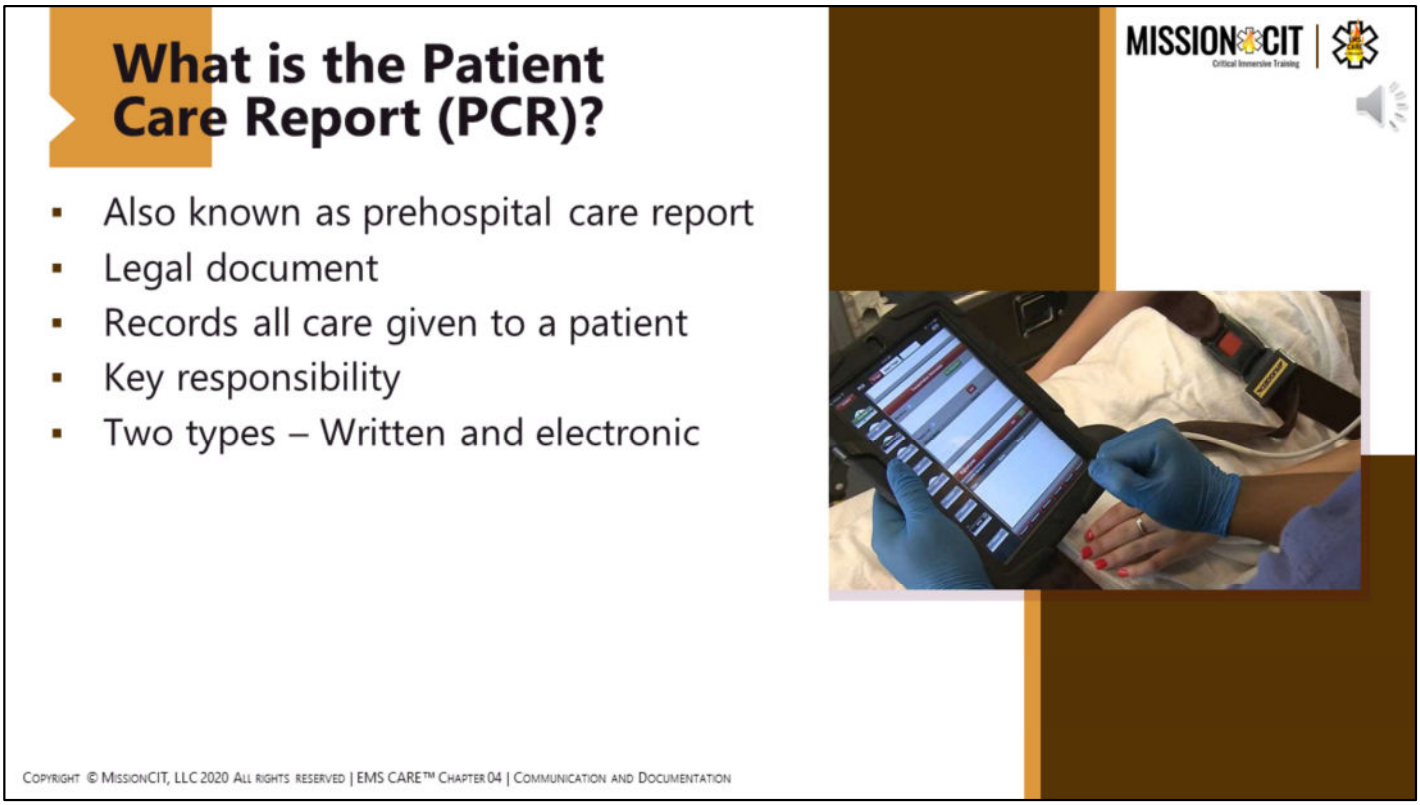


Thank you, Missah!

Welcome to this lesson where we talk about an important aspect of communication, which is its written form called documentation.

The material you present in your documents will come in handy for healthcare professionals who will be treating the patient in the future.

