



Division 03

Communication and Information Management/Technology

Chapter 15 – Electronic Patient Care Report

March 2009

POLICY

This General Order establishes the procedures for Fire/EMS Department personnel to complete electronic patient care reports (ePCR).

DEFINITIONS

Electronic Patient Care Report (ePCR) – A standardized patient care report form that has been adopted by the Prince George’s County Fire/EMS Department for the intended use to document patient assessments and treatment modalities.

EMS-Related Incident – incident types including, but not limited to:

- Ambulance and Medic Locals
- Rescue Locals
- Motor Vehicle Crashes
- Ambulance and Medic units assigned to the EMS Group during a working fire
- EMS units assigned to rehabilitation group during a working incident.

Unit Response – Any time a unit is assigned to an incident by Public Safety Communications and is listed as “responding” and/or “on the scene.”

Tour of Duty – Career - the end of employee’s scheduled shift

Tour of Duty – Volunteer – point in the current day when a volunteer member chooses to no longer participate in emergency operations.

PROCEDURES

1. General Guidelines

In accordance with State Law, COMAR 30.03.04.04, each emergency medical service (EMS) operational program is required to provide the Maryland Institute of Emergency Medical Services System (MIEMSS) a Maryland Ambulance Information System report for all EMS-related responses. To meet this State regulatory requirement, the Department utilizes an ePCR.

Confidentiality

The patient care data gathered while performing EMS duties is considered protected health information under the Health Insurance Portability and Accountability Act (HIPAA). Any hand written accounts of patient information must be destroyed once the ePCR is completed.

Public Disclosure

The Department’s Information Management Division (IMD) is the only division authorized to provide reports to the public or other agencies. All requests for reports shall be referred to IMD.

Quality Assurance

All electronic patient care report data is subject to review as part of the Department’s Quality Assurance Plan.



2. Indications

A patient care report must be completed by each unit that responds to an EMS-related incident.

Additionally, any patient contact requires the completion of individual patient care report.

All electronic patient care reports shall be completed prior to the end of the tour of duty.

Fire/RMS vs. ePCR Documentation

Electronic Patient Care Reports provide documentation of response information. Therefore, Records Management System (RMS) reports are not required when an ePCR is completed.

When the EMS unit responds on a non-EMS related call as part of a suppression unit, an ePCR is not required if the completed RMS report accounts for the personnel assigned to the EMS unit.

For fire incidents with an EMS component, (e.g. a civilian or firefighter injury) only the EMS units are responsible to complete an ePCR. All other suppression units are required to enter their reports into RMS.

3. Requirements

The ePCR system provides a number of data fields to accurately and completely document the incident, including, but not limited to, the following:

- Location of the incident
- Patient Identification Information
 - Full Name
 - Date of Birth
 - Social Security Number (if possible)
 - Home Address

➤ Home Phone

- All available CAD data indicating dates and times
- Incident numbers in proper format: YR-DAY-INC# (e.g. 090230123)
- A complete narrative of events that occurred on the incident, including all patient assessments, treatments, and outcomes.
- Complete documentation of any patient refusal
- Receiving facility by facility code

Required fields must be completed to submit the official report.

The attached EMS Patient Information Form (Attachment #1) is intended to assist personnel with uniformly collecting and reporting all of this information.

Patient Transports

An ePCR shall be generated for each and every patient being transported by a Fire/EMS unit.

The ePCR must be completed and provided to the receiving facility staff prior to returning to service. This is critical because the information is incorporated into the patient's medical record.

A copy of the completed ePCR must be provided to the receiving hospital, unless the hospital is not equipped with a computer terminal. In those instances, the report must be faxed or hand-delivered to the receiving hospital as soon as possible.

Prince George's County Fire/EMS Department bills an Emergency Transportation Fee for all patient transports. The Ambulance Signature Form (Attachment #2) grants consent for Prince George's County, and its authorized agents, to bill a



patient and their respective insurance providers. Providers must secure a signature, or suitable substitute, from all patients that are transported by the Prince Georges County Fire/EMS Department.

