IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION

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IEMSA

July – September 2005

VOICE

A **VOICE** FOR **POSITIVE** CHANGE IN **IOWA** EMS

Iowa Emergency Medical Services Association

NEWS *to* SHARE

Are you working on an exciting program that needs to be shared with the membership of IEMSA? Do you know of an EMS-related educational program that needs to be showcased? Has your service won an award or done something outstanding? Do you want to honor a special member of your staff or of the community? If so, you can submit an article to be published in the IEMSA newsletter! In order to do this, just prepare a press release (and pictures, if appropriate) and e-mail it to iemsa911@netins.net by the following date: **November 17 (to be mailed by December 10)**.

The Newsletter Committee will review all articles submitted and reserves the right to edit the articles, if necessary.

IEMSA Vol. 2005-03 • July – September, 2005
VOICE

Iowa Emergency Medical Services Association Newsletter is Published Quarterly by:
IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION
2600 Vine Street, Suite 400 • West Des Moines, IA 50265

2005 IEMSA MEETINGS

BOARD MEETINGS:
THE IEMSA BOARD OF DIRECTORS WILL MEET ON THE FOLLOWING DATES IN 2005. EACH MEETING (WITH THE EXCEPTION OF THE ANNUAL MEETING) WILL BE HELD AT THE RACCOON RIVER NATURE LODGE, 2500 GRAND AVENUE, WEST DES MOINES. ALL MEETINGS, WITH THE EXCEPTION OF THE ANNUAL MEETING WILL BE HELD AT 1:00 P.M.

- **September 15**
- **October 20**
- **November 10**
  – ANNUAL MEETING
- **December 15**

ADDITIONAL
Important Dates:
Mark Your Calendar —
ANNUAL CONFERENCE
November 10 - 12, 2005
Annual Conference & Trade Show
Des Moines, Iowa

THE COST OF DOING BUSINESS

BY JEFFERY D. DUMERMUTH, PRESIDENT, IEMSA BOARD OF DIRECTORS

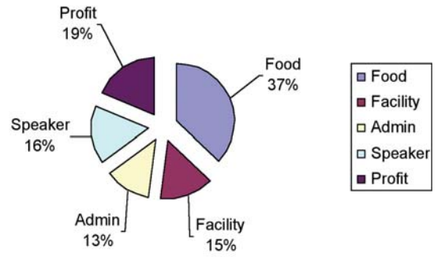
As we are finalizing the plans for our 2005 Conference and Trade Show, I felt it essential to talk with our members about the importance of the Conference to our Association.

Our Association operates primarily on funds received from membership dues and profits from our annual conference. Yearly, the IEMSA Board of Directors struggles with two primary questions that directly affect our members — should we make any change in our dues structure and should we make any change in our registration fees for the Conference to assure we operate in the black.

We have worked hard to limit any changes to our fee structures. We have added many benefits over the past couple of years without making any changes to our annual membership dues, which remain at $25. We haven't changed our fees because we know that the majority of our members work in EMS as volunteers, and we want to try to give the biggest value for the least amount of financial outlay from our members.

Often times we are asked why the conferences cost so much to attend. As we prepare to mail out this years brochure, I felt it appropriate to provide an outline of how the registration fees are spent. Astonishingly, the cost of food and rental of our venue quickly eats up 52% of the revenues we receive. This year it is projected that we will spend nearly $75,000 for food and venue rental. We are tied to our current location since no other facility can handle a conference as large as ours. 29% of the remaining revenue is spent on conference materials, administration and speaker fees. The remaining 19% of your registration fee is profit that we have relied on to operate our Association.

2004 ANNUAL CONFERENCE



We have been notified our costs this year will be increasing between 17% and 20% for food and venue rental which essentially erases any profits we may have hoped to make from the conference.

The Bottom Line…. as we look at the fee schedule this year for our conference, there is no way that we cannot raise registration fees. We have made every effort to minimize our costs and to limit the amount of registration fee increase. While our expenses will increase nearly 20% we have only increased our registration fees by 7% for our members.

Know that we take this very seriously and will continue, as we always have, to strive to provide you with the best value for your educational needs, while maintaining the highest quality experience you expect. I look forward to seeing you all in November. ■

IEMSA *Extends* Group Purchasing Contract

The first year of IEMSA's Group Purchasing Program came to a close on July 31st, and, according to our Affiliate members, it was a great success! **"We saved more than the cost of our annual dues as Affiliate Members on our first order through IEMSA's Group Purchasing Program. This is the best deal we've gotten in a long time" said Dubuque Fire Rescue. According to Algona EMS, "We purchased only 11 items and realized a savings of over $350."**

IEMSA is pleased to announce that it plans to continue its relationship with Tri-anim Health Services, Inc. and Alliance Medical for another two years. The Membership Committee embarked on a bid process that mirrored the one used last year. Tri-anim and Alliance came out on top again! We look forward to working with them on this very beneficial project.

When asked to tell us how they felt about being the preferred vendors for IEMSA's Group Purchasing program, Tri-anim and Alliance offered the following:

Tri-anim has a 30 year history as the nation's leading specialty supplier in respiratory and anesthesia products. We are pleased to continue our growth in the EMS market with our partnership with IEMSA and the group purchasing efforts. With over 50,000 products from more than 350 different manufacturers, Tri-anim can help you with all of your supply and equipment needs. To order, call 800-TRI-ANIM (874-2646) or visit www.Tri-anim.com.

We at **Alliance Medical** are proud of our longstanding commitment and partnership with IEMSA and its members. Through our Value Added Program (VAP), we are able to offer IEMSA members significant savings, continued discounts, credit for expired drugs, special offers, and seasonal VAP deals. With over 16,000 different product choices, we are your one-stop shop for supplies, equipment and uniforms. Visit www.AllMed.net/VAP for more information.