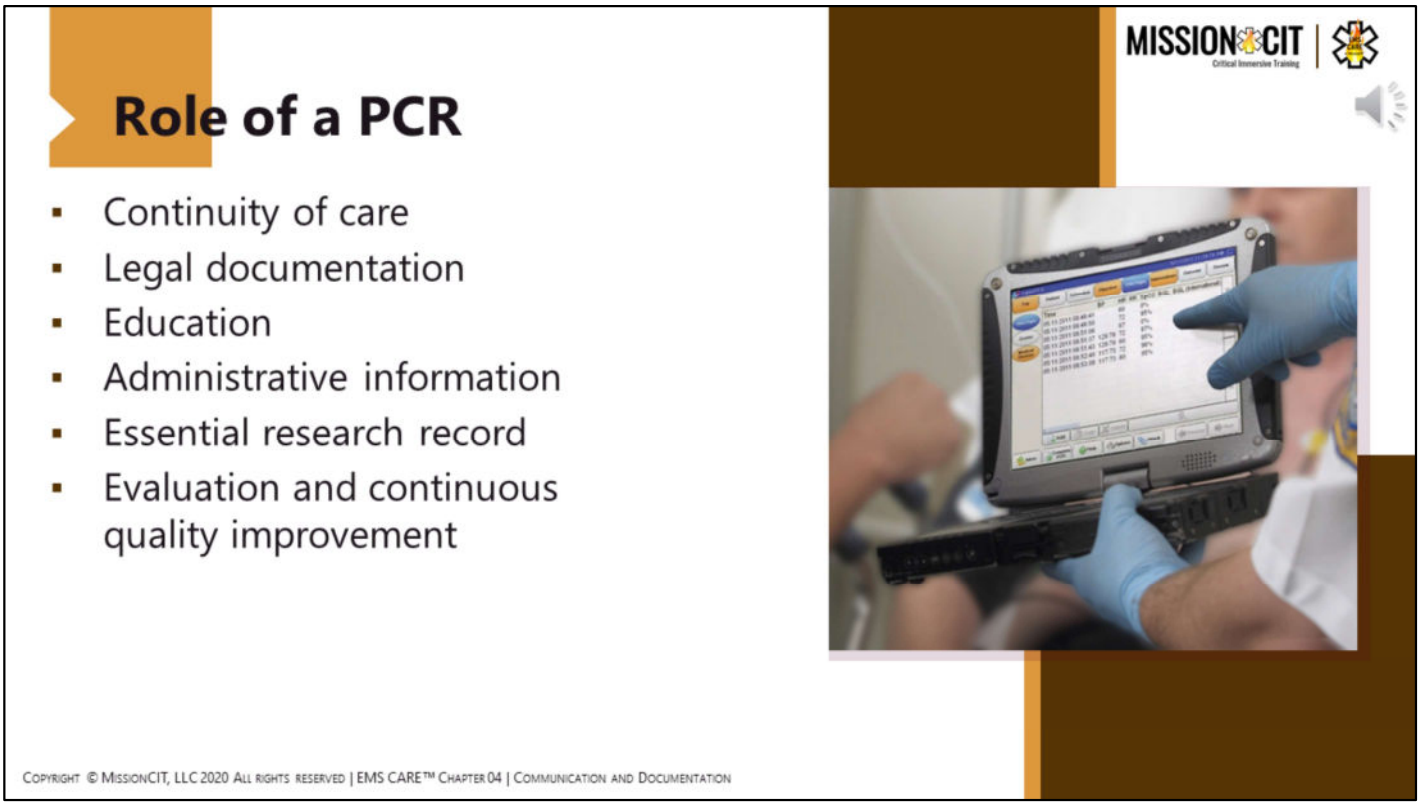
So, let's learn about the finer nuances of documentation to make it highly usable.



The Patient Care Report, also known as the Prehospital Care Report, is a legal document that records all care given to the patient, right from dispatch to hospital arrival.

