Chapter 4, Communications and Documentation

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1. Introduction to Communications and Documentation in EMS

- **Communication** is sending information from one person to another [4]. This can be **verbal** or through **body language**, which is non-verbal [4].
- **Effective communication** is a key part of pre-hospital care [5].
- It helps build a good relationship with patients and co-workers [6].
- Verbal skills let you gather information from patients and bystanders [8].
- Communication helps coordinate with other responders at a scene [8]. It is also vital for transferring patient care to hospital staff [8].
- **Documentation** is the written or electronic record of patient care [9].
- It proves that appropriate care was given [10]. It also shares the patient's story with those providing future care [10].
- Good reporting and records ensure care continues smoothly [11]. They also ensure proper transfer of responsibility [11].
- Records help comply with health department and law enforcement rules [11]. They meet administrative needs of your organization [11].

- Documentation also helps fund EMS research [12].
- Communication systems like computers, radio, and telephone connect EMTs to other services [12]. You must know how to use these systems effectively [13].

2. Therapeutic Communication and Special Populations

- **therapeutic communication** uses verbal and non-verbal methods [15]. It encourages patients to share their feelings [15]. It builds a positive relationship with each patient [15].
- The **Shannon Weaver communication model** helps understand communication [16]. It has five parts: sender, thought, message, receiver, and feedback [18]. The sender encodes a thought into a message and sends it to the receiver [18]. The receiver decodes the message and sends feedback [19].
- Several factors and strategies affect communication [20]. These include age, culture, body language, eye contact, and voice tempo [20].
- **ethnocentrism** is thinking your culture is better than others [27]. People with this view interpret messages through their own perspective [28].
- **cultural imposition** is forcing your views on others [28]. Healthcare providers might do this, thinking their views are superior [28].

Factor/Strategy	Description	Evidence
Age, Culture, Experience	Influences how a person communicates	[21]
Body Language, Eye Contact	Greatly affected by culture; powerful communication tools	[22]
Facial Expressions	Can show the mood of the patient	[29]
Clothing, Sex, Posture	Factors to consider during communication	[20]
Education	Influences how a person communicates	[21]
Voice Tempo, Volume	Offer clues about mood and importance of message	[25]

Environment	Can affect communication (e.g., noise)	[20]

- When communicating with **older patients**, identify yourself and be competent [76]. Do not assume they are confused [76]. Assess for medical reasons behind confusion [77]. Approach slowly and allow time for responses [78]. Be patient and watch for confusion or sensory issues [78]. Locate personal items like hearing aids or glasses [82]. Share concerns about their home or pets with hospital staff [83].
- When communicating with **children**, understand their fear [84]. Allow them to keep a favorite toy [84]. Have a family member nearby if possible [84]. Be honest about procedures [85]. Respect their modesty [86]. Use an appropriate tone and vocabulary [87]. Position yourself at their level [88].
- When communicating with **hearing impaired patients**, position yourself so they can see your lips [90]. Be careful not to lose hearing aids [90]. Have paper and a pen available [91]. Speak slowly and distinctly, never shouting [91]. Listen carefully and give short answers [91]. Learning simple sign language phrases like sick, hurt, and help can be useful [92].
- When communicating with **visually impaired patients**, ask if they can see at all [94]. Explain everything you are doing [96]. Stay in physical contact [97]. Transport mobility aids like a cane [98]. If possible, transport guide dogs with the patient [99]. Arrange care for the dog if it cannot be transported [100].
- When communicating with **non-English speaking patients**, you must still get a medical history [102]. Use short, simple questions [102]. Point to body parts [103]. Use a family member or friend to interpret until a professional is available [103]. Consider learning common phrases in other languages [104]. Pocket cards or translation apps can help [105]. Remember to ask for a translator at the hospital [106].

3. Nonverbal and Verbal Communication Techniques

- **Nonverbal communication**, or body language, provides more information than words alone [29].
- Facial expressions, body language, and eye contact are important [29].
- Pay attention to your own body language, especially with hostile patients [33]. Stay calm to diffuse the situation [34]. Assess the scene for safety [35]. Avoid an aggressive posture [36]. Make good eye contact but do not stare [37]. Speak calmly and confidently [38]. Never threaten the patient verbally or physically [38].