Please remember to take advantage of the valuable, cost-saving program. All it takes is a current IEMSA Affiliate Membership. If your service is not currently an Affiliate member, just visit the Membership Information page of www.iemsa.net, download the Affiliate member application, complete it, and fax or mail it to IEMSA with payment. Your benefits will become effective immediately. ■

Iowa EMS Research

M. J. HARTLEY, PS/C, REMT-P, EMS COORDINATOR, IOWAROCS

As many Iowa EMS providers may have heard, a new EMS research effort has begun in our state that will involve many of you directly, and potentially impact all of you. On September 1, 2004, the National Institutes of Health (NIH), the Canadian Institutes of Health Research and others initiated a five-year grant to study techniques to improve patient outcomes from cardiac arrest and severe traumatic injury. The project is called the Resuscitation Outcomes Consortium (ROC).

Ten Regional Clinical Centers (RCCs) were chosen from North America to participate, eight in the United States and two in Canada. Iowa was chosen along with Milwaukee, Pittsburgh, Birmingham, Dallas, San Diego, Portland, Seattle, British Columbia and Toronto. At this time, 12 EMS agencies in Iowa will be participating in the specific clinical trials and data collection.

Unfortunately, much of what we have done in the way of pre-hospital care has not been based upon sound clinical research. Often times it has been the experts' "best guess," in many cases, that has guided our care. There is now a concerted effort to base our care on sound clinical research, and the ROC is one result of that effort.

This unprecedented EMS research effort has rekindled interest in pre-hospital research in Iowa. Nothing of this scope has ever been attempted in Iowa or the U.S. Through participation in the early defibrillation trials, Iowa EMS providers have already contributed to the science that has saved many cardiac arrest victims. We have that opportunity again, only this time on a much grander scale.

From a historical perspective, EMS research is more difficult because of the requirement for informed consent. Since EMS patients cannot provide informed

consent prior to an intervention, the process to permit emergency investigation with delayed informed consent has been developed. Under these requirements, communities are notified through media announcements and public meetings that their EMS agencies are participating in clinical trials. Patients and families who are enrolled are notified within a reasonable time and are given the opportunity to continue their participation. This process has been termed "exception to informed consent."

Cardiac Arrest

Our first cardiac arrest research effort is likely to focus on quality of CPR; collecting data on how it is performed in the field and investigating ways to improve it. We will concentrate on ventilation rate, compression rate and "hands off" time during the first 5 minutes of CPR. Other considerations may be a trial of early versus delayed defibrillation.

We will also be able to evaluate the Impedance Threshold Device (ITD). This simple device, when added to your BVM, ETT or Combitube, may dramatically improve systolic blood pressure produced by chest compressions.

We don't know what the ideal ventilation rate is. And, we know that the longer your hands are off the chest in a given minute, the worse the patient outcome. We need to know just how much "hands off" time there is in the field and find ways to minimize it.

Trauma

The trauma trial will evaluate new techniques to improve pre-hospital treatment of patients with serious life-threatening hemorrhage or traumatic brain injury. Resuscitation of hemorrhagic shock using hypertonic saline is the best-developed study to date, but awaits approval. Another investigation considered by the ROC includes modulation of end-tidal carbon dioxide in the intubated patient after cardiac arrest and trauma.

Finally, before we can begin our interventional trials, we must establish a data collection mechanism. The foundation for our data collection efforts will be the Resuscitation Outcomes Consortium Epistry (epistry = epidemiological data registry). We will use this format to collect the data required for the interventions. Additionally, this database will collect patient data from all cardiac arrest and severe trauma within the ten ROC sites. In Iowa, we will collect much of the data from existing data banks including the Iowa Bureau of EMS' "EMS Patient Registry," the "Iowa Trauma Registry," and data from the Iowa Hospital Association. The Epistry data collection may begin as early as January 2006.

In summary, the ultimate determinant for the success or failure of pre-hospital research is you, the EMS provider. Without support from the field personnel, EMS research is doomed to fail. Your active and consistent participation in these trials will answer critical questions that ultimately will save more lives. Many of you will have the opportunity to contribute directly to this life-saving effort. We are eagerly looking forward to working with you! ■

— The Iowa ROC's

Visit our web site at **www.iowarocs.org**

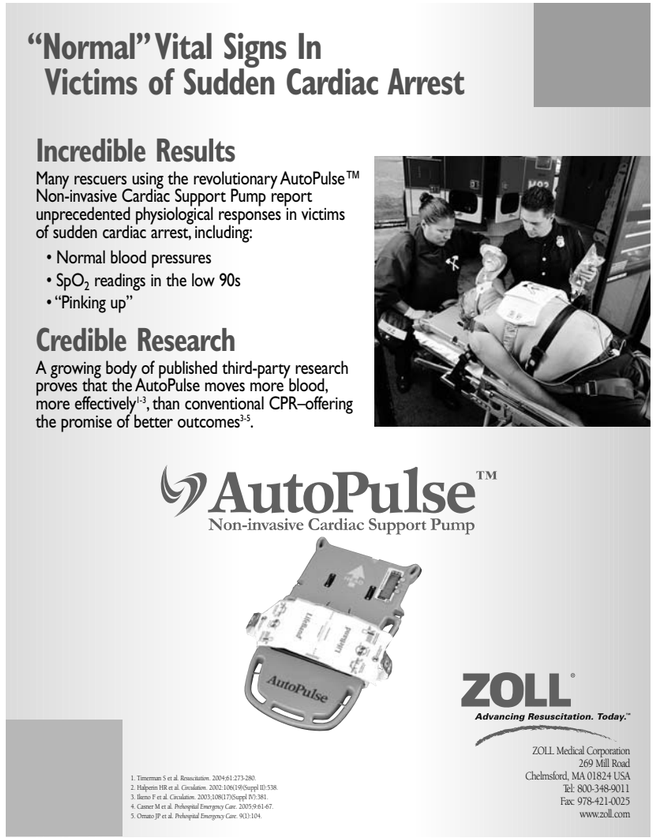
ZOLL AED Plus Basic

Available at Special Pricing

IEMSA and ZOLL Medical Corporation have teamed up to provide the ZOLL AED Plus Basic system to designated rural services in Iowa according to the criteria of the federal grant. As a special bonus, ZOLL is willing to offer IEMSA Affiliate Services the opportunity to purchase this system at the Grant price of $1249.74 (tax included). This system comes complete with the ZOLL AED Plus Basic, a carrying case, 2 sets of adult defibrillation pads, 2 sets of pediatric defibrillation pads, a battery, a training AED and the ability to download a free software program for post-use evaluation.