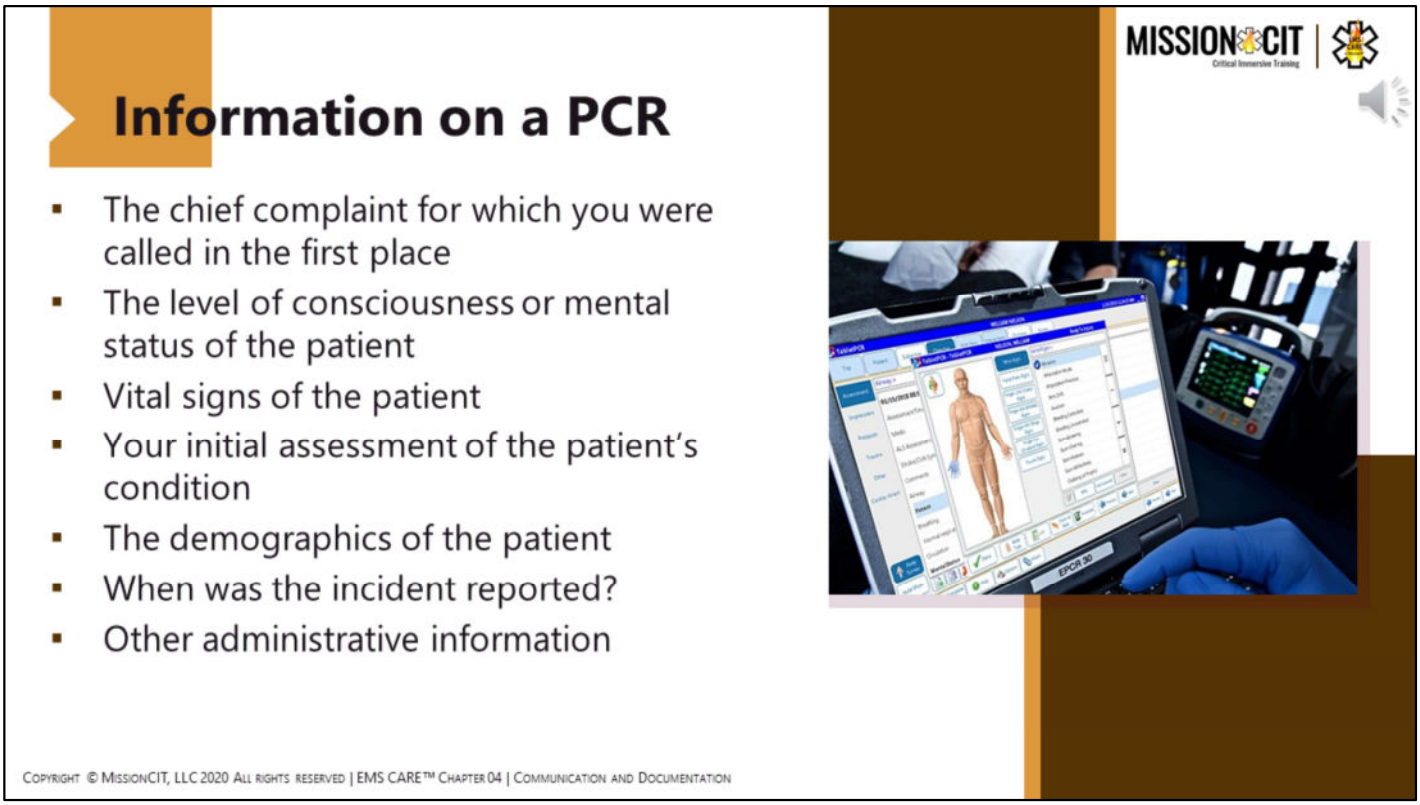
This is an important document and writing this document is one of the central roles of every EMT.

There are two broad types of PCRs, and they are the written and electronic ones.



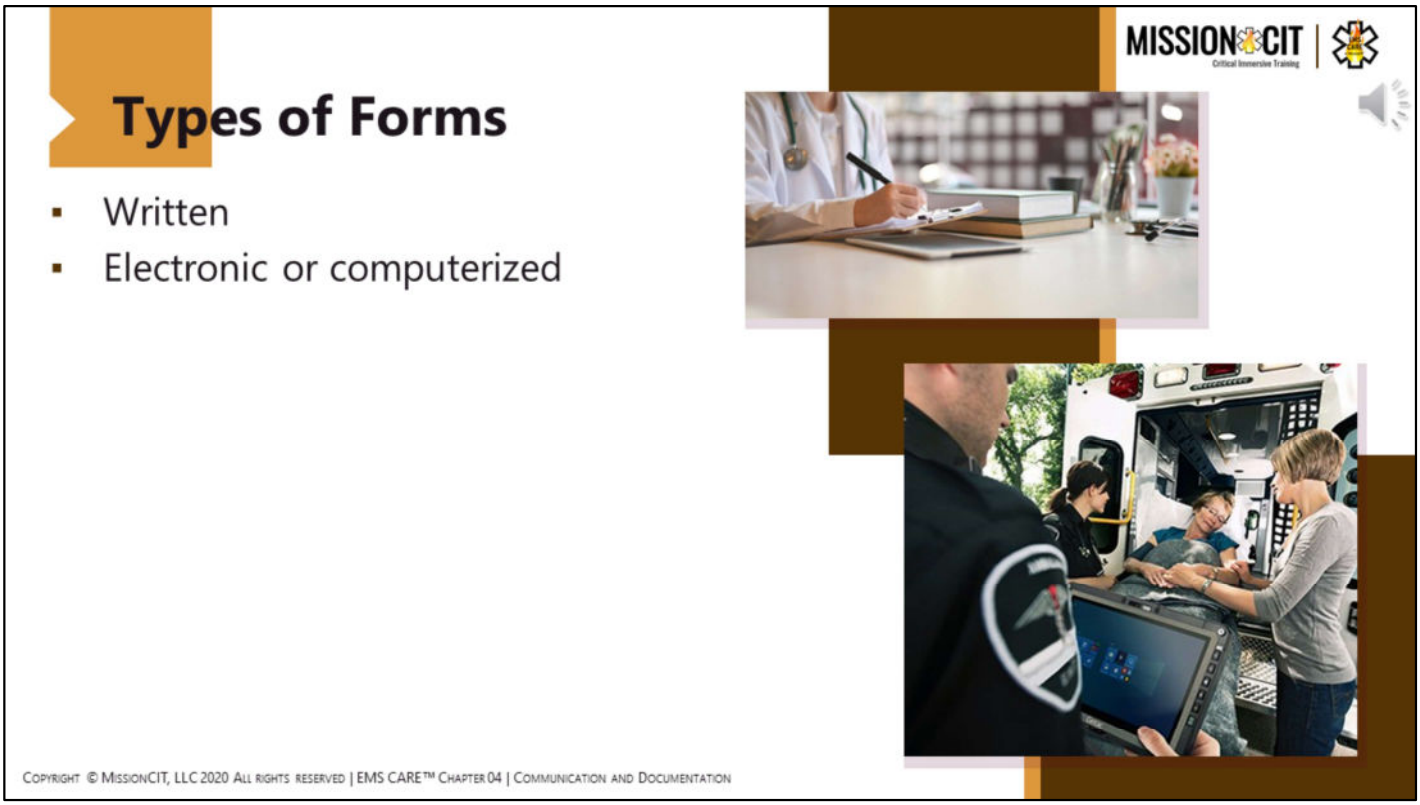
The PCR plays six important functions and they are as follows.