- **Physical factors** like noise can obscure a message's meaning [40]. Cultural norms dictate the space between people when communicating [41].
- Your gestures, body movements, and attitude are key to building trust [42].
- **Verbal communication** involves asking questions [45].
- **open-ended questions** require detailed answers [45]. Use them whenever possible [45]. An example is, "What seems to be bothering you?" [46].
- **Closed-ended questions** have short answers like yes or no [46]. Use these if the patient cannot give long answers [47]. An example is, "Are you having trouble breathing?" [47].
- Several tools can help obtain information [49]. **facilitation** encourages patients to talk more [49]. A **pause** gives them time to think and respond [50]. **reflection** is restating their words to confirm understanding [51]. **empathy** is being sensitive to their feelings [53]. **clarification** asks them to explain what they meant [54]. **confrontation** makes a patient in denial focus on urgent issues [55] . **interpretation** restates the complaint to confirm understanding [56]. **Explanation** provides factual information [57]. A **summary** provides an overview of the conversation and next steps [58].
- **Touch** can show care and compassion [58]. Use it consciously and sparingly [59]. Approach slowly and touch the shoulder or arm respectfully [59]. Avoid touching intimate areas for communication purposes [60].
- **Interview techniques to avoid** include giving false assurance or unsolicited advice [60]. Do not ask leading or biased questions [61]. Avoid talking too much or interrupting [61]. Do not use "why" questions, authoritative language, or jargon [61].
- **Family, friends, and bystanders** can be helpful [62]. Allow the patient to answer if possible [62]. Do not be afraid to ask others to step aside [63]. Decide if their presence helps or hinders care [64].
- **Golden rules** help calm and reassure patients [64]. Make eye contact and keep it [64]. Provide your name and use the patient's proper name [64]. Tell the truth [64]. Use language they understand [64]. Be careful what you say about the patient [64]. Be aware of your body language [64]. Speak slowly and clearly [64]. If the patient is hard of hearing, face them [64]. Allow time for answers [64] . Act and speak calmly and confidently [64].

4. Emotional Intelligence in EMS

- **emotional intelligence** involves people skills [65]. It is the ability to understand and manage your own emotions [65]. It also means properly responding to the emotions of others [65].

- It helps diffuse conflicts and build rapport [66]. It leads to more effective communication [66]. It helps manage difficult situations [66].
- Attributes of emotional intelligence include **self-awareness**, recognizing your emotions and their effect [67]. **Self-regulation** is controlling impulsive emotions and behaviors [67]. **Motivation** is motivating yourself and others positively [68]. **empathy** is understanding others' concerns and needs [69]. **Social skills** are developing positive relationships through effective communication [70].
- To improve emotional intelligence, assess how you react to stress [71]. Work on staying calm with minor irritations [71]. Practice mindfulness [72]. Focus on the present moment without blame [72]. Take responsibility for your actions [72]. Consider how your actions affect others [72].
- The **behavioral change stairway model** helps manage crisis situations [73]. Steps include active listening, displaying empathy, building rapport, and exerting influence [75].

5. Mission Critical Communications and Patient Handover

- **Mission critical communications** are those where disruption causes task failure [107].
- A **shared mental model** is important for teams to work effectively [109]. It is the shared understanding of what is happening [109].
- Building this model requires answering four questions [111]. What is the patient's main priority? What is the history of prior care? What is the patient's current state? What are the patient's immediate needs? [111]. Answering these questions quickly helps avoid errors [111].
- **Effective patient care handover** is crucial for good patient care [112]. Handover is the transfer of patient information and responsibility [113].
- Communication failures during handover are a source of medical liability [114].
- When giving a handover report, initiate eye contact [115]. Manage the environment to reduce distractions [115]. Ensure ABCs (airway, breathing, circulation) if priority care is needed [116]. Provide a structured report [117].
- Acronyms like **SBAR** (Situation, Background, Assessment, Recap of Treatment) or **SBA2T** (Situation, Background, Assessment, Treatment) can be used [117].
- The verbal report should include the patient's priority condition, prior care, current state, and immediate needs [118].

- When receiving a handover report, maintain eye contact [119]. Manage the environment [119]. Ensure understanding [119]. Summarize the report [119]. Gather supplementary patient documentation [119].

6. Written Communications and Documentation: The Patient Care Report (PCR)

- The **patient care report (pcr)**, also known as the pre-hospital care report, is a legal document [121]. It records all aspects of patient care from dispatch to the hospital [122].
- PCRs can be **written** or **electronic** [123].
- The PCR serves six functions [124].

