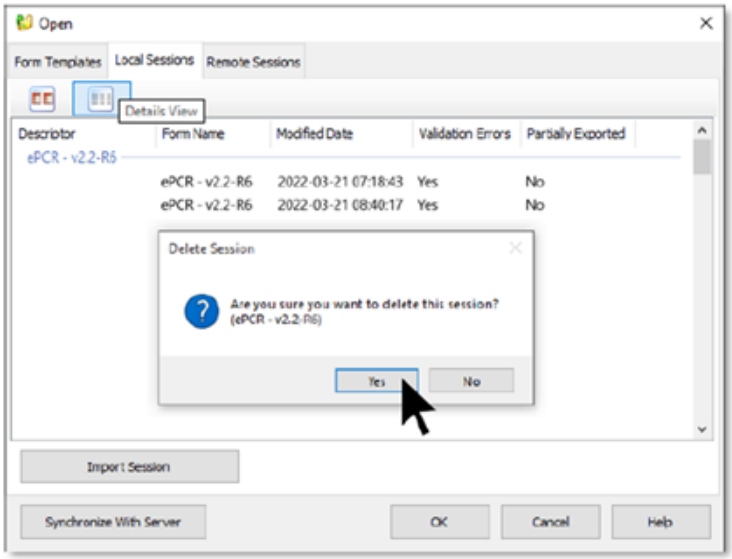
ePCR PDF (Local Copy) will be generated



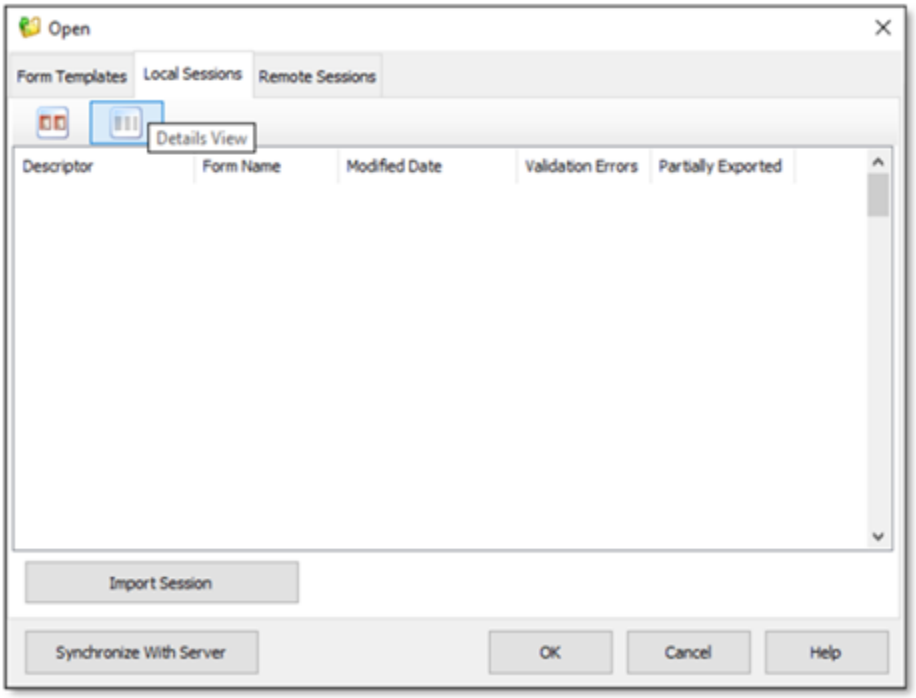
8) After submitting all “Valid Unsubmitted ePCR”, Area Lead / Manager will start deleting the remaining “Local Sessions” one by one



If the identified “Local Session” is ok to delete, confirm the deletion (Area Lead and Manager only)



9) After submitting the “Valid Unsubmitted ePCR” to server”, the “Local Sessions” tab will look like the below image



For any technical issues, report this immediately to the IT helpdesk for further assistance.