- Continuity of care
- Legal documentation
- Education
- Administrative information
- Essential research record
- Evaluation and continuous quality improvement



Now that you know the importance of a PCR, let's now see what information must go into it.

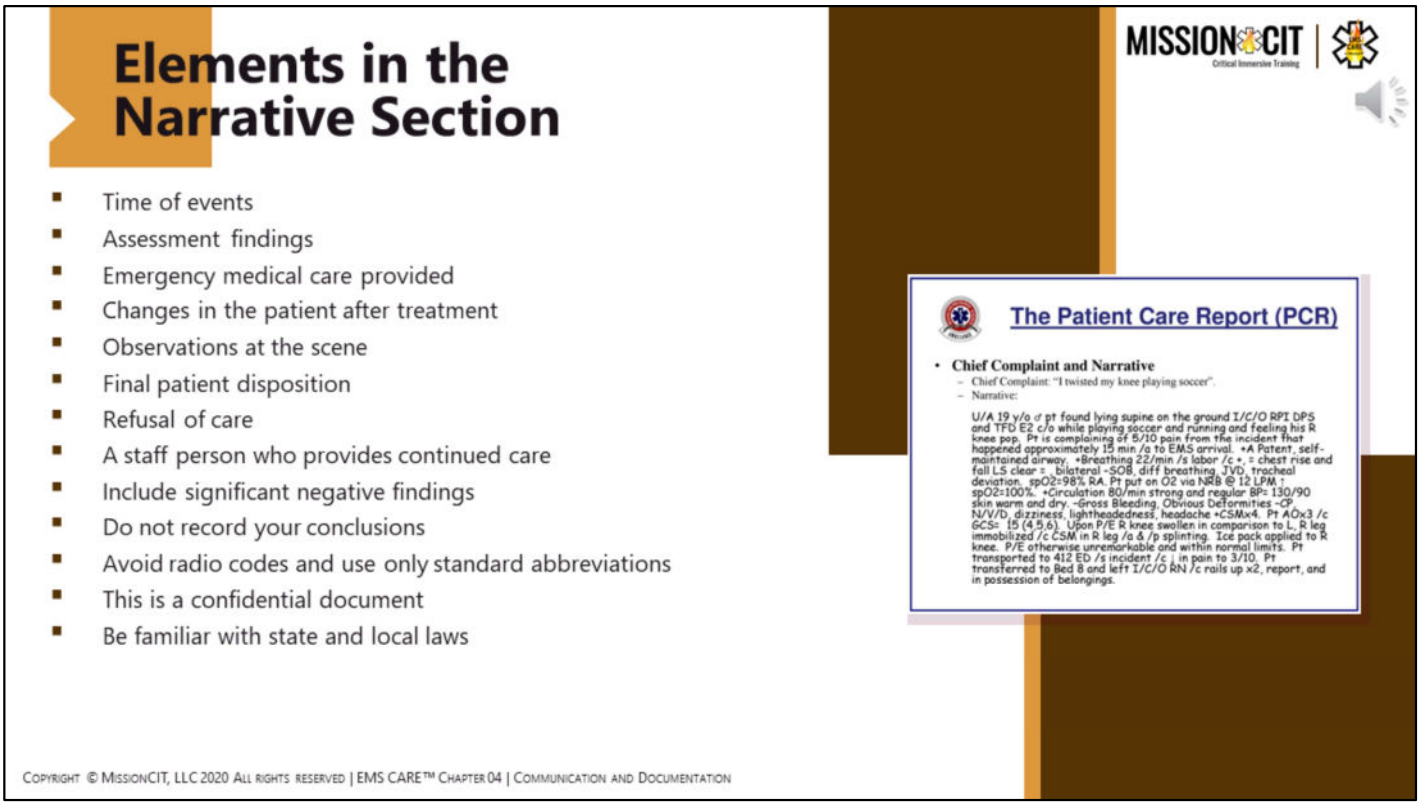
- The chief complaint for which you were called in the first place.
- The level of consciousness or mental status of the patient.
- Vital signs of the patient.
- Your initial assessment of the patient's condition.
- The demographics of the patient.
- When was the incident reported?
- Other administrative information such as the EMS unit that was notified, when it arrived on the scene, what time the unit left the scene, the time when it arrived at the receiving facility, and when the patient care was transferred to the appropriate healthcare professionals.