ZOLL Medical Corporation is committed to developing technologies that help advance the practice of resuscitation. With products for pacing, defibrillation, circulation, ventilation, and fluid resuscitation, ZOLL provides a comprehensive set of technologies that can help clinicians, EMS professionals, and lay rescuers resuscitate sudden cardiac arrest or trauma victims. ZOLL also designs and markets software that automates the documentation and management of both clinical and non-clinical data. ZOLL has operations in the United States, Canada, the United Kingdom, Germany, France, The Netherlands, Australia, and Austria. With direct operations, international offices, and business partners in all the world's major markets, ZOLL markets and sells its products in more than 140 countries. For more information, visit www.ZOLL.com.

We hope you will take advantage of this generous offer. You can contact Paul Maraman, EMS Territory Manager from ZOLL at 1-800-242-9150, X9770 to order. You will need to provide your Affiliate Membership number to Paul in order to verify that you qualify to order at this discounted price. ■



Over the years, many EMS providers have given countless hours of their dedicated service to many Iowans. Some have even given their life as a result of their commitment to Iowa EMS.

Please join IEMSA in **HONORING OUR OWN**... EMS Providers who are no longer with us.These honorees may be volunteer or career individuals who have died in the last ten years.

Please send a photo along with the following information:

Decedent's Name _____

Date of birth/Date of Death_____

Died in the line of duty ☐ YES ☐ NO

Years of service/Service name

Also include your name, address, and phone number should we need to contact you.

Please send a stamped, self-addressed envelope if you would like your photo returned.

SEND TO: Mr. Thomas Summitt
IEMSA
1718 Timberline Drive
Muscatine, Iowa 52761-2502

Organizations Interested in Honoring Our Own....

If your EMS group or agency would be interested in being featured in this year's Honoring Our Own DVD Presentation at the IEMSA Conference in Nov, please contact Tom Summitt at **563.263.2125**, or by email at **tcsummitt@machlink.com**. We would also like to feature honor guards from different agencies from around the state. If interested, please contact Tom at the email address above.

MEMBERSHIP ANNOUNCEMENTS:

GROUP PURCHASING
Affiliate Members — Don't forget to check out the discounts available through IEMSA's Group Purchasing program. Visit the Group Purchasing Page of www.iemsa.net to get connected with Alliance Medical, Inc. and Tri-Anim Health Services, Inc.

ANNUAL MEETING MINUTES
The minutes of the 2004 Annual Meeting are posted on the Publications Page of www.iemsa.net.

LEGISLATIVE UPDATES
IEMSA's Legislative Agenda and "Talking Points" can be found at www.iemsa.blogspot.com.

MEMBERSHIP DATABASE
Occasionally, we make our membership list available to carefully screened companies and organizations whose products and organizations may interest you, as well as board candidates who wish to solicit your vote. Many members find these mailings valuable. However, if you do not wish to receive these mailings (via postal service or e-mail), just send a note saying "do not release my name for mailings" to the IEMSA office via fax (515-225-9080) or e-mail (iemsa911@netins.net) or regular mail (2600 Vine St., Ste. 400, West Des Moines, IA 50265). In order to ensure the correct adjustment to our data base, please include your name, address and membership number.

Welcome New IEMSA Members

MAY 2005 — JULY 2005

CORPORATE SPONSORS:

AIR-EVAC
Tri-anim Health Services, Inc.

AFFILIATES:

Adair County Ambulance
Allerton First Responders
Bancroft Ambulance
Bernard Rescue Unit, Inc.
Carter Lake
Chickasaw Ambulance Service, Inc.
Decatur County Ambulance
Dubuque Fire Rescue
East Poweshiek Ambulance Service
Hancock Fire & First Responders
Hiawatha Fire Department
Lisbon-Mt. Vernon Ambulance
Logan Fire & Rescue
Lone Tree Fire & Rescue
Mercy Medical Ambulance –Centerville
Mercy Oelwein Ambulance
Meriden Fire Department
Mondamin Fire & Rescue
Regional Health Services Ambulance
Titonka Ambulance Service

INDIVIDUALS:

Donald D. Bauerkemper
Bonnie Boetel
Paul H. Brewer
Andrea Brouwer
Dan Brown
Barb Christenson
Doreen Cook
James Cook
Kerry Crouch
Terri Durgin
Rodney Ellingson
David Gerber
Gene Gonyier
Jason Griffin
Larry Guttau
Tracy Hall
Joe Holmbo
Renee Hurtig
Jerry Kahler
Mark Kalarovich
Dawn Kinkade
Jordan Knapp
Larry Landon
Jenny Link
Kim Lopez
Dean Luttrell
Rodger Maletta
Steve Mark
Dennis Massner
Tim Meaney
Linette Mellinger
Phillip Newton
Cindy Pattee
Dominique Petrillo
Deb Schroeder
Jack Scott
Melinda Scott
Tim Sechler
Scott M. Slough
Anne S. Smith
Rick Steines
Judy Weller
Stephanie Wittrock

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION

Board of Directors

COMPLETE CONTACT INFORMATION IS AVAILABLE AT WWW.IEMSA.NET

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VICE PRESIDENT
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SECRETARY
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Lori Reeves

LOBBYIST
Cal Hultman

OFFICE ADMINISTRATOR
Karen Kreider

AUTHOR:
This article was written by **Julie Scadden, REMT-P, PS** an EMS Instructor from northwest Iowa. Julie is the current President of the Buena Vista County EMS Association, a Consultant/CQI officer for data in Sac County EMS, and has been a staff paramedic for both areas for many years.

CONTINUING *education*

IF YOU DIDN'T DOCUMENT IT, YOU DIDN'T DO IT.

BY JULIE SCADDEN, REMT-P, PS

How many of us were taught that little pearl of wisdom during our initial EMT training? As EMS moves deeper into the health care arena, pre-hospital Patient Care Reports (PCR) have risen to new levels of importance for healthcare both scientifically, legally and monetarily. Documentation has become a necessity for EMS System development to attain higher levels of efficiency in the public healthcare field. As we move slowly forward in the development of pre-hospital public healthcare, documentation has not moved along with us.

