General Order Number: 03-15	**Effective Date:** December 5, 2023
Division: Communication and Information Management/Technology	
Chapter: Electronic Patient Care Report	
By Order of the County Fire Chief: Tiffany D. Green	**Previous Revision Date:** December 7, 2022

POLICY

This General Order establishes the procedures for Fire/Emergency Medical Services (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. The current ePCR for the Department is the Maryland State Electronic Medical Data Systems (eMEDS).

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

- Ambulance and Medic Locals
- Rescue Locals
- Motor Vehicle Crashes
- CO Alarms with Potential Victims
- Ambulance and Medic units assigned to the EMS Group during a working incident
- EMS units assigned to rehabilitation group during a working incident

eMEDS Elite – The statewide EMS data repository. eMEDS Elite serves as the access point for Clinicians to complete and access ePCRs, manage their profile, and access to Quality Assurance (QA)/Quality Improvement (QI) messaging.

Mobile Data Terminal (MDT) – Vehicle mounted computer that may also be used for the completion of an ePCR.

Patient Encounter – Any face-to-face interaction or verbal communication with person(s) requesting EMS care or who have an apparent injury or illness.

Tablet Computer – A ruggedized tablet/notebook style computer such as the Panasonic Toughbook used for completing ePCRs. All EMS transport units and ALS equipped engines are assigned a tablet computer and an AC power adapter.

Tour of Duty – Career - The employee's time at work.

Tour of Duty – Volunteer – The time a volunteer is available to participate in emergency operations.

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."

PROCEDURES / RESPONSIBILITIES

I. General Guidelines

In accordance with State Law, COMAR 30.03.04.04, each 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.

A. Confidentiality

1. The patient care data gathered while performing EMS duties is considered protected health information under the Health Insurance Portability and Accountability Act (HIPAA). Any handwritten or hardcopy accounts of patient information must be destroyed once the ePCR is completed. Protected health information (PHI) cannot be stored on a personal electronic device as outlined in *General Order 03-05, Health Insurance Portability and Accountability*.

B. Public Disclosure

1. The Department's Technology and Information Services Office (TISO) is the only division authorized to provide reports to the public or other agencies. All requests for reports shall be referred to TISO.

C. Quality Assurance

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

2. Users are required to log into eMEDS Elite at least once per tour of duty or when the system shows the user has new messages.

II. Indications

A. Report Completion

1. An electronic patient care report must be completed by each unit that responds to an EMS-related incident. Additionally, any patient encounter requires the completion of individual patient care report.

2. All electronic patient care reports shall be completed and posted to Elite prior to leaving the facility (for patients transported) and by the end of the tour of duty for EMS

incidents that did not involve a patient transport.

B. Fire/RMS vs. ePCR Documentation

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

2. For fire incidents with an EMS component (e.g., a civilian or firefighter injury), all EMS units, and only the suppression units involved in a patient encounter are responsible for completing an ePCR. All other suppression units are required to enter their reports into RMS.

C. Documentation of Transition of Patient Care: ALS to BLS

1. In accordance with Maryland EMS Clinician Protocols, if an ALS Clinician terminates their Clinician-Patient relationship, the ALS Clinician who performed the ALS Assessment/Interventions must complete a patient care report and, if applicable, the EKG of any type shall be uploaded into the patient care report utilizing the "Downloaded EKG" dropdown found under "Provider Actions" and choose "EKG Waveforms + ADD" and a copy sent with the BLS unit to the receiving facility.

III. Requirements

A. General Requirements

1. The ePCR system provides several data fields to document the incident accurately and thoroughly, including, but not limited to, the following:
   a) All Crew member names, to include their affiliation i.e., Career/Volunteer Company Number
   b) Location of the incident
   c) Patient Identification Information
      - Full Name and Date of Birth
      - Social Security Number (SSN) – If the SSN is not obtained, it must be documented in the narrative why the information was not obtained.
      - Medical Record Number (MRN)
      - Home Address
      - Home Phone
   d) All available Computer Aided Dispatch (CAD) data indicating dates and times
   e) Incident numbers in proper format: YR-DAY-INC# (e.g., 090230123)
   f) Procedures/Medications/Skills/EKGs in the appropriate data fields.
   g) A complete narrative of events that occurred on the incident, including all patient assessments, pertinent negatives related to the injury or illness, treatment performed, response to treatment, transport information including whether an ALS Clinician from another unit upgraded the level of care to the patient on the transporting ambulance, and transfer of care to the receiving facility.