There are two types of forms and you can choose the one that best meets your needs.

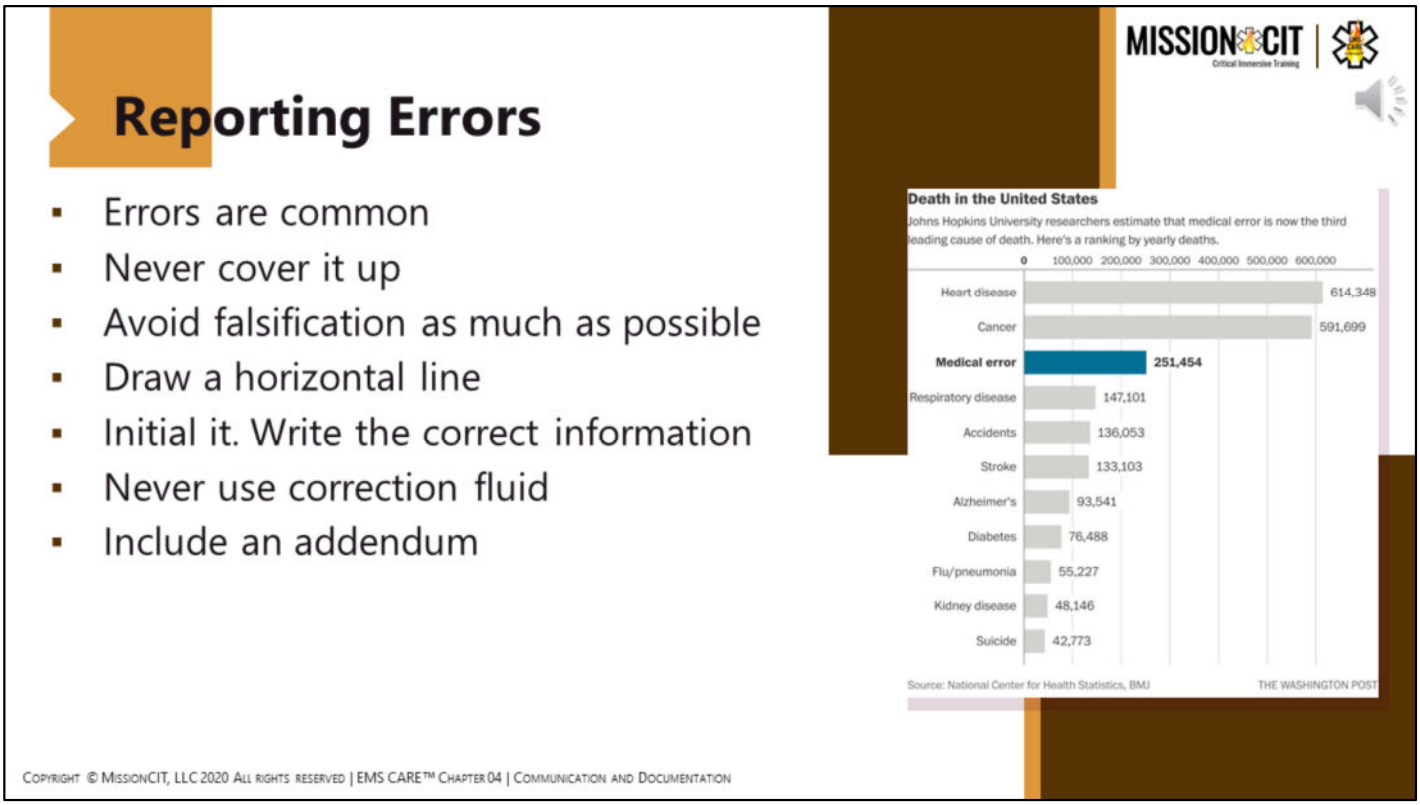
The first form is the written one which is the traditional one that has been around for many decades. This has a checkbox for some of the common questions and a narrative section for more detailed information.

