



Documenting the Unusual
Occurrence:
An EMS Way of Life...

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One-Ida 10 Has Arrived On Scene...



Scenario One:

- Five Minutes to Review Your Notes.
- Ten Minutes to Talk with Partner.
- Do Not Volunteer Information Unless Asked.
- PCR and Refusal are Provided.



Scenario One Discussion:

- Description of Call
- Medical Call or Non-Medical Call?
- Assessment?
- Patient History
- Patient Vitals
- Documentation.

Condition of Right Calf?

- Gangrenous Ulcer.
- Did your Assessment Catch it?
 - Did previous assessments catch it?
- How to Document?

Documenting the Unusual Occurrence:

- EMS calls are, for 99.9% of the population, an 'unusual occurrence.'
- If it wasn't documented, it wasn't done.
 - Corollary: If it is important enough to *do*, it is important enough to *document*.

Paralysis by Paperwork?

- Exercise Good Judgment
- Benefit from Good Training
- Identify key points to document
- When in doubt, document.

Reasons for Documentation:

- Passing Medical Information on to following treaters.
- Documenting treatment for billing purposes.
- Demonstrating compliance with SOPs.
- Training aid.
- Minimizing / mitigating liability.

What to document:

- Facts
- Objective Observations
 - Patient Assessment
- Verbal Statements
 - Only if noted contemporaneously?
- 'Road signs'
- Compliance Tools
- Opinions?

'Road signs'



- Key points that caused a decision to be made, or that caused a deviation in plans.
 - Assessment finding that generated need for treatment (e.g. administering medication).
 - External condition that impacted treatment (e.g. complicated extrication, detour, train crossing, weather).
 - Changes in patient condition (diminished responsiveness, changes in vital signs, etc.)
- Whenever possible, any 'external records'
 - EKG printout

Compliance Tools:



- Initial comments to any PCR:
 - Response time, reason for dispatch, BSI, scene safe, A&O, PMS, baseline vitals.
- Identification of others present at scene / during treatment.
- Required elements of treatment:
 - Repeat vitals at set intervals.
 - Other required treatment (e.g. blood sugar level)

Opinions?

- “Patient was clearly intoxicated.”
 - Diabetic? Accidental OD? Other?
- “Patient was alert but disoriented to time and place; patient exhibited slurred speech, inability to walk unassisted...”
- “Patient advised of ETOH x 10 in past 30 minutes.”
- “Bystander who identified self as patient’s roommate Dave advised of ETOH x 10 in past 30 minutes.”

Opinions, Continued:

- “Fractured right humerous.”
 - EMT with x-ray vision?
 - “Obvious comminuted fracture to right humerous approximately six inches distal from shoulder, with bone protruding from open wound.”
- “Suspected cardiac tamponade.”
 - “Patient exhibited jugular vein distention, hypotension, muffled heart sounds, low voltage QRS complexes...”

A Note on Terminology:

- Follow your hospital's SOPs.
- Follow your hospital's SOPs.
- Widely accepted abbreviations and 'medical shorthand' are generally acceptable.
 - "Beck's triad" v. "hypotension, JVD, muffled heart sounds."

What *Not* To document:

- Opinions without any factual base.
- Statements of *what you think might have happened*.
- Accusations of criminal misconduct
 - Talk to your department and EMS coordinator before completing report.
 - Mandatory reporting (e.g. child abuse/neglect)
- Anything you wouldn't want a jury to read on a projection screen (unless true).



Documenting the *Unusual* Occurrence:

- What is the Unusual Occurrence?
 - The Miller test (“I know it when I see it”).
 - Deviations from SOPs.
 - Any kind of accident involving patient care or transport.
 - Any accident resulting in injury to patient, bystanders or emergency personnel.
 - Any condition that is especially virulent (e.g. Ebola).
 - Mistakes made in patient diagnoses, care or treatment.
 - Talk to officers before completing report.



Mistakes, Errors and Omissions, Oh My!

- Documentation of errors and omissions should be *factual* and not *judgmental*.
- Errors do not need to be expressly identified, but should be accurately reported.
 - “Patient was administered 1mg atropine IV push every 3 minutes up to .5mg/kg dosage, which was a mistake because the maximum therapeutic dosage is .05mg/kg.”
 - “Patient was administered 1mg atropine IV push every 3 minutes for X minutes, with Y doses administered.”

Supplemental Reports

- If it should be documented and you don't have a place to document it, generate some form of supplemental report.
 - General purpose form to serve as addendum to normal run report/PCR.
 - Review with officers before completing.
 - *BUT*, complete contemporaneous with occurrence.

Records used in Surprising Ways:

- People v. Kando
- People v. Hatchett
- People v. Botsis
- Barker v. Eagle Food Centers

People v. Kando

- Defendant suffering from 'religious delusion' and believed he 'had been in a fight with Satan'.
- Defense offered argument that defendant was not guilty of attempted murder and aggravated battery because of insanity.
- Court reviewed records from paramedics to determine if defendant had made statements to the paramedics which corroborated or conflicted with his claimed mental state.

People v. Hatchett

- Mortally wounded victim identifies his murderers ('Quick and Little Ride') to the police before arrival of EMS.
- Court compares statements offered to police with condition of victim / statements made to EMS on arrival to determine if identification was admissible as 'dying declaration', and to determine if victim was lucid enough to make statement.

People v. Botsis

- DUI defendant charged with reckless homicide; passed out shortly before car accident occurred.
- Paramedic records used to determine mental and physical condition of defendant at time of accident, based on recitation of statements made by defendant, to paramedics, during treatment.