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This signature form is a legal document that authorizes billing of government and third party insurance providers. Any false statements on this form can be interpreted as fraud and may carry criminal consequences.

Transfer of Care

Providers must document the transfer of patient care to the receiving facility in the narrative. This is accomplished by documenting the following:

- Receiving Facility Name
- Patient Care Area (e.g. Bed #2)

- Name of the healthcare provider accepting patient care
- Time of transfer

Patient Refusals

Any patient refusing transport shall have a patient assessment and vital signs performed and documented, unless the patient refuses the assessment as well.

Any patient refusing care must be informed of the following:

- Limitation of a pre-hospital assessment.
- Assessment findings.
- Treatments rendered.
- Anticipated complications or adverse effects.
- Medical decision making capability.
- Patient's right to seek medical attention at a later time by any means, including 911.

The ePCR shall document that all of the elements listed above were discussed. The patient must understand the risk of refusing medical care and acknowledge that understanding by signing a "Refusal of Care" Form (Attachment #3).

Patients may elect to refuse treatment and/or transport to a hospital. Patients who refuse treatment or transport will be required to sign the "Refusal of Care" Form. The Fire/EMS Department incident number and ePCR number must both be documented on all "Refusal of Care" forms.

The original (top) copy of the "Refusal of Care" form will be forwarded to IMD. The canary colored copy may be provided to other agencies as needed (e.g. Law enforcement agencies for patients who refuse care and/or are detainees/arrestees). The pink copy is the



patient's copy and shall be provided to the patient or the patient's guardian, if a minor

Advanced Airway Verification

An "Advanced Airway Verification" form (Attachment #4) must be completed when an ALS Provider performs any advanced airway maneuvers on a patient. The physician from the receiving hospital **MUST** sign the Advanced Airway Verification form and check off the manner in which the airway was verified. The Advanced Airway Verification form must be forwarded to the AEMS Office at the end of each tour of duty.

Controlled Substances

For ALS Providers, a "Controlled Substance" Form (Attachment #5) must be completed when documenting controlled substance waste disposal. This form will also be used to receive replacement narcotics at the hospital. The completed form must be forwarded to the AEMS Office at the end of each tour of duty

5. Responsibilities

EMS Providers

Each EMS provider shall ensure that an ePCR is completed for each response, as outlined in this General Order. Failure to complete a report may be considered neglect or falsification of records by omission, and may result in disciplinary action.

Volunteer Chief/Career Station Supervisor

Each Volunteer Chief or Career Station Supervisor shall ensure 100% compliance on ePCR documentation for all subordinates.

The career supervisor or volunteer chief will be held accountable when a consistent pattern of non-compliance exists.

Performance is verified by the following:

- **Improved Field Documentation**

EMS Providers will use the attached "EMS Patient Information Form" to uniformly document every patient encounter. This written information will be used to transfer a complete account of the patient identification, assessment, and interventions performed.

All aspects of patient care shall be documented in the field using the EMS Patient Information Form (Attachment #1). This information must be transferred entirely into the ePCR system to appropriately document the incident.

- **ePCR Review**

- Each supervisor will review ePCR compliance prior to the end of the "tour of duty."
- The provider responsible to complete the ePCR will login to the system with their supervisor.
- Review all completed reports listed. These should be compared to a CAD printout for the unit and/or the station log book for the timeframe in question. Any missing reports must be completed.

- **Log Book Documentation**

A reference number is generated for each ePCR. This number will be documented along with the incident number for each unit response in the station log book.

