County of Santa Cruz

HEALTH SERVICES AGENCY

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EMERGENCY MEDICAL
SERVICES PROGRAM

Policy No. 4100
Revised 07/11

Emergency Medical Services Program

Approved

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Medical Director

Subject: PCR DOCUMENTATION

This document outlines standards for filling out the Web PCR. Its intent is to clarify those areas of the PCR subject to interpretations. The goal is to foster charting accuracy and consistency. Comments are included only for those areas of Web PCR that require clarification.

Patient Information Screen
Transport medics will enter the Hospital's Medical Record Number in the field designated for "Medical Record Number" using the "face sheet" provided by the hospital. If the face sheet is unavailable when the PCR is completed, indicate, "no face sheet".

Dispatch Information Screen
- ***Patient medic*** is the medic authoring the PCR. ***Radio medic*** will be the supporting medic from the same agency, if there is one. If the PCR is written by a fire medic, and he/she is the only medic on the engine, the radio medic field will be left blank.

- **Call times** – Fire department PCRs will only include ***transport*** and ***facility*** times if the fire medic accompanies the patient to the ED. If the fire medic does not accompany the patient to the ER, the documented times will include: received, enroute, on scene, and available. The transporting medic's chart will include all times.

- ***First Resp***: The first paramedic unit on scene
- ***Other Resp.:*** The second paramedic unit on scene.
- ***Other Provider***: BLS agencies (CHP, dog catcher, etc.) along with Calstar, law, etc.

Event, History and Vitals Information Screen
This section contains patient data reflecting the **first** clinical evaluation of the patient.
With regards patient status, a determined or pronounced patient is a status 5 patient.
A complete explanation of patient status levels can be found in Policy 1090.

Head To Toe Exam Screen

Reflects the first head-to-toe exam of the patient.

- ***WNL –*** Must have qualifiers to say why the body system was within normal limits.
- ***Abnormal*** – Must have qualifiers to say why it was abnormal.
- ***No Exam –*** May be used without qualifiers; however, notation should be made as to why important, pertinent parts of the exam were omitted, if indeed they were.

Disposition / Treatment Information Screen

Disp.: Names the actual agency transporting the patient.

Narrative: The narrative should include the subjective history of the present illness or injury. It should start by commenting about what the scene looked like upon the medic's arrival:

"Arrived to find patient in care of PD, c/o lacerations to face. Per PD, patient…"
"Arrived to find patient in care of AMR, with CPR in progress."

The narrative may include mnemonics (PQRST, PASTMEDS, etc) along with associated review of systems (additional symptoms that patient is complaining of).

The narrative should not include lengthy information about patient treatment and treatment response. This should be included in the treatment section.

Treatment Record:

- First line should always be "assessment," whether this indicates assessment of the scene or of the patient. The first arriving medic should write in the comments section what he/she saw on arrival. The second arriving medic should write that the patient was in the care of the first-in medic, and the care being rendered.
- When a skill is attempted, separate successful from unsuccessful attempts on different lines. If you are unsuccessful, indicate why in the comments section.
- If you consider a treatment but don't actually do it (intubation, etc.), write "O" (for considered) under "attempt," and then explain in the comments section.
- For IV attempts/fluids – document attempt, size of catheter, whether you were successful/unsuccessful, and then for "amount " indicate the infusion <u>rate</u> – "TKO", "W/O", "125cc/hour." In your comments section also include evidence that the IV was patent.
- The last line of the treatment section should include your comments documenting your patient's status either at the hospital or when AMR transported without you (for fire folks not transporting), or prior to leaving the patient who has AMAed. Include qualifiers such as "mild" "moderate" "severe" or use the 1 – 5 status numbering system. This line should also include total amount of IV fluid infused, and any pertinent changes in the patient's status not previously mentioned.