Documentation has been viewed as the necessary "evil" that we were forced to learn, (usually poorly), because the elusive and scary "THEY." They told us we had to do it. EMT textbooks only devote a small part of a chapter to the topic of documentation. Many EMS instructors cover it briefly, sometimes only showing an example of a run sheet without any serious discussion or demonstration on how to fill it out. There has also been no serious "formal" continuing education on this topic. This leaves EMS providers with the drowning experience of copying what others do to learn. This is sometimes good, most times very ugly.

Case Study

About 2 years ago, you and your crew responded to a lady's house with presumed hyperventilation. You got her to the local hospital but you never heard what happened to her. You assumed she was treated and released. You remember that she was much better by the time you got her to the hospital – she complained of severe shortness of breath and anxiety when you got to her house but was sleeping upon arrival to the ED.

Today, your service director telephones you at home, stating that a court order has been written, requesting your documentation on the above lady's ambulance call. The City Attorney has contacted the Service Director and states that there are court documents showing intent to sue the ambulance service for negligence by the above lady's family.

Will your patient care report hold up? Will it prove that you did a good job?

In the court room 2 months later (with the lady's family in the front row), your patient care report has been scanned onto a series of slides that are being projected onto a huge screen. You notice that you forgot to note the respiratory rate on both sets of vital signs taken. And oops, you wonder if that jury over there will notice that you forgot to note her past medical history of congestive heart failure? Gee Whiz – you even see that you didn't spell ambulance right – is that a big deal?

Why Document? There are at least 5 good reasons:

Questions most often asked at a documentation class: "Why do we have to document? What does documentation do for my small service and me?"

1.) Communication

Documentation provides communication with other health care providers and establishes a "continuum of care" for the patient. During admission of your patient to a busy Emergency Department (ED), with nursing staff attempting to listen to your verbal report and the patient at the same time, causes confusion. What might happen when you leave that ED without leaving a copy of your documented findings and treatment? Patient care transfers in a busy ED can be hectic and chaotic with unintentional inattention to verbal reports. The documentation left with the ED staff, describing the patient's pre-hospital assessment findings and treatments, can provide vital information and avoid treatment mistakes and duplications that could be detrimental and life-threatening to the patient.

2.) Quality Care

Audits of patient care reports are a valuable and essential tool for every Continuous Quality Improvement (CQI) program in EMS. Individual skill proficiency can be tracked with continuing education geared toward improvement of any deficiencies noted. Protocol compliance can be monitored through review of documentation by the Medical Director. This ensures that the minimum standard of care has been provided to each patient. Accurate, efficient and complete documentation demonstrates credibility of the provider as well as the service the provider functions under. This furthers the efforts of liability protection and risk management for both the providers and services.

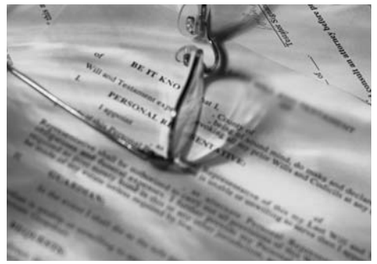
3.) Research & Funding

Documentation provides vital data for research to improve and prove effective assessments and interventions of our patients. Data gathered from pre-hospital documentation will be important in the endeavor to provide continuous, sustainable funding for EMS through the grant process and Federal appropriations. Grant funding will continue to be the mechanism used to provide the money needed for training of new EMS personnel, continuing education of existing personnel, as well as funding the training equipment for education. Data gathered through documentation is needed to provide statistics and information to prove the need to establish programs that provide, protect and enhance the well being of the pre-hospital providers.

4.) Public Health

Documentation becomes imperative in the event of a public health outbreak. EMS provides first-line information for public health alerts through reporting of trends in signs and symptoms or illness originating from a specific geographical area. The Health Alert Network (HAN) is integral in spreading information to all health care entities, and the information may begin with EMS.

As an example of this: in 1985, an outbreak of gastroenteritis in Oregon that was caused by a religious cult contaminating salad bars with salmonella was originally thought to be a natural event. Comparing health care information amongst all health care providers (EMS, E.D.s, and Infectious Disease personnel) helped find the culprit in this event.



5.) Reimbursement

Money for reimbursement of emergency medical services and medical transportation is very controlled and patient-care documentation can be the determining factor as to whether or not your service will be paid by those agencies such as Medicare, Medicaid and many insurance companies. Documentation must adequately demonstrate the need of the service to pass the evaluation it will receive in determining if your claim will be paid or denied. Reimbursement from Medicare, Medicaid, HMOs and private insurance will determine the mortality of the small town transporting ambulance services, making education of the providers on good documentation a necessity.

Who needs to Document?

In a word, EVERYONE — all who provide patient care, including First Responders and all levels of EMTs and paramedics. Under Iowa Code 132.8(3), Ambulance and nontransport service programs are required to "complete and maintain a patient care report concerning the care provided to each patient." Ambulance services are required to provide, at a minimum, a verbal PCR upon delivery of a patient to the receiving facility and then provide a complete, written PCR within 24 hours to the receiving facility.

How is EMS Documentation used by Lawyers?

Patient Care Reports (PCR) are the legal record of the events that occurred during EMS patient contact. Copies of PCRs are left at the receiving facility and become part of the patient's permanent medical record. Medical records are used to determine the validity of any legal case by determining the extent of injury as well as the series of events occurring during patient contact. PCRs will be used to determine if the assessment and treatment of the patient was performed within a "standard of care" by the EMS provider and whether patient care was transferred to the next appropriate level in healthcare.

In order for the legal system to prove negligence it must prove the following 4 items: 1) a healthcare relationship was established (Patient: EMS Provider); 2) the care of the patient was outside the standard of care; 3) an injury to the patient occurred; and 4) this injury was due to the failure in the standard of care. The PCR will be the key exhibit in all facets of this legal process.

Lawsuits can be filed by anyone, anytime and for any reason. Lawsuits are a financial strain, (win or lose), on the health care profession. The juries deciding the merits of malpractice are usually made up of lay people, not healthcare professionals. These juries are more likely to identify with the patient. Additionally, the attorneys have a vested interest in implicating a judgment error on the part of the providers, as they receive a percentage of the award, if successful.