REFERENCES



The Code of Maryland Regulations
(COMAR) 30:03:04:04

FORMS/ATTACHMENTS

Attachment #1 – EMS Patient Information Sheet

Attachment #2 – Ambulance Signature Forms

Attachment #3 - Patient Refusal of Care Form

Attachment #4 - Advanced Airway Verification

Attachment #5 – Controlled Substance Form

Attachment #6 – Hospital Fax Numbers



Prince Georges County Fire/Emergency Medical Services Department Ambulance Signature Form

Patient Name:	Receiving Facility:
Transport Date: MM/DD/YYYY	Jurisdictional Incident Number: YY-DDD-INC #

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Prince George's County, Maryland for any services provided to me by the Prince George's County Fire/Emergency Medical Services (EMS) Department now or in the future. I understand that I am financially responsible for the services provided to me by Prince George's County, Maryland, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Prince George's County, Maryland any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Prince George's County, Maryland. I authorize Prince George's County, Maryland to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Prince Georges County, Maryland and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Prince Georges County, Maryland now or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: By signing below, I acknowledge that I have been made aware that I may obtain a copy of the Prince George's County Fire/Emergency Medical Services Department's Notice of Privacy Practices using the website (<http://www.co.pg.md.us/Government/PublicSafety/Fire-EMS/index.asp>) or by contacting Information Management at (301) 883-7183.

ONE of the following three Signature Sections must be completed for each transport

<p style="text-align: center;">SECTION I – PATIENT SIGNATURE</p> <p>This Section is for emergencies or non-emergencies. The patient must sign here unless the patient is physically or mentally incapable of signing.</p> <p>X _____ Patient Signature or Mark Date</p> <p>If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness. This can be an ambulance crew member.</p> <p>X _____ Witness Signature Date</p> <p>_____ Witness Printed Name</p>	<p style="text-align: center;">SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE</p> <p>This section is for emergencies or non-emergencies. Complete this section only if patient is physically or mentally incapable of signing.</p> <p>Reason the patient is physically or mentally incapable of signing: _____</p> <p>Authorized representatives include only the following individuals (check one):</p> <p><input type="checkbox"/> Patient's Legal Guardian <input type="checkbox"/> Patient's Health Care Power of Attorney <input type="checkbox"/> Relative or other person who receives government benefits on behalf of patient <input type="checkbox"/> Relative or other person who arranges treatment or handles the patient's affairs <input type="checkbox"/> Representative of an agency or institution that furnished care, services or assistance to the patient.</p> <p><i>I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.</i></p> <p>X _____ Representative Signature Date Printed Name of Representative</p>
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SECTION III - EMERGENCIES ONLY - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section **only** if **all** of the following are true: (1) the call is an **emergency** ambulance transport, (2) the pt was physically or mentally incapable of signing, **and** (3) no authorized representative (Section II) was available or willing to sign on behalf of the pt at time of service.

A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason pt incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____
Signature of Crewmember Date Printed Name of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. This signature is not an acceptance of financial responsibility for the services rendered to this patient.

X _____
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation (required only if signature in Section B above cannot be obtained)

If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of signed documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

Patient Care Report (signed by representative of facility) Facility Face Sheet/Admissions Record
 Patient Medical Record Hospital Log or Other Similar Facility Record



REFUSAL OF CARE FORM

Patient's Name: _____ Date: _____

Incident #: _____ EMAIS #: _____ Incident Location: _____

ACKNOWLEDGEMENT OF INFORMATION

I have been offered an evaluation, medical care and/or transportation to a medical facility; however I am refusing the services offered as checked below. I have been advised and understand the risks and consequences of refusing care/transport, including the fact that a delay in treatment and/or transport by means other than an ambulance could be hazardous to my health and, under certain circumstances include disability or death.

RELEASE FROM RESPONSIBILITY WHEN PATIENT REFUSES SERVICES

This is to certify that I, _____, am refusing the services offered
(Patient's name)

by the emergency medical services provider(s). I acknowledge that I have been informed of the risks involved and hereby release the emergency medical services provider(s), the physician consultant, and consulting hospital from any liability, claim, or cause of action which I may now or hereafter have in any way related to my decision to refuse medical care/transport.

I have read and understand the "Acknowledgement of Information" and "Release from Responsibility". I refuse the following services:

- | | | | |
|---|--------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Examination/Assessment | <input type="checkbox"/> Medications | <input type="checkbox"/> IV/IO | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Spinal Immobilization | <input type="checkbox"/> Care | <input type="checkbox"/> Transport | <input type="checkbox"/> All Services |

Signature: _____

Relationship (if not the patient) Parent Guardian

Disposition: Placed in care of self Released to law enforcement
Placed in care/custody of: Parent Guardian Other _____

Agency: _____
Name/ID #: _____

Form Completed by: _____ I.D. # _____

If you change your mind or your condition changes, call 9-1-1 (in an emergency), go to an emergency department in your area, or call your private doctor (if appropriate).