Barker v. Eagle Food Centers

- EMS dispatched to reported call of woman “who had slipped on wet floor.”
- EMS report indicated as above.
- Paramedic and EMTs *had no knowledge of the condition of the floor.*

Lack of Records is Surprising:

- *Abruzzo v. City of Park Ridge*
- *American National Bank v. City of Chicago*
- *Antonacci v. City of Chicago*

Abruzzo v. City of Park Ridge

- 911 call at 1:06am for 15yo “nonresponsive child who required CPR.”
- Engine and paramedic ambulance dispatched. Allegedly, EMTs knew patient had history of drug abuse. No transport and no documentation / refusal.
- Second 911 call at 9:00am; patient in cardiac arrest upon arrival. Patient transported to hospital; died. Cause of death was anoxic encephalopathy d/t cocaine/opiate intoxication.
- Failure to properly document first call.

American National Bank v. City of Chicago

- 7:55am: Female patient calls 911 to report asthma attack; lives on third floor of building. EMS dispatched to “heart attack” victim.
- EMS talked to all occupants of third floor except for one apartment (no response). EMS confirmed address with dispatch; dispatch attempted call-back to no avail.
- Neighbor advised EMS that occupants of apartment were young couple with no medical problems. EMS leaves the scene; no report.
- That afternoon, dispatched to same building; man let EMS into the apartment and they find original caller dead on the floor.

Antonacci v. City of Chicago

- Patient with heart attack.
- EMS responds; began treating patient; patient has pulse.
- Patient's family alleges that EMS failed to run EKG and failed to defibrillate patient.
- EMS run report indicates EKG was completed and patient was in asystole.
- Court expressly noted that there was no EKG strip or "evidence in the record to confirm an EKG actually was performed."

Difficult to Document Calls:

- Washington v. City of Evanston
- Fagocki v. Lake In The Hills

Washington v. City of Evanston

- 2:48pm: Paramedics call medical control: Woman in labor, 8.5mos pregnant, 2nd floor apartment.
- Attending ER MD orders EMS to immediately transport patient pursuant to SOPs, and calls for OB resident to come to ER.
- 2:56pm: Paramedics second call to medical control: Both legs and butt protruding; they have not initiated transport. OB resident advises EMS to attempt to deliver child on-scene. No pulse, no resp.
- 3:14pm: Plaintiffs decide to transport patient; head spontaneously delivers. Child is cyanotic, no pulse.
- 3:22pm: EMS arrives at hospital with patients.

Washington v. City of Evanston Part II:

- Call timeline is *critical*
 - Especially when administering drugs or CPR.
- Explain deviation from SOP / medical control direction.
 - Why did they not initiate transport if they were only 5 minutes out?

Fagocki v. LITH

- 50yo, 300# female has severe allergic reaction to peanuts while eating; goes to immediate care center. Arrived at 4:53pm, comatose, cyanotic, and having difficulty breathing; was sitting in passenger seat of car.
- MD at urgent care center diagnoses anaphylactic shock, advises staff to call 911; administer epipen; get his airway bag. MD trying to use BVM without success. No epipen present; no epinephrine administered.
- Five paramedics arrive on scene at 4:56pm. Takes 2 minutes to remove patient from car and get her into ambulance. While placing patient in ambulance, patient fell off gurney d/t weight and size.
- MD claims he offered to intubate patient and paramedics refused. Paramedics dispute that issue.
- Paramedics administer benadryl and no epinephrine. Paramedics attempt to intubate but jaw is clenched. Paramedics administer versed in multiple doses (instead of versed + etomidate).
- Paramedics start transport and at 5:22pm, they believed that they had successfully intubated patient.
- Paramedics arrive at hospital at 5:25 and ER staff finds intubation into esophagus rather than trachea. Patient suffers irreversible brain damage / coma.

Fagocki v. LITH Part II

- Difficult Issues:
 - Conflict with MD (superior license)
 - Timeline
 - Accident in patient handling (fell off gurney)
 - Administration of multiple drugs
 - Difficult intubation / clenched jaw

Unusual Occurrences, Continued:

- 'Off-duty' or 'out of district' responses:
 - Department policy on responding to out of district incidents / MVAs?
 - Hospital policy? (Level of licensure outside of district).
 - Equipment provided / used? (e.g. Airways)
 - Documenting incidents.
 - DUI MVA; called as witness.

Unusual Occurrences, Continued:

- Conflict with Other Department / Other Treater:
 - Mutual aide or multiple victims.
 - Observe breach of SOPs or protocol.

Documentation Best Practices:

- When in doubt, document.
- Have a 'supplemental reporting form' available, in addition to all other documentation you utilize.
 - Train your employees to use the form.
- Train to make notes of timelines and road signs during treatment.
- When an unusual occurrence happens, check with officers *before completing and filing report.*

Scenario Two:

- Five Minutes to Review Your Notes.
- Ten Minutes to Talk with Partner.
- Do Not Volunteer Information Unless Asked.
- PCR and Refusal are Provided.



EMERGENCY!!

- Your department is paged out for a structure fire with four nuns and twenty children trapped on the third floor of the only three-floor building in your town.
- Every mutual aid department within 100 miles is currently attending the IAFFPD training seminar in Peoria, IL.

Scenario Two Discussion:

- Description of Call
- Medical Call or Non-Medical Call?
- Assessment?
- Patient History
- Patient Vitals
- Documentation.
- Should I stay or should I go?
 - Does fire impact treatment?

Scenario Two Aftermath:

- Patient was suffering from DVT, throws a clot, has a stroke, suffers permanent brain damage.
- Patient is now only able to pursue a career as a fire chief.

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