The other option is the electronic or computerized version where you can fill in the details directly online.



The narrative section is a detailed description of the events and the patient's condition. Typically, it must contain,

- Time of events.
- Assessment findings.
- Emergency medical care provided.
- Changes in the patient after treatment.
- Observations at the scene.
- Final patient disposition.
- Refusal of care.
- A staff person who provides continued care.
- Include significant negative findings and important observations about the scene.
- Do not record your conclusions about the incident, just use clear descriptions that do not make any judgments about the patient's condition.
- In written documentation, avoid radio codes and use only standard abbreviations.
- Remember that the report itself is considered a confidential document.
- Be familiar with state and local laws concerning confidentiality.



Despite your best efforts, reporting errors are common, especially the first few times.

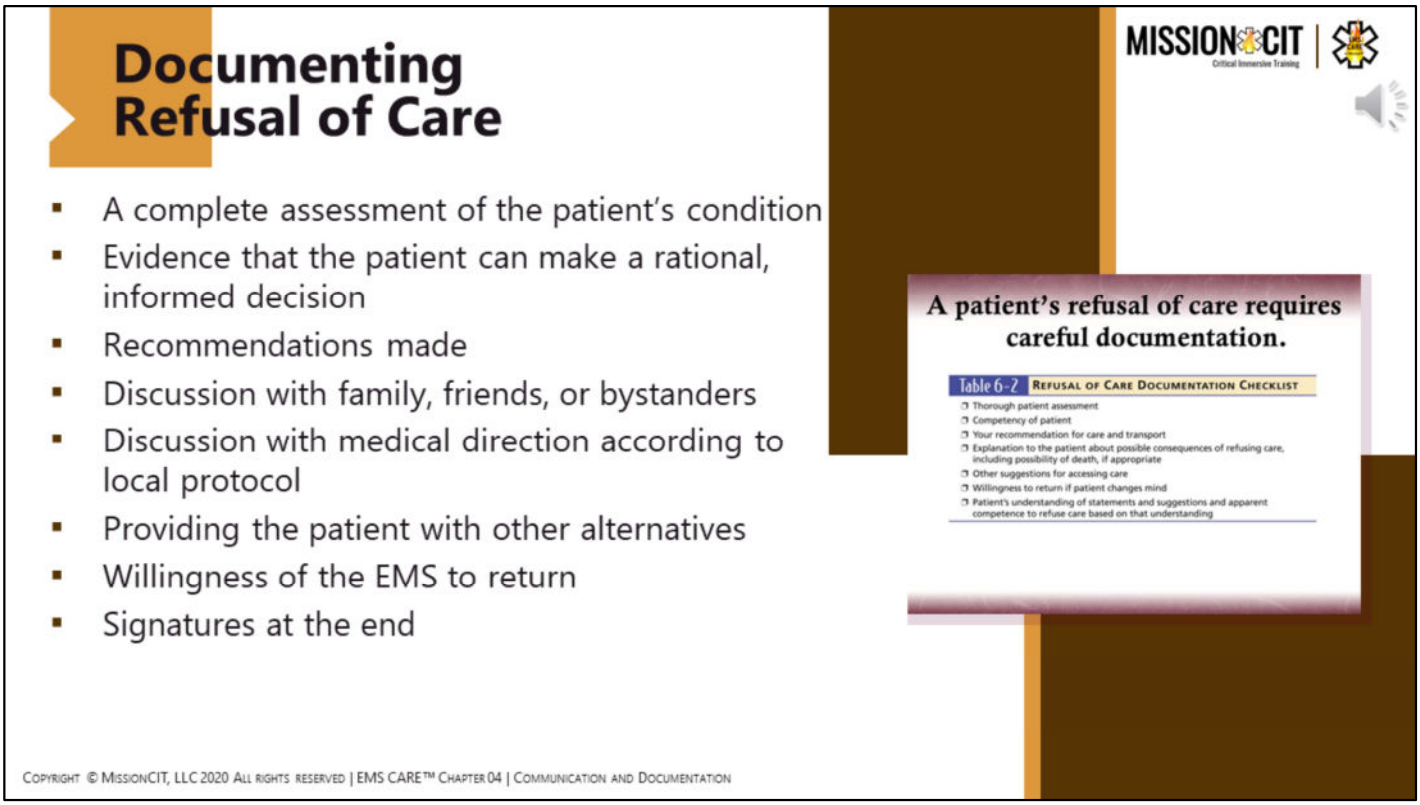
If you leave something out or record it incorrectly, do not try to cover it up. Simply add a note about the mistake, so people can see it.

