

A06: Documentation Standards

Jennie Helmer

Reviewed: December 2, 2020

Introduction

All BCEHS employees providing out-of-hospital care in British Columbia are required to complete an electronic patient care record (ePCR) for every patient encounter. This document is an important part of the patient's journey. It is the duty of every BCEHS employee to complete patient documentation in a timely, conscientious, and thorough manner. Documentation duties also include recording relevant patient details, findings, management plans, and outcomes in a manner that is clear and understandable to other health care providers. In this context, 'documentation' may also refer to material or data produced outside of the ePCR, including monitor, defibrillator reports, and downloads.

Only one ePCR per patient is provided to the receiving facility. Generally, the most qualified paramedic, or EMR, involved in the patient's care will be responsible for completing the ePCR, and in most cases, this duty will fall to the attending paramedic or EMR. In some circumstances, additional highly trained paramedics will assist in the conveyance of a patient; in this case, the paramedic with the higher level of qualification may contribute content to the ePCR that accompanies the patient.

In cases where care is delegated to lower levels of paramedic or EMR care, the higher qualified paramedic must still complete a separate ePCR documenting their assessment and decisions.

Essentials

- An ePCR must be completed for each request for service, regardless of whether an assessment is conducted, care is provided, or the patient is conveyed by ambulance.
- The ePCR must be completed as soon as possible, no later than the end of the scheduled shift or work assignment during which the call occurred.
- The ePCR documentation must be accurate, legible, and complete.
- In situations where more than one patient is assessed, an ePCR must be completed for each patient.
- Ensure all data entered on the ePCR is correct prior to finalizing the completed form; errors or omissions identified after finalization will require paramedics or EMRs to document the correction in a clearly identified addendum through their unit chiefs or designated supervisors.

General

- The ePCR software contains a number of data collection features that should be used as designed.
- Where an option exists to capture information through a built-in function of the software (e.g., advanced airway data), paramedics and EMRs must use these tools and not rely on free text entry options to record data. This is particularly important when systems of care are involved or where procedures are being performed as the information gathered informs BCEHS practice.
- Corrections to finalized ePCRs must be done through a paramedic or EMR's unit chief or designate.
- Data acquired from cardiac monitors, including cardiac arrest records and 12-lead ECGs, must be downloaded into the ePCR software and attached to the patient care record. This material must also be sent to the Cardiac Arrest and Major Trauma registry when required.
- Automated external defibrillator (AED) case records must be downloaded to the Cardiac Arrest and Major Trauma registry as soon as practical. [Instructions for downloading are available.](#)
- When an intervention or treatment has been performed, paramedics and EMRs must ensure that an outcome is described, including complications. These complications should be comprehensively documented for research and follow-up purposes.
- Various groups use the information recorded in the ePCR for a variety of purposes, including:
 - Clinical
 - Information about the call history, patient assessment findings, patient care provided, and the response to treatment, is important to receiving facilities and referral teams to support the patient's ongoing care.
 - Administrative

- Statistics can assist in maintaining effective paramedic and EMR services and provide valuable information for future planning.
- Research
 - ePCR information can be used to help answer quality assurance and research oriented questions, which will contribute to future advances in out-of-hospital care and best practice.
- Legal and Regulatory
 - The ePCR is a legal document and is part of the patient's medical record.
 - The report must be complete and of a quality suitable for use as evidence in an investigation or legal proceeding.
 - The ePCR may be requested by external organizations including law enforcement, the Coroner's Office, the Ministry of Health, and the patient.