Even if a standard of care was not clearly defined, carelessly written reports suggest the patient's treatment was also carelessly provided, even though that is not usually the case.

Documentation Guidelines

Accepted standards for EMS documentation are patient care reports that are factual, accurate, complete and timely. The physical report can follow formats determined by the individual or service, such as SOAP or CHARTE.

SOAP:

S **Subjective**: What you are told
O **Objective**: What you see/hear/feel
A **Assessment**: Your field impression
P **Plan**: What treatment did you render?

(Continued to page 10)

(Continued from page 9)

CHARTE:

This is similar to SOAP but the subjective and treatment areas are divided into two parts. This format provides a place to document problems at the scene.

- **C** **Chief Complaint:** What the patient tells you.
- **H** **History:** Immediate past history-just prior to event; include medications
- **A** **Assessment:** The full assessment. Include OPQRST and SAMPLE
- **R** **(Rx) Treatment:** Any treatment prior to EMS and from EMS at the scene
- **T** **Transport:** Treatment given enroute to the hospital and mode of transportation.
- **E** **Exceptions:** Any problems encountered during the trip.

The advantage of CHARTE is that it breaks down the incident into logical parts. The disadvantage is that you are not always going to use the total format, leaving blanks that might confuse the reader.

EMS services should have a written policy on documentation standards and confidentiality. A consistent use of one format within a service will insure uniform documentation. Uniform documentation diminishes confusion during the report audit process and facilitates training new staff to that service's documentation standards.

Documentation Do's and Don'ts of Hand-Written Reports

THE DON'TS:

1. Don't obliterate or erase errors. This could be interpreted as a "consciousness of negligence."
2. Don't document for anyone else or allow anyone else to document for you.
3. Don't use abbreviations that are not approved by local or state protocol, service or hospital, (FTD, CTD and FUBAR are NOT approved abbreviations). A list of approved abbreviations is in the amendment section of the Iowa EMS Protocols or check your local hospital list.

THE DO'S:

1. Do use black ink and the same color of ink throughout the report. Do "X" out large areas that are blank on the form. Draw a line to the end of the space or write "nothing follows" to indicate a completion of your narrative.
2. Do sign the PCR that you have written.
3. Do be neat; write and spell legibly and correctly. Documentation reflects the care a patient is given. You want your report to be as professional as the care you gave.
4. Do document events and treatments prior to your arrival and file an addendum if necessary to add information that may have been inadvertently left out on the initial report.
5. Do attach the monitor strips to the PCR if you have attached the cardiac monitor to the patient. Some services ask for a time to be accurately noted on the rhythm strip (don't rely upon the ECG machine to have the accurate time annotated).

Just the Facts- Please!

Factual documentation will be a record of what you see, feel, hear and smell during the call. Documentation of patient behavior that may have contributed to the illness should include non-compliance of previous treatment orders, i.e. failure to take prescribed medication, verbal or physical abuse of their care giver (or other individuals present) and refusal to follow verbal request of their care giver.

Documentation can include what the patient tells you in their own words. Using word-for-word quotes or "patient states…," insures that your documentation of those statements is precise and makes the difference between fact and fiction. Do not describe a provider's interpretation of what the patient said. Do not get personal! Avoid judgmental or descriptive narrative on the patient's behavior or assessment findings, i.e, "Patient smells of ETOH," "Patient was a huge jerk and called us nasty names even after we told him to shut up!" Bad documentation can and will make a good EMT look bad!

Elements of a Patient Care Report – Tell the Story

The components of a Patient Care Report will include the date and times of the call, the history of events, scene observations, pertinent patient history, physical examination, treatments rendered and any changes in the patient's status. The report should reflect the flow of events that take place from the time of dispatch to the transfer of care onto the receiving facility.

Dispatch information should include what kind of call this is: emergency or routine, illness or injury. Additionally, you should note how you were dispatched: communications center, 911, physician, hospital, or other support agency. Was the response uneventful or were there difficulties such as weather conditions, detours, wrong address or directions given?

Documentation of what is observed on scene proves vitally important in the continuum of care for most patients. Scene observations include where the patient was found and what their body position was. How many patients? Were there others on the scene rendering aid (law enforcement, First Responders or bystanders)? Is the patient unconscious or talking? Your description of that scene is very important. You are the only ones who see the patient in their own environment (if at home) or in the scene of the trauma.

Documentation of the focused history should indicate a mechanism of injury or nature of illness. When there is a mechanism of injury, what type? Give approximate speed, number of vehicles, damage to vehicles, patient ejected: how far, were they wearing a seatbelt, did they have airbags deployed or wearing a helmet.

If a medical emergency, documentation should include how long they have been ill or had symptoms, any previous diseases, surgeries, medications, allergies and treatments the patient has been receiving. Most educational programs and reference books refer to the OPQRST and SAMPLE as the acronym to remember when assessing and documenting history. Onset, Previous History, Quality of the pain or dyspnea, Referral area if pain, Severity of the pain or dyspnea (1-10), and Time issues (intermittent or steady). Sample includes Symptoms, Allergies, Medications, Previous history, Last meal and Events prior to illness.

Physical examination will include the level of consciousness and level of orientation using the Glasgow Coma Scale as a guide. The story should follow the actions, i.e., primary survey first, resuscitation (if any), then onto the rest of the exam. Head-to-toe exam includes assessment of eyes, ears, nose, throat, cardio-respiratory, GI/GU complaints and extremities. Assessment of vital signs should always include pulse, respirations,

blood pressure and skin condition. Pulse Oximetry, if available, should be assessed prior to and following O2 delivery.

Documentation of treatment rendered should include the actual treatment and time it was initiated. Describe the reason for any treatment delays. List the protocol referenced to provide the care. Verbal and/or written orders from medical control should be documented to support treatment decisions. The patient's documented condition must justify the type of treatment that was administered.

Patient status prior to and following treatments as well as throughout transport should be documented, including any change in patient condition. Communications with medical control should be documented with the time medical control was contacted as well as what medical control was ordered. Documenting who assumed patient care upon arrival at the receiving facility establishes a continuum of appropriate care for the patient.