h) Vital Signs - A complete set of vital signs includes, at a minimum, heart rate/ regularity/strength, respiratory rate, pulse oximetry, blood pressure, Glasgow Coma Score, pain score assessment, and blood glucose (when required by MIEMSS protocols)
   - A minimum of two (2) complete sets of vital signs are required for all patients transported to a health care facility.
   - For patients not transported, a minimum of one (1) complete set is required per patient encounter, except two (2) complete sets of vital signs shall be required when any medical intervention (such as medication administration) is performed.

i) Complete documentation of any patient refusal
j) Receiving facility
k) Signatures (as shown in Attachment 2 - Required Signatures)
l) Billing Information:
   - Driver from Scene to Hospital Affiliation (select Career for career driver and Select Volunteer Company Number for Volunteer Driver)
   - Primary Clinician from scene to Hospital Affiliation (select Career for career Clinician and Select Volunteer Company Number for Volunteer Clinician)
   - Transport Vehicle M Number

2. Required fields must be completed, and the clinician will ensure a validation score as close to 100% as possible prior to submitting the official report. If the clinician is unable to obtain the required information, leave the field blank and document the reason in the narrative. In the event of a "John Doe," use the hospital's assigned name. If unable to obtain the SSN, leave the field blank.

3. The attached Maryland Short Form (Attachment 1) can be used to assist personnel with uniformly collecting and reporting all this information.

B. Patient Transports

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

2. The ePCR is posted to the receiving facility's eMEDS Hospital Dashboard and will display the status of the report as in progress or complete. The ePCR must be submitted as complete and available to the receiving facility staff prior to clearing the hospital. (Note- if using the Field-Bridge software to complete the report, the clinician must "Post" the report to the State-Bridge site prior to leaving the hospital.) This is critical because the information is incorporated into the patient's medical record.

3. In rare circumstances where the patient's ePCR is not completed prior to leaving the hospital, Clinicians are required to leave a Maryland Short Form (Attachment 1) for inclusion in the patient care record before leaving the receiving facility. Additionally, if the short form is utilized, clinicians must ensure the ePCR is completed on the Elite site by the end of the tour of duty.

4. Prince George's County Fire/EMS Department bills an Emergency Transportation Fee for all patient transports. The HIPAA Billing Form tab on the Signatures page of the ePCR grants consent for Prince George's County, and its authorized agents, to bill a patient and their respective insurance carrier. Clinicians must secure a signature, or suitable substitute, from all patients that are transported by the Prince George's County Fire/EMS Department. Clinicians must also secure a signature from the Receiving Facility staff and the clinician who completed the report must sign the report. A chart outlining specific signature requirements is attached to this General Order and may be updated as needed. (Attachment 2)

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

6. In the event a Toughbook is not available to complete the ePCR, the Maryland Short Form, Signature Form, and HIPAA Release forms must be completed before leaving the receiving facility. The Patient Refusal form must be completed before leaving the scene of an incident.

C. Transfer of Care

1. Clinicians must document the transfer of patient care to the receiving facility in the narrative. This is accomplished by documenting the following:
   a) Patient Care Area (e.g., Bed #2)
   b) Name of the healthcare clinician accepting patient care
   c) Time of transfer
   d) Securing a signature from the receiving facility staff

D. Supplies/Logistics

1. Clinicians must document all attempts of a procedure utilizing EMS Supplies under the "Provider Actions" tab choosing the "Procedures" dropdown in the eMEDS ePCR. The documentation must include the name of the procedure, time, who performed/ attempted, size of equipment, number of attempts whether successful or unsuccessful, IV location, and any complications.

2. Clinicians must document all medications given to a patient under the "Provider Actions" tab choosing the "Medications" dropdown in the eMEDS ePCR. The documentation must include if the medication was given prior to arrival, time, the clinician who administered, route, dose, drug, the patient's response to the medication, and the authorizing physician if applicable.