Avoid falsification at all costs because it results in poor patient care and may result in your suspension and or legal action.

If you discover an error as you are writing your report, draw a single horizontal line through the error, initial it, and write the correct information next to it.

Never erase or cover the error with correction fluid.

In the case of electronic documents, include an addendum if there's no option to amend it.



Refusal of care is a common source of lawsuits and this is where thorough documentation is crucial and can save you from legal implications.

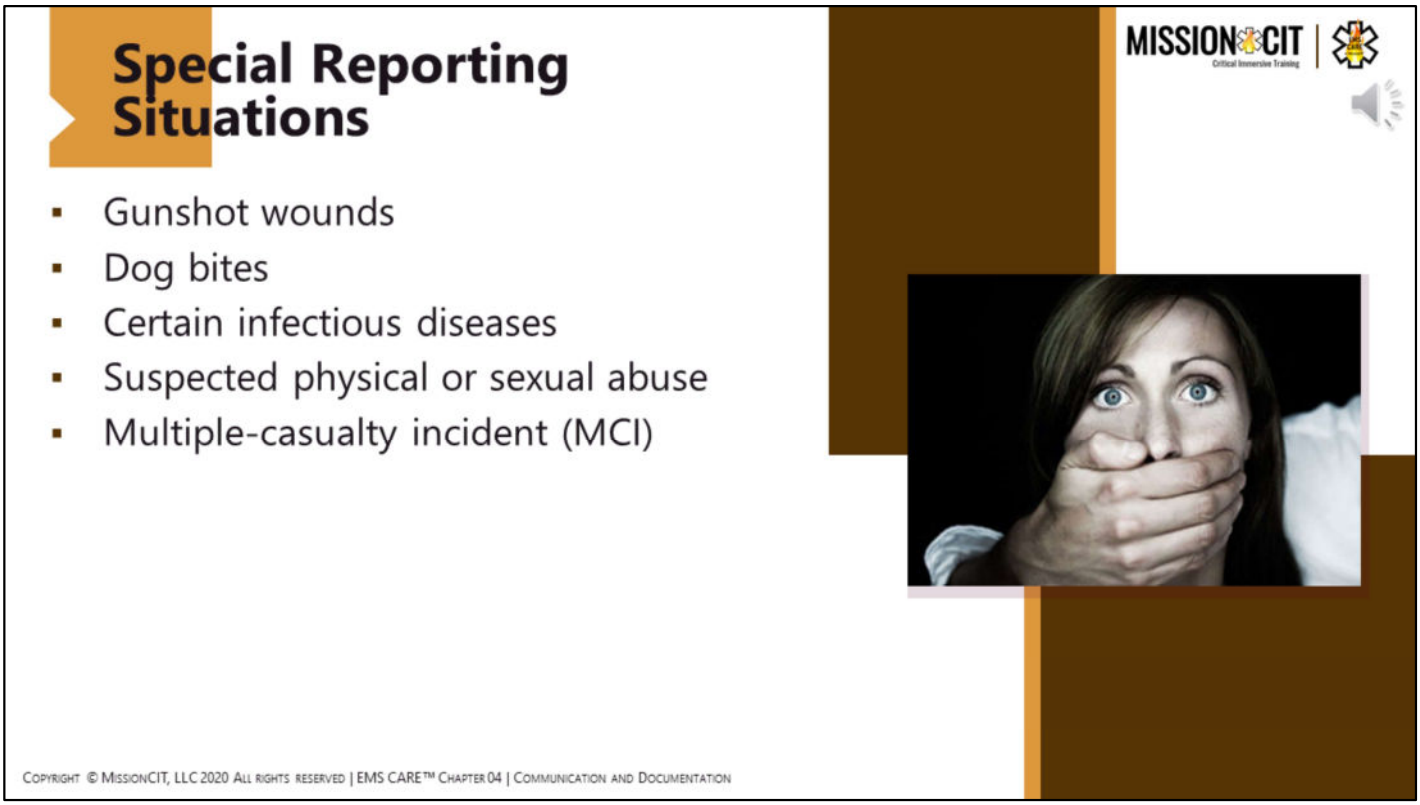
As a part of your job, document any assessment findings and emergency medical care given, including the condition of the patient and other administrative information such as the time of arrival.

Whatever happens, never leave the place without the patient signing a refusal form. Also, have a family member, police officer, or bystander sign the refusal form as a witness.

Depending on the local requirements, the PCR might contain:

- A complete assessment of the patient's condition.
- Evidence that the patient can make a rational, informed decision.
- Discussion with the patient as to which care or transportation EMS recommends.
- Discussion with the patient as to what may happen if he or she does not allow care or transportation.
- Discussion with family, friends, or bystanders to try to encourage the patient to allow care.
- Discussion with medical direction according to local protocol.