Conclusion

EMS documentation is a skill. This skill (like all skills) can be developed and improved through the conscious effort and maintenance of the skills and knowledge required by the EMS standard of care. Documentation may be the only defense against allegations of negligence. This may be the only chance to paint an accurate picture of the patient and the events leading to your treatment and transport decisions.

EMS educators must provide adequate instruction of documentation during EMS classes. Administrators must understand the importance of adequate patient-care documentation that includes disciplinary action to ensure their service's documentation meets the required standards.

First Responders, EMTs and Paramedics need to realize that their documentation is as important as the other lifesaving skills they perform every day. Skills maintenance should include the skill of documentation. EMS will continue to be viewed with a suspect and critical eye until EMS providers accept responsibility for the content of their patient care documentation, ensuring factual, accurate, complete and timely documentation as part of the patient's "continuum of care."

It is true: "If you didn't document it, it wasn't done."

If you can't be a good example……then you'll just have to be a horrible warning!!

REFERENCES:

1. *Anita Bailey; "Documentation", 2004, PowerPoint® presentation*
2. *Jerry Johnston, Henry County Health Center EMS; "EMS Documentation Policy," 09/89, 03/05*
3. *Iowa Department of Public Health, Bureau of EMS website; Iowa Code, April, 2005*
4. *Navajo Nation Fire & Rescue Services Web, "EMS Documentation-Standard Operating Guidelines," Feb. 2005*
5. *Anderson, C., "Patient Care Documentation," EMS Magazine, 2005*

10 QUESTION POST-ARTICLE

Quiz

1) Choose the correct statement regarding documentation

A) The only good communication to other health care providers about what happened to the patient in the EMS setting occurs through the PCR.

B) The PCR is part of the required CQI program in your EMS system, monitored by the Medical Director.

C) Funding for your EMS program (equipment and education) may depend upon the data derived from your PCRs.

D) All of the above statements are correct.

2) First Responders do not have to fill out PCRs.

A) True

B) False

3) Proving negligence in a court of law depends partially upon the PCR. In order to prove negligence

A) they will attempt to show that you did not provide care within the EMS standard.

B) the patient does not have to prove that there was an injury.

C) the EMS standards of care are not referred to.

D) the injury claimed by the patient does not have to be related to your negligence.

4) Carelessly written PCRs suggest poor treatment.

A) True

B) False

5) Choose the correct statement about the SOAP format of documentation

A) The "S" stands for subjective. This means documenting what you see, hear, and smell.)

B) The "O" stands for onset. Write when the illness/injury occurred.

C) The "O" stands for objective. This refers to documenting what you see, hear, and smell.

D) The "S" stands for severity. How bad is the dyspnea or pain on a 1-10 scale?

6) There are some simple "Do's and Don'ts" to PCRs. Choose the *incorrect* statement about these rules:

A) You should not completely cross out errors.

B) Do sign your PCRs.

C) Any abbreviations may be used

D) Use black ink.

7) The most appropriate way to correct a written error on your PCR is

A) to erase it and try again.

B) to draw a simple line through it (so it still can be read) with the correction near it. Placing your initials next to that correction is helpful.

C) to leave it in the sentence and place an addendum at the end of the form where you can rewrite that paragraph.

D) to blacken it with a pen and rewrite the word or phrase that you want.

8) You are completing your report on a lady you just transported that was involved in motor vehicle trauma. You extricated her, provided spinal immobilization and oxygen, then you transported her according to State protocols. In order to document this appropriately,

A) your record should include your objective and subjective findings prior to treatment and transport, how you completed the treatment, and how the patient tolerated those treatments.

B) you need not describe this in any patient notes as these are standard treatments for a trauma victim and your checkboxes should cover it.

C) use only computerized charting as this information is relayed onto the State.

D) return to your quarters and complete your standard documentation before the end of the month.

9) You have completed an adult medical emergency ambulance job and are filling out your PCR. The patient had an onset of this illness at 1000 hrs. and the pain is worsened by walking and moving, lessened by lying on his side. The quality of the pain is dull, at the umbilicus, with radiation to the lower abdomen at a 7 on a 1-10 scale. What other question needs to be answered to follow this format?

A) What time the pain stopped.

B) If the pain is constant or intermittent.

C) What the allergies are.

D) Whether the patient called his doctor or not.

10) Your crew encountered a tough call last month and there have been many complaints from the general public. The bottom line is — you got lost going to a call. Your written record does not even mention why it took you 1 hour to get to this call (and there was a bad patient outcome). What can you do?

A) Forget it. The public will get over it. Things happen and they don't understand.

B) Get out in the public and let them know that it was a Dispatch problem.

C) Write an addendum. Write something that covers your rear

D) Write an addendum that describes, in detail, the honest series of events that placed you at this scene 1 hour after dispatch and have it filed with the medical record.

IEMSA

CONTINUING EDUCATION

answer form

CLIP AND RETURN

(Please print legibly.)

Name _____

Address _____

City _____

State _____ ZIP _____ – _____

Daytime
Phone Number _____ /_____–_____

Iowa EMS Association
Member # _____

EMS Level _____

E-mail _____

1.	A. ☐	B. ☐	C. ☐	D. ☐
2.	A. ☐	B. ☐		
3.	A. ☐	B. ☐	C. ☐	D. ☐
4.	A. ☐	B. ☐		
5.	A. ☐	B. ☐	C. ☐	D. ☐
6.	A. ☐	B. ☐	C. ☐	D. ☐
7.	A. ☐	B. ☐	C. ☐	D. ☐
8.	A. ☐	B. ☐	C. ☐	D. ☐
9.	A. ☐	B. ☐	C. ☐	D. ☐
10.	A. ☐	B. ☐	C. ☐	D. ☐

IEMSA Members completing this informal continuing education activity should complete all questions, one through ten, and achieve at least an 80% score in order to receive the one hour of continuing education through The University of Iowa Hospitals' EMSLRC, Provider #18.

