Section: Standards for Medical Documentation
Subject: ELECTRONIC PATIENT CARE REPORT (EPCR) – RESCUE COMPANIES
Section #: 360.03
Issue Date: February 1, 2012
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Approved By: Michael Lozano, Jr., M.D., HCFR Medical Director

1. This policy, and the standards for documentation contained within, is an addition to all other HCFR policies governing the proper and timely documentation of encounters between members of HCFR and patients.
    a. The assigned Rescue Officer or Acting Rescue Officer will ensure that the ePCR will address and fulfill all requirements of the HCFR Standards of Medical Documentation to include patient demographics, past medical history, medications, assessment, vital signs, treatment, procedures and correct dispositions, etc.
    b. The assigned Rescue Officer or Acting Rescue Officer will review each report's narrative to ensure it portrays an accurate and thorough representation of the incident. A detailed physical exam should also be documented in this section. It is understood and expected that this will repeat some of the information noted in various check box type portions of the report. This is the only written medical record of what the scene was like, what the mechanism of injury might have been, any pertinent negatives etc. It may also be used in court, so be careful to support any comments about apparent intoxication, apparent mechanism of injury and so on. The narrative section should paint a complete picture of the patient encounter for the reader. While not mandatory, the CHART method is recommended.
    c. The Flow Sheet shall be used as a record of chronological events of the patient's care from the time the first provider makes patient contact, until the patient is transferred to the care of another agency or receiving facility. The Flow Sheet does not replace the requirements of the narrative section. All vital signs, treatments and interventions shall be documented in the flow sheet section.
        i. Medication doses shall be listed as the actual dosage administered to the patient, not the dosing regimen listed in the protocol.
    d. It is important for procedures to be attributed to the personnel who actually performed them, and not simply the apparatus to which they are assigned.
        i. When suppression company personnel perform skills after care has been transferred to the rescue, the crewmember will be added to the "Assist" tab of the rescue ePCR so that all skills performed by that crewmember may be attributed to him/her.
            1. "Engine 1" cannot perform a skill; the skill is to be attributed to the specific crewmember who performed the skill.
        ii. In the event that a paramedic student performs a skill, attribute the skill to the supervising paramedic and document the performance of the skill by the student in the narrative section.

2. General Requirements for the ePCR:
    a. Each response for a call, including cancellations, test pages, structure fires etc., by a Rescue Company will be documented using departmental approved ePCR software and hardware.
    b. At the beginning of each shift, Rescue Officers will ensure that they have a properly functioning tablet computer; with charged batteries, accessories, and an operational printer.
        i. The oncoming crew shall sign on after the off-going crew logs off.
        ii. When building a roster in ePCR software, the officer or acting officer will be the first crew member listed.
        iii. Due care shall be exercised when building a roster to ensure accuracy. Rosters will need to be updated with every change in personnel to accurately reflect members on a call.
        iv. The IIO systems coordinator will be notified via email and STATS ticket of tablet/OMG problems.

1. The Quality Management Chief shall be notified via email of on-going tablet/OMG problems not able to be resolved by IIO staff within 3 business days.

c. The appropriate CAD entry for each response shall be linked to each ePCR.
   i. In the event of CAD failure, or if the incident's CAD entry is not visible on the list, use the "Add a CAD" feature.

d. The Rescue Officer will ensure that all reports for the shift are completed and uploaded to the server prior to leaving the station.
   i. All required fields, as indicated by red font, within each report must be completed
   ii. The narrative section, as described above, must be completed.
   iii. The Flow Sheet, when indicated, must be completed.
   iv. If the CAD or Server is down at the end of shift, preventing the uploading of reports, the Battalion Chief, and Quality Management Chief will be notified by email and the reports will be saved on the computer for submission the next shift.

e. The signature capture feature will be used for patient responsibility, refusals of care/transportation, etc.
   i. In the event that a tablet PC or this feature is unavailable, hard copies of the appropriate forms will be signed and forwarded with the shift paperwork. When document scanners are available, the front and back (when applicable) of these form will be scanned and attached to the ePCR.
   ii. For patient release/refusal the MERF form shall be used as the non-electronic form for signature only when indicated as above.
      1. The MERF shall have date of service, incident number, unit/shift, patient's name and short narrative describing signature (i.e. patient refusal, see ePCR for report) on the front of the form as a minimum data set for record keeping and clarity purposes.
      2. The patient release/refusal will be completed on the back of the form to include appropriate check boxes, crew member names, incident number, time, patient's signature, patient printing of name and witness signatures when indicated.
   iii. For <u>all transports</u>, patient signature <u>must</u> be obtained at the time of service.
   iv. If the patient is unable to sign the "Responsibility" form, you must document why the patient is unable to sign and have the following three signatures collected at the time of transfer:
      1. Responsibility Patient Unable to Sign (PUTS)
         a. Crewmember must sign this, verifying the patient is unable to sign for him/herself.
      2. Receiving Agency Signature
         a. Hospital representative must sign this form electronically.
      3. Either:
         a. Responsibility
            i. Patient representative as defined as: spouse, legally appointed power of attorney or healthcare surrogate, or legal guardian must sign this form, or:

b. Representative Unable to Sign
    i. Crewmember must sign this form, attesting to the fact that no patient representative, as defined above, is available.
4. Non-electronic version would be the Ambulance Billing Authorization Form.
5. When completion of the Ambulance Billing Authorization Form is necessary, include the incident number and date of service in the top right corner of the form.
6. When use of the Ambulance Billing Authorization Form is necessary, notation of same and method of submittal will be included in the signature section of the ePCR.