3. Clinicians must document any AED attempt under the "Provider Actions" tab choosing the "Downloaded EKG" dropdown in the eMEDS ePCR. The documentation must answer if the device was used prior to EMS arrival and include time, number of shocks, and document any complications in the narrative.

4. Clinicians must document any EKG 12 leads, 4 lead rhythm changes, transcutaneous pacing, defibrillation, and/or cardioversion under the "Provider Actions" tab choosing the "Downloaded EKG" dropdown in the eMEDS ePCR. The documentation must answer if a device (AED) was used prior to EMS arrival and include time, number of shocks delivered, Energy, pacing rate, ectopy, Type of EKG Lead, and ECG Interpretation.

E. Patient Refusals

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

2. Any patient refusing care must be informed of the following:
   a) Limitation of a pre-hospital assessment
   b) Assessment findings
   c) Treatments rendered
   d) Anticipated complications or adverse effects
   e) Medical decision-making capability
   f) Patient's right to seek medical attention later by any means, including 911

3. The ePCR shall document all the elements listed above. The Clinician must accurately complete all sections within the "Patient Refusal" tab. "Section 4: Patient's Statement" must be completed using the patient's own words in quotes as to why they are refusing care/services. The patient must then sign under the "Signatures" tab; "Signatures + Add"; choosing "Patient" from the list and choosing "Refusal of Services" as the signature reason.

4. If Elite is offline, units will utilize the paper "Refusal of Care" form (Attachment 3). The incident number and ePCR number need to be clearly displayed at the top of the form. The original copy will be forwarded to TISO, scanned, and added to the ePCR. The pink copy is the patient's copy and shall be provided to the patient or the patient's guardian if a minor.

5. 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. If a patient is not competent (by age, mental status, or other condition) to refuse treatment and/or transport, a guardian or other appropriate individual must make the decision on behalf of the patient and sign the refusal form.

F. Import of EKG and LifePak 15 Data

1. The ALS Clinician must import the data from the LifePak 15 into the eMEDS report for any patient encounter where EKG leads were applied, or capnography was utilized.

G. Advanced Airway Verification

1. The "Airway Confirmation" field must be completed in eMEDS when an ALS Clinician performs, or attempts to perform, any advanced airway interventions on a patient.

H. Controlled Substances

1. The "Controlled Substance Field" under the "Signatures" tab must be completed in eMEDS by the ALS Clinician whenever a controlled substance is utilized. An appropriate signature must be obtained for controlled substance waste if applicable. The ALS Clinician is responsible for complying with *General Order 05-18, Advanced Life Support – ALS – Controlled Substances*.

IV. Responsibilities

A. EMS Clinicians

1. Each EMS Clinician 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.

B. Volunteer Chief/Career Station Supervisor

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

2. The Career Station Supervisor or Volunteer Chief will be held accountable when a consistent pattern of non-compliance exists.

REFERENCES

The Code of Maryland Regulations (COMAR) 30.03.04.04
General Order 05-18 – Advanced Life Support (ALS) Controlled Substances
General Order 03-05 – Health Insurance Portability and Accountability
Maryland EMS Clinician Protocols

FORMS / ATTACHMENTS

Attachment #1 – Maryland Short Form
Attachment #2 – Ambulance Signature Form
Attachment #3 – Patient Refusal of Care Form

Maryland Institute for
Emergency Medical Services Systems

Short Form Patient Information Sheet

Jurisdiction: _____ **Date:** _____
Incident # _____ **Time Arrived at Hospital:** _____
Unit #: _____
Age: _____ **DOB:** _____ **Wt:** _____ **Kg** **Gender:** ❑M ❑F
Priority: ❑1 ❑2 ❑3 ❑4 **Trauma Category:** ❑A ❑B ❑C ❑D
Patient's Name: _____
Patient's Address: _____
City: _____ **State:** _____
Point of Contact: _____ **Phone Number:** _____
Chief Complaint: _____
Time of Onset: _____ **Past Medical History: (DNR/MOLST ❑A1 ❑A2 ❑B)**
Cardiac ❑ CHF ❑ Hypertension ❑ Seizure ❑ Diabetes ❑ COPD ❑ Asthma ❑
Other: _____
Current Meds: _____ _____ _____ _____
_____ _____ _____ _____ _____
Allergies: Latex ❑ Penicillin/Ceph ❑ Sulfa ❑ Other: _____