Original: Prince George's County Fire/EMS Department Canary: Other Agency Pink: Patient

Witness Information

Signature: _____ Name: _____ (Print)

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____



ADVANCED AIRWAY VERIFICATION

Incident #: _____

EMAIS #: _____

Date: _____ Unit #: _____

Provider: _____

ET Tube placement _____ cm at teeth (Also to be documented on EMAIS)

Starting ETCO2 _____ Ending ETCO2 _____ (Also to be documented on EMAIS)

To Be Completed By Verifying Physician

ET Tube Placement:

- Tracheal (Adequate Depth)
- Tracheal (Right Mainstem)
- Esophagus
- Hypopharynx

ET Tube placement verified by:

- Auscultation
- Visualization
- Colorimetric Device
- Capnography

Difficult Airway:

- Yes
- No

Intubated/Re-Intubated at Hospital:

- Yes
- No

Combitube® Properly Placed:

- Yes
- No

Verifying Physician: _____



PRINCE GEORGE'S COUNTY, MARYLAND
FIRE/EMS DEPARTMENT



Request for Narcotic Replacement and Verification of Narcotic Waste

Date: _____ Unit: _____ Incident # _____

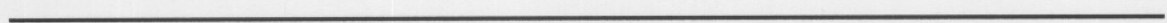
Patient's Name: _____ Hospital Destination: _____

Drug Wasted (If Any): **Morphine Sulfate** **Valium**

Amount Wasted: _____

Witnessed by: _____
(Signature)

(Print Name)



Date: _____ Unit: _____ Incident # _____

Patient's Name: _____ Medical Record # _____

Drug Requested (If Any): **Morphine Sulfate (10mg/ml)** Qty. _____

Valium (10mg/2ml) Qty. _____

(Paramedic)

(Pharmacy Representative)

Hospital Fax/Phone Numbers

Hospital	EMAIS Code	Emergency Department Phone Number	Emergency Department Fax Number
Andrew's Air Force Base	354	240-857-2333	240-857-8890
Anne Arundel Medical Center	221	443-481-6810	443-481-5575
Bowie Health Center	353	301-809-2024	301-809-2045
Calvert Memorial Hospital	266	410-535-8344	410-535-8335
Children's National Medical/ Trauma Center	317/717	202-476-5203	202-476-3311
Civista Medical Center	291	301-609-4160	301-934-4139
Doctor's Community Hospital	329	301-552-8665	301-552-8668
Fort Washington Hospital	522	301-203-2250	301-203-2270
George Washington University Hospital	335	202-715-4911	202-715-4909
Georgetown University Hospital	737	202-444-2000	202-444-2952
Greater Southeast Hospital	316	202-574-6541	202-574-7061
Holy Cross Hospital	244	301-754-7000	301-754-7504
Howard County General Hospital	223	410-740-7777	410-740-7551
INOVA Fairfax Hospital	230	703-504-3065	703-504-3076
Laurel Regional Hospital	352	301-497-7954	301-497-8741
Medstar Trauma Center	728	202-877-7210	202-877-3996
Prince George's Hospital/Trauma Center	232/632	301-618-3752	301-618-3962
Providence Hospital	288	202-269-7001	202-269-7990
R.Adams Cowley Shock Trauma Center	634	410-328-8869	410-328-8858
Southern Maryland Hospital Center	343	301-877-4505	301-877-4668
Suburban Hospital Trauma Center	649	301-896-3880	301-896-1358
Union Memorial Hospital - Curtis Hand Center	714	410-554-2626	410-554-2960
Washington Adventist Hospital	328	301-891-5070	301-891-6346
Washington DC Veterans Affairs Medical Center	376	202-745-8360	202-745-8356
Washington Hospital Center	327	202-877-5515	202-877-7516