Function of the PCR	Description

- Examples of information collected on the PCR include chief complaint and mechanism of injury [127]. It also includes the level of consciousness, vital signs, and ongoing assessment [127]. Patient demographics, transport information, and destination choice are documented [127].
- Administrative information includes incident times, such as dispatch, arrival on scene, and arrival at the facility [129]. It also notes when patient care was transferred and the unit was back in service [129].
- Electronic PCRs (ePCRs) comply with nemsis data requirements [131]. They can transmit information directly to hospital computers [131].
- The **narrative section** of the PCR is very important [132]. Two common narrative formats are **CHART** and **SOAP** [132].
- The **CHART** method stands for Chief complaint, History, Assessment, Treatment, and Transport [133]. It starts with dispatcher information and the chief complaint [135]. History includes details of the current event and medical history [137]. Assessment describes all assessments, including vital signs [140]. Treatment details all interventions performed [141]. Transport explains how the patient was moved, positioned, and taken to the hospital [142].
- The **SOAP** method stands for Subjective, Objective, Assessment, and Plan [143]. Subjective includes information from the patient or others [145]. Objective details are gathered from your assessment, vital signs, and physical findings [146]. Assessment summarizes key findings and provides your impression of the problem [147]. Plan documents the treatment provided [148].

- Regardless of the method, the narrative should include times of events and assessment findings [148]. It should also detail emergency care provided and changes in the patient [148]. Observations at the scene and final patient disposition are included [148]. Refusal of care and the name of the person taking over care must be documented [148]. Avoid radio codes and abbreviations [148].
- All PCRs are **confidential** documents [149]. Once complete, distribute copies to appropriate locations [149].

7. Health Information Exchanges (HIEs) and Reporting Errors

- **Health Information Exchanges (HIEs)**, abbreviated as HIE, improve data sharing [150]. They allow EMS to share data with other healthcare providers [151].
- HIEs let EMS providers access relevant patient data [152]. They help avoid duplicating data entry [152]. They allow viewing patient outcomes related to hospital care [152].
- EMTs can contribute to and access electronic health information through HIEs [153].
- Most HIEs follow the **SAFER framework** [154]. SAFER stands for **Search, Alert, File, and Reconcile** [154].
- **Search** means EMS can search for hospital records [155]. This helps with treatment and transport decisions [155]. **Alert** means hospitals are notified of incoming patients [156]. Information from the EMS ePCR populates hospital dashboards [156]. **File** means data from the EMS ePCR is put into the patient's health record [157]. **Reconcile** provides feedback to EMS agencies on patient outcomes [157]. This data is used for billing and quality improvement [158].
- It is important to report errors accurately [159]. Do not try to cover up omissions or inaccuracies [159]. This is falsification and can lead to poor care, suspension, or legal action [159].
- The proper way to correct a mistake on a **handwritten report** is to draw a single horizontal line through the error [160]. Initial it and write the correct information next to it [161].
- If an error is found after submitting, follow the same process [162]. Add a note with the correct information [162].
- If information was omitted, begin a new section with the word **"addendum"** [163]. Add the new information and your dated initials [164].
- Never use correction fluid or erase errors [165].

8. Documenting Refusal of Care and Special Reporting Situations

- **Documenting refusal of care** is very important [166]. It is a common source of lawsuits [166].
- **Thorough documentation** is crucial [166].
- Include all assessment findings and emergency care given [167]. Have the patient sign a refusal of care form [167]. Have a witness like a family member or police officer also sign [167].
- Documentation should include evidence the patient made a **rational, informed decision** [167]. Detail discussions about recommended care and potential consequences of refusal [167]. Include discussions with family or bystanders who tried to encourage care [167]. Note discussion with medical direction if required by protocol [167].
- Also document providing the patient with alternatives [168]. Examples include seeing their family doctor or having someone drive them to the hospital [168]. Document the willingness of EMS to return [168]. Obtain signatures and complete the PCR [168].
- **Special reporting situations** depend on local requirements [169]. Examples include gunshot wounds and dog bites [169]. Certain infectious diseases, suspected abuse (physical or sexual), and mass casualty incidents (MCIs) are also special situations [169].

9. Communication Systems and Equipment

- **Radio and telephone communications** connect EMS teams with other services [170]. This includes fire and law enforcement [170]. They help the entire team work together and provide safety [171].
- A **base station radio** contains the transmitter and receiver [172]. It is usually in a fixed location [172]. A channel is an assigned frequency for communications [173]. A dedicated line, or hotline, is for specific point-to-point contact [174].
- A **mobile radio** is installed in a vehicle like an ambulance [176]. Ambulances often have more than one [177].
- **Portable radios** are handheld [178]. They are essential at MCI scenes or when away from the ambulance [178]. They help communicate with dispatch, other units, or medical control [179].
- **Repeater-based systems** use a special base station radio called a repeater [180]. The repeater receives signals on one frequency and transmits them on

another [181]. This allows units that cannot reach each other directly to communicate [181].