For those who have access to email, please email the above information, along with your answers to: adamr@uihc.uiowa.edu

Otherwise, mail this completed test to:
Rosemary Adam
University of IA Hospitals and Clinics
200 Hawkins Drive, EMSLRC So. 608GH
Iowa City, IA 52242-1009

The deadline to submit this post test is **DECEMBER 10, 2005.**

IOWA EMS ASSOCIATION *endorses* I.C.E. CONCEPT

The Iowa Emergency Medical Services Association has endorsed the use of the I.C.E. (In Case of Emergency) concept which has recently received significant media attention.

There is no simpler way of letting the emergency services know who to contact should you be involved in an accident than by using ICE.

Standing for In Case of Emergency, ICE will allow ambulance crews and police officers to quickly contact a nominated person who can be informed of the incident.

- Type the acronym ICE followed by a contact name (for example, ICE - mom or ICE — David) into the address book of your mobile phone
- Save their phone number
- Tell your ICE contact that you have nominated them

ICE ADVICE Follow these hints to get the best out of ICE:

- Make sure the person whose name and number you are giving has agreed to be your ICE partner
- Make sure your ICE partner has a list of people they should contact on your behalf - including your place of work
- Make sure your ICE person's number is one that's easy to contact, for example a home number could be useless in an emergency if the person works full time
- Make sure your ICE partner knows about any medical conditions that could affect your emergency treatment — for example allergies or current medication
- Make sure if you are under 18, your ICE partner is a parent or guardian authorized to make decision on your behalf — for example if you need a life or death operation

For more information visit the "I.C.E." website at
www.icecontact.com

The National EMS Scope of Practice Model: *Freedom within Limits*

BY ROSEMARY ADAM*

In 2000, the National Highway Traffic Safety Administration (NHTSA) released the *EMS Education Agenda for the Future: A Systems Approach*. This document identified steps to enable implementation of the EMS Agenda for the Future. The Education Agenda identified five system components that needed to be developed. One of the components included a National EMS Scope of Practice.

The National Scope of Practice Committee is composed of a diverse group of Physicians, EMS providers, EMS educators and state regulators. In September of 2004, the first draft was released with a period of public comment that lasted until January 30, 2005. The first draft also included a series of questions that the committee requested input on to help give direction in the development of the second draft.

The second draft was released in April 2005. Work is now being done on the final draft that is to be released in September of 2005. Once adopted, the national Scope of Practice will serve as a model for development of curricula and national certification standards.

Draft 2.0 identifies four levels of EMS providers: Emergency Medical Responder, Emergency Medical Technician, Advanced Emergency Medical Technician and Paramedic. Each of the levels has a distinct role and skill set. Following is a description of the skill levels with a listing of the entry-level skills at each level.

Emergency Medical Responder (EMR)

The EMR will initiate immediate lifesaving care to critical patients while awaiting additional EMS response. The interventions at the EMR level will be simple, non-invasive interventions with minimal equipment, based on assessment findings.

Skills:

Airway and Breathing
Insertion of Airway adjuncts intended to go into the oropharynx
Use of positive pressure ventilation devices (i.e. BVM)
Suctioning upper airway
Oxygen administration
Pharmacological interventions
Unit dose auto-injectors for self or peer rescue
Medical/Cardiac Care
AED

Emergency Medical Technician (EMT)

The EMT will provide basic emergency care and transportation for critical and emergency patients. The EMT will perform basic, non-invasive interventions, based on assessment findings, and is a link from the scene to the emergency health care system. The EMT is the minimum staffing for transport.

Skills:

Airway and Breathing
Insertion of Airway adjuncts intended to go into the oropharynx or nasopharynx
Pharmacological interventions
Patient assisted medications
The following OTC
Activated charcoal
Oral glucose
Oral analgesics
ASA
Trauma care
PASG

Advanced Emergency Medical Technician (AEMT)

The AEMT will provide basic and high benefit, lower risk advanced emergency medical care and transportation for critical and emergency patients. The AEMT will base treatments on assessment findings and be a link from the scene to the emergency health care system.

Skills:

Airway and Breathing
Insertion of airways that are NOT intended to be placed into the trachea
Tracheobronchial suctioning of an intubated patient
Ventilation of an intubated patient
Pharmacological interventions
Establish and maintain a peripheral IV
Administer non-medicated IV fluid
NTG
SQ Epi
IM Glucagon
IV D50
Inhaled beta-agonist
Narcotic analgesic (for chest pain)
Assist with nitrous oxide

Paramedic

The paramedic is an allied health professional who provides advanced emergency care for critical and emergent patients. The paramedic performs basic and advanced interventions, based on advanced assessment and the formulation of a field impression, linking the scene to the healthcare system.

Skills:

Airway and Breathing
Endotracheal intubation
Percutaneous cricothyrotomy
Decompress the pleural space
Gastric decompression
Pharmacological Interventions
Intraosseous cannulation
Enteral and parenteral medications
Access indwelling catheters and implanted IV ports
Administer IV medications
Maintain blood or blood products
Medical/Cardiac Care
Cardioversion
Manual defibrillation
Transcutaneous pacing

The creators of the national Scope of Practice have identified the necessity of flexibility so that States can adopt the model to their individual needs. At the same time, this document attempts to establish national consistency in the skills of prehospital care providers. This consistency will enable national standards leading to increased understanding of EMS by the public and benefit providers by making reciprocity between states easier.

A copy of the national scope of practice is available at www.emsscopeofpractice.com. The *EMS Educational Agenda for the Future: A Systems Approach* can be obtained form the National Highway Traffic Safety Administrations website: www.nhtsa.dot.gov. ■

*References from Joe Ferrell, Bureau of EMS Education Coordinator

NEW LOCATION FOR BUREAU OF EMS

The Bureau of EMS has moved!

They can be reached as follows:

IDPH – BUREAU OF EMS
Lucas State Office Building
321 E. 12TH STREET
DES MOINES, IA 50319

1-800-728-3367 (existing)
515-281-7689 (new)

AT-LARGE/REGIONAL NOMINATIONS REQUESTED

It is time to consider your At-Large and Regional representatives to the IEMSA Board of Directors. The At-Large position has been vacated by the resignation of Melissa Sally-Mueller and will have to be filled for a one-year term. The regional representatives elected will serve two-year terms beginning in January, 2006. Those board members, whose terms expire in December, 2005 are as follows: Rod Robinson – SW Region, John Copper – NC Region, Brad Madsen – SC Region, Ric Jones and Lee Ridge – NE Region, Cindy Hewitt – SE Region, and Evan Bensley and John Hill – NW Region.