Assessments

Vitals

Time: _____
Temperature _____
B/P: _____ / _____
Pulse: _____
Respirations: _____
SAO2: _____%
Capnography: _____
Carbon Monoxide: _____

Repeat Vitals

Time: _____
B/P: _____ / _____
Pulse: _____
Respirations: _____
SAO2: _____%
Capnography: _____
Carbon Monoxide: _____

Respiration

Left		Right
❑	Clear	❑
❑	Rales	❑
❑	Labored	❑
❑	Stridor	❑
❑	Rhonchi	❑
❑	Wheezes	❑
❑	Decreased	❑
❑	Agonal	❑
❑	Absent	❑

Skin

❑ Warm
❑ Hot
❑ Cool
❑ Dry
❑ Clammy
❑ Diaphoretic
❑ Cyanotic

Pulse

❑ Regular ❑ Irregular
❑ JVD ❑ Peripheral Edema
Cap Refill: _____ seconds

GCS

Eyes (4): _____
Motor (6): _____
Verbal (5): _____
TOTAL: _____

Pupils

❑ PERRL
❑ Unequal
❑ Fixed/Dilated

Neuro

❑ A ❑ V
❑ P ❑ U

Assessment

Procedures

Cardiac Rhythm:

_____

Perform 12 Lead Yes ❑ No ❑12
Lead Transmit Yes ❑ No ❑

Glucometer:

_____

❑IV1 ❑IV2 Time Started _____
❑IO ❑EJ
Amount Infused:

_____

CPR Performed Yes ❑ No ❑
ROSC Yes ❑ No ❑
Induced Hypothermia Yes ❑ No ❑

Cincinnati Stroke Scale

Normal/Abnormal

Facial Droop Normal ❑ Abnormal ❑
Arm Drift Normal ❑ Abnormal ❑
Speech Normal ❑ Abnormal ❑
Last Known Well Time/Date: _____

Los Angeles Motor Scale (LAMS)

Facial Droop		*Grip Strength*	
Absent	0	Normal	0
Present	1	Weak Grip	1
		No Grip	2

Arm Drift	
Absent	0
Drifts Down	1
Falls Rapidly	2

Score: _____

Oxygen

❑ NRB Mask ❑ King Airway
❑ Nasal Cannula ❑ CPAP
❑ NPA/OPA ❑ NDT
❑ BVM ❑ Ventilator
❑ ET ❑ NT ❑ NGT
❑ Easy Tube

Treatment:

Jurisdictional Additions:

Print Clinician Name: _____

PRINCE GEORGE'S COUNTY, MARYLAND
FIRE/EMS DEPARTMENT

REFUSAL OF CARE FORM

Patient's Name: _____ **Date**: ☐☐/☐☐/☐☐☐☐

Incident Location: _____ **Inc #:** ☐☐-☐☐☐-☐☐☐☐

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 RESPONSIBLITY WHEN PATIENT REFUSES SERVICES

This is to certify that I, _____, am refusing the services offered by the
(Patient's Printed Name)
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 that 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:

☐ Examination/Assessment ☐ Medications ☐ IV/IO ☐ Other_____
☐ Spinal Immobilization ☐ Care ☐ Transport ☐ **All Services**

Patient/Representative Signature: _____

Relationship (if not the patient) ☐ Parent ☐ Guardian

Disposition: ☐ Placed in care of self Placed in care/custody of: ☐ Parent ☐ Guardian
☐ Released to law enforcement ☐ 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).

Witness Information

Signature: _____ **Name:** _____
(Print)

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone #:** _____

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

Rev (3/2009)

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

SECTION I – PATIENT SIGNATURE

This Section is for **emergencies or non-emergencies**. The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____
Patient Signature or Mark Date

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.

X _____
Witness Signature Date

_____
Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

This section is for **emergencies or non-emergencies**. Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

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.

X _____ _____
Representative Signature Date Printed Name of Representative

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