v. If a family member or patient representative is signing for the patient, you must include their relationship to the patient.
vi. If a hospital representative is signing for the patient, you must include the name of the facility and their printed name along with signature.
vii. If the hospital employee refuses to sign this form, notify your Battalion Chief and email the Quality Management Chief for follow-up with hospital administration. Attempt to obtain a hospital face sheet, note the incident number on the top right, and scan into ePCR.

f. Controlled substance processing will be handled using original hard copy documentation.
g. The Lifepak® vital signs and ECG file will be uploaded and embedded into each report.
    i. If you are unable to embed the ECG file into the report electronically, a printed copy of at least a 6-second strip shall be scanned and attached to the ePCR. This is rare, and should only be associated with documented equipment failure.
    ii. Erroneous vital signs imported from the LifePak® should be manually corrected to reflect the clinical judgement and actual findings of crew members.
h. A hard copy of the report (abbreviated or completed) will be provided to the ED staff for any patient transported, prior to leaving the ED.
    i. This hard copy must provide information to the receiving hospital at the time the patient is transferred that contains "all known pertinent incident, patient identification and patient care information" as a requirement of FAC 64J.
    ii. Copies of all EKG rhythm strips and 12-lead EKGs shall be provided prior to leaving the ED.
    iii. In the event that an ePCR cannot be completed and printed prior to leaving the hospital, a legible copy of a completed MERF form shall be left in the ER, which must include all observations, care rendered, vital signs, and pertinent information and events that occurred prior to the transfer of care to the receiving facility (patient name, initial v/s, GCS, etc.).
    iv. The completion of a MERF form does not replace the requirement for an ePCR to be completed nor does it diminish the elements required for satisfactory completion of the ePCR. All information on the MERF should be duplicated in the ePCR
    v. The auto-fax feature is used to submit completed reports to the indicated receiving facility.
        1. This does not meet the requirement of paperwork transfer at the time of patient transfer to the ED, and should not be relied upon for this purpose.
    vi. A fax will be sent to the Medical Examiner's Office upon the completion of an ePCR for a deceased person.

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i. Login PIN numbers shall not be shared.

j. Patient information contained within the MERF or ePCR; whether on the tablet computer, station PC, or printed copy shall be considered PHI and maintained as confidential in accordance with the department's HIPAA policy.

k. Crew members are to check at each login for messages from the System Administrators and reply as requested.
   i. These may come from the Quality Management Chief, Medical Director, Quality Assurance Officer, or other Rescue Division member.
   ii. If you have any reports which you were unable to upload previously, do so upon login.

3. Patient information/guarantor information – Accurate, complete information is important. With incorrect or incomplete information, bills may never be paid, which will eventually decrease the quality of care Fire Rescue is able to provide. It is understood that you may not always be able to get all the information requested, but try and get as much of the below as possible.
   a. Patient name (correct spelling, no nicknames)
   b. Patient's address
   c. Date of birth
   d. Patient's phone number
   e. Patient/Guarantor's social security number
   f. Patient's Medicaid number
   g. Patient's Medicare number
   h. Guarantor's name
   i. Worker's Compensation claim information
   j. Private insurance information (company name, policy number, etc.)

4. An Emergency Room chart/medical record number shall be obtained for all transported patients and the number recorded in all ePCRs for appropriate billing.
   a. Should the ER chart/medical record number not be available prior to the crews departure from the facility:
      i. The Rescue Officer or Acting Rescue Officer shall call the facility to obtain the ER chart number prior to the end of their shift.
      ii. Difficulties encountered when contacting facilities for chart/medical record numbers should be documented.

5. When document scanners are available, hard copy documents and forms relating to patient care shall be scanned and attached to the patient's ePCR.
   a. When signatures are captured on MERF or Ambulance Billing Authorization forms, these forms will be scanned and attached to the ePCR.
   b. All forms referenced in the ePCR, either directly or indirectly, shall be attached to the ePCR prior to completion. Examples are: medication Lists, patient history and physical sheets, DNROs, and other associated pertinent information.
   c. Face sheets, when obtained, shall be scanned and attached to the ePCR.
   d. Controlled Substance forms, Stroke Alert forms, STEMI Alert forms. SEPSIS Alert forms and other pertinent departmental forms shall be scanned and attached to the ePCR

e. All hard copy documents shall be shredded (cross-cut) in accordance with HIPAA policy AFTER you ensure the document has been scanned and attached to the ePCR. Use care to ensure the correct side of the document was scanned prior to shredding the document.

6. National Fire Incident Reporting System (NFIRS) Tab Completion:
   a. NFIRS data must be reported on every call run by HCFR
   b. One apparatus on each incident is responsible for entering a specific NFIRS Incident type on each call.
      i. On a medical call, the first suppression unit on scene will always complete the NFIRS tab within the medical report, choosing the most appropriate three-digit incident type from the available options.
         1. This is regardless of whether or not the patient is transported.
      ii. All other apparatus on the call should complete a "Supplemental" NFIRS Incident type to avoid multiple incident types from being reported on the same call.
      iii. If no suppression unit arrives on scene, or they are cancelled on arrival, the rescue company will complete the NFIRS tab with the appropriate three-digit code.
         1. Suppression companies performing a "Unit Assist" will still complete the NFIRS tab with the appropriate incident type.