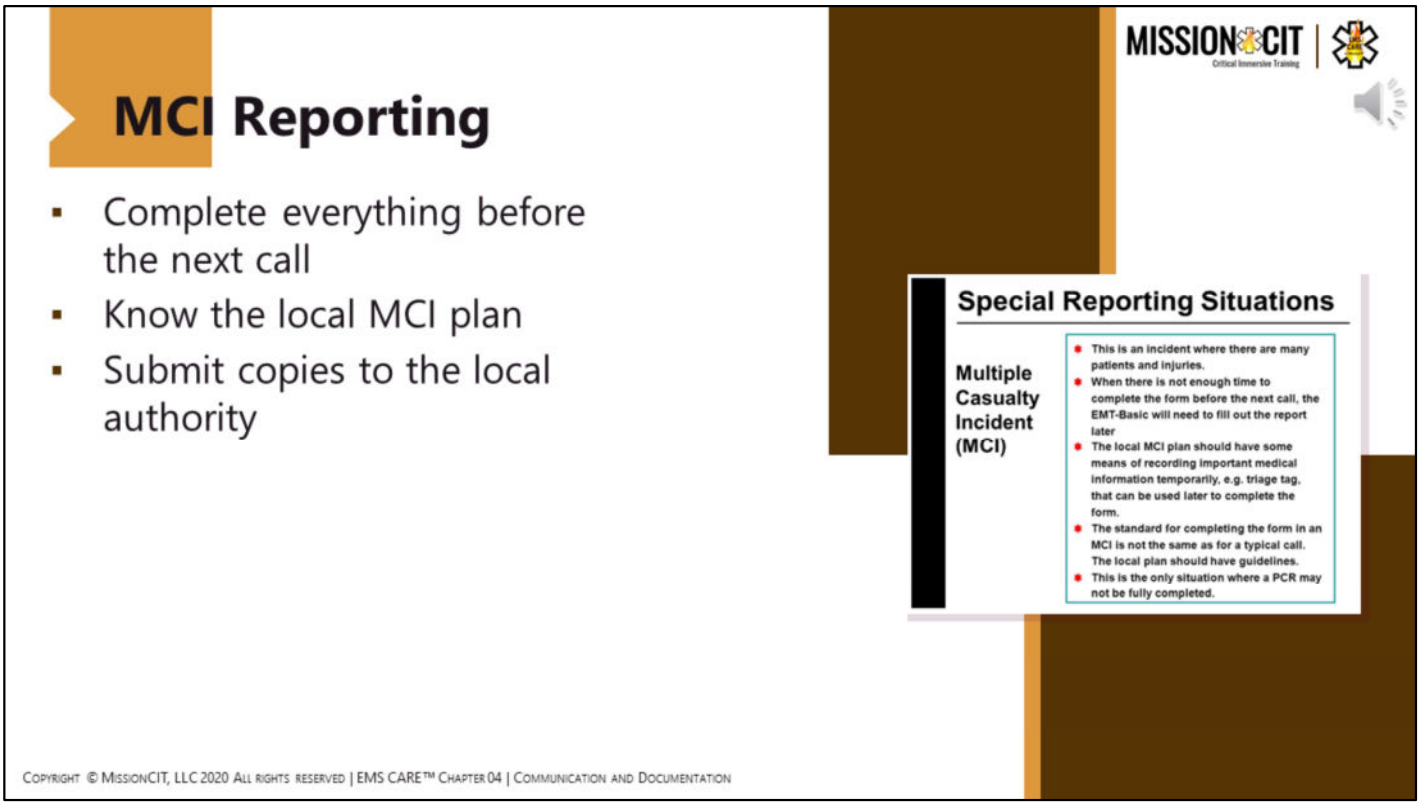
- Providing the patient with other alternatives. For example, going to see his or her family doctor, or having a family member drive him or her to the hospital.
- Willingness of the EMS to return.
- Signatures at the end of the PCR of the patient, witness, and the EMS.



Some situations would require special reporting requirements.

Depending on the local requirements, the PCR can include details of:

- Gunshot wounds
- Dog bites
- Certain infectious diseases
- Suspected physical or sexual abuse
- Multiple-casualty incident (MCI)



In multiple or mass casualty incidents, you may not have the time to fill the complete form. In such situations, you can make a note of the events and details, and fill out the forms later. However, this has to be completed before the next call.

Also, the local MCI plan must have some means of recording important medical information temporarily. You must be aware of this plan.

The report and copies must be submitted to the local authority as per the established authority.

This brings us to the end of this lesson and in the next one, Missah will talk about using different communication devices.