- **Digital equipment** is used in the field [185]. **Telemetry** converts electronic signals into coded audible signals [186]. These can be sent by radio or phone to a hospital receiver [187]. It is used for data from cardiac monitors [187].
- **Cellular and satellite telephones** are also used [189]. EMTs often use cellular phones to talk to hospitals [189]. Satellite phones are another option [189].
- A **scanner** searches across several frequencies [190]. It stops when it receives a broadcast [190]. Conversations can be easily overheard [191].
- Ambulances usually have an **external public address system** [192].
- Two-way radio hardware includes **simplex**, **duplex**, and **multiplex** [193]. **Simplex** is push-to-talk, release-to-listen [194]. **Duplex** allows simultaneous talk and listen [195]. **Multiplex** uses multiple frequencies for simultaneous transmissions [195].
- **MED channels** are reserved for EMS use [196]. **Trunking** systems assign many frequencies and use a computer to find an open one [197].
- **Mobile data terminals (MDTs)** are computers in the ambulance [198]. They receive data from dispatch and provide expanded capabilities [199]. For example, they can show a map to the dispatched address [200].

10. Regulations and Protocols Governing Radio Communications

- The **Federal Communications Commission (FCC)** regulates all radio operations in the US [202].
- The FCC has five main EMS-related responsibilities [202].
- They **allocate specific radio frequencies** for EMS use [203].
- They **license base stations** and assign call signs [204].
- They **establish license standards** and specifications for EMS radio equipment [205].
- They **set limitations for transmitter power outputs** [206].
- They **monitor radio operations** [206].
- FCC rules regarding EMS communications are found in **Part 90, Subpart B** [207].

11. Communication with Dispatch and Medical Control

- The **dispatcher** receives the initial 911 call [209]. Their responsibility starts with screening calls and assigning priority [210]. This is done according to protocols [211].
- They select and alert the correct EMS unit [212]. They direct the unit to the location [213]. They coordinate EMS with other public safety services [213]. They also provide emergency medical instructions to the caller [214].
- The dispatcher assigns units based on factors like the problem's severity and response time [215]. The level of training and need for additional support are also considered [215].
- The dispatcher should give responding units information [216]. This includes the nature and severity of the illness or injury [216]. The exact location and number of patients are provided [217]. Response of other agencies and special advisories (like traffic or weather) are given [219]. They also provide the time the units were dispatched [219].
- EMTs should report any problems during the run to dispatch [220]. They should inform dispatch upon arrival at the scene [220]. The arrival report should include obvious details from the scene size-up [220].
- Radio communications must be brief and clear [221]. Use plain English and avoid codes [221]. Report only important information [222].
- The main reason for radio communication with **medical control or hospitals** is to facilitate communication [223]. Medical control can be at the hospital or another facility [224].
- Consulting with medical control serves many purposes [225]. It notifies the hospital of an incoming patient [225]. It allows requesting advice or receiving orders [225]. It advises the hospital in special situations [225].
- Plan and organize your radio communication before transmitting [226]. A patient report to medical control commonly includes 10 elements [226]. These include unit ID, service level, patient condition, and estimated time of arrival [226]. Patient age, gender, chief complaint, and history are included [226]. Physical findings, care given, patient response, and any questions from the facility are also part of the report [226].
- The role of medical control is either **offline (indirect)** or **online (direct)** [227]. You may need to call medical control for direct orders [227]. This could be for administering certain treatments or determining transport destination [227]. Permission might be needed to stop treatment or not transport [227].
- In many areas, medical control is provided by hospital physicians [229]. However, variations exist, and it may come from a freestanding center [230].
- When calling medical control, your report must be precise and contain only important information [232]. Never use codes unless directed by local protocol

[233].

- After receiving an order from medical control, **repeat it back word for word** [234]. Receive confirmation [234]. Do not follow an order that does not make sense [235].

12. Information Regarding Special Situations and Equipment Maintenance

- You may initiate communication with hospitals about **extraordinary situations** [236].
- Notifying a small rural hospital early about multiple patients from a crash helps them respond [237]. An entire hospital system must be notified of any disaster [237].
- Other special situations to relay include hazardous material incidents or rescues in progress [238]. Possible multiple casualty incidents (MCIs) should also be communicated [238].
- When identifying special situations to the hospital, several points are important [239]. The earlier you notify them, the better [239]. Provide an estimated number of patients needing transport [240]. Identify any special needs patients might have, like burns or hazmat exposure [240]. This helps the hospital prepare [241].
- **Maintenance of radio equipment** is necessary [242]. Like other EMS equipment, it must be serviced at the start of each shift [242]. Check your radio equipment [243].
- Radio equipment may fail during a run [244]. You must have and follow a backup plan [244].
- **Standing orders** are written documents signed by the medical director [245]. They outline specific directions and permissions [245]. When followed properly, they have the same authority as orders given over the radio [246].