The following are guidelines for this process.

Nomination Requirements: The nominee must be an active member of IEMSA. Nominations can be submitted by using the format provided. Nominations must be received in the IEMSA office by September 23, 2005 at noon.

Upon receipt at the IEMSA office, the nominations will be checked to ensure compliance with the nomination process. The nominee's membership status within the association will also be verified.

Successful nominations will comprise the final ballot which will be mailed on October 7, 2005. These ballots will be due back in the IEMSA office by November 7, 2005. Detailed instructions will be provided on the ballot.

We urge all members with an interest in becoming involved with their professional organization to consider nomination. Please complete and return the At-Large/Regional Nomination Form by **September 23, 2005**.

Your involvement truly makes a difference!

AT-LARGE/REGIONAL NOMINATIONS FORM

Regional Representative Nomination ☐ At-large Nomination ☐

Nominee's Name: _____

Company/Service: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Brief biography of nominee describing involvement in EMS
(50 words or less – use a separate sheet of paper if necessary):

_____

_____

_____

Nominator's Name: _____ Phone Number: _____

Mail to:
IEMSA – At-Large/Regional Nomination
2600 Vine Street, Suite 400
West Des Moines, IA 50265

IEMSA Award Nominations

Don't miss this opportunity to recognize excellence in EMS!

Do you work with a person who exemplifies what a professional emergency medical services provider should be? Are you proud of the accomplishments made by the ambulance service you work for? Did an EMS instructor have an extraordinary ability to shape your career through his or her teaching? Do you know of someone in your community who supports EMS activities in a special way? GREAT! Nominate them for the annual IEMSA Awards. Below is a description of each award given at the annual IEMSA Conference and Trade show held each November.

Individual: The nominee must be currently certified by the State of Iowa, have strong and consistent clinical skills at his/her certification level, and have made an outstanding contribution to the EMS system either within or outside of his/her squad or service. Award recipients MUST be (or become) an active Iowa EMS Association member. Two awards in the Individual category will be presented — volunteer and career.

Service: The nominee must be currently certified by the State of Iowa, have made outstanding contribution(s) in the last year to public relations, information and education (PI&E), maintain a positive and outstanding relationship with the community it services and take visible and meaningful steps to assure the professionalism of its personnel and the quality of patient care. Two awards in the service category will be presented — volunteer and career.

Friend of EMS: Any individual who has made outstanding contribution(s), which enhance the quality of EMS at the local, regional or state level.

Hall of Fame: Any individual who has made outstanding contributions to EMS during longevity in the field (10+ years). This individual may be someone to recognize posthumously. This will be an ongoing plaque displayed in the Association Office.

Instructor: Any individual who instructs and/or coordinates on a full-time or part-time basis; has dedication to EMS through instruction, number of years in EMS and/or number of years instructing EMS. Two awards in the Instructor category will be presented — full time and part time.

Winners of these prestigious awards will be announced at the Recognition Banquet at the Annual Conference and Trade show held in November. Each award winner will receive a plaque to commemorate their achievements and will be recognized in The Voice. Winners of the Hall of Fame award will have their name engraved on a permanent plaque that is displayed at the IEMSA office (when it is not being displayed at the IEMSA booth).

In order to nominate a person or service for one of these awards, you must 1) complete the Award Nomination Form, 2) include a letter of recognition/nomination and 3) submit your nominations to the IEMSA office any time between now and September 23.

IEMSA AWARD NOMINATION FORM

INDIVIDUAL: ☐ Volunteer ☐ Career
SERVICE: ☐ Volunteer ☐ Career
INSTRUCTOR: ☐ Full Time ☐ Part Time
FRIEND OF EMS: ☐
HALL OF FAME: ☐

Nominee's Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Certification Level & Number: _____

Nominator's Name: _____

Address: _____

City/State/Zip: _____

Day Telephone: _____

Evening Telephone: _____

Mail Nomination Form and Letter of Recognition/Nomination to:

IEMSA AWARDS
2600 Vine Street, Suite 400
West Des Moines, IA 50265

DEADLINE: SEPTEMBER 23, 2005

The Conference is Coming;
The Conference is Coming

BY BRAD MADSEN, CONFERENCE CO-CHAIRMAN

Doesn't it seem like the summer has really flown by? It's hard to believe that it's August already and before we know it, Labor Day will have come and gone and there will be a chill in the air. Fall seems right around the corner and the Annual IEMSA Conference and Trade Show is just 3 months away! Every year conference planners put a lot of time and effort into making the conference even better than the year before and this year has been no different. Planning begins early for a conference this big; many speakers were contacted in December of 2004 and we're already contacting speakers for the 2006 conference! In January (to our relief), we learned that the Polk County Convention Complex would remain open and available to host us in 2005 and beyond. "It's a good thing, too." "The "Plex", (as it has come to be known) is the largest venue of its type in central Iowa and we've almost outgrown it! If the conference gets much bigger, we'll need to move it to the new Iowa Events Center.

Even though the conference will be held in the same facility this year, look for some major changes in the layout. We are excited to offer an expanded vendor hall and a keynote room better suited for everyone to hear and actually see the keynote speakers. We have read your comments from last year and we have listened! Also, look for a couple of different lunch options and possibly a better system for tracking continuing education. The Marriott and Savory hotels have once again blocked off a limited number of rooms for conference attendees and both have made a firm commitment to provide you with unparalleled customer service! Contrary to popular belief, those surveys you fill out DO get read, so make sure to have your voice heard by filling it out again this year!

EVEN THOUGH THE CONFERENCE WILL BE HELD IN THE SAME FACILITY THIS YEAR, LOOK FOR SOME MAJOR CHANGES IN THE LAYOUT.

Speaking of filling things out… We would like to remind you to fill out your registration form completely and …GASP… plan ahead! Your diligence in filling out the registration form in its entirety and selecting the classes you wish to attend, enables us to assure that there are enough copies of course material for everyone. And speaking of the registration form (Don't tell anyone I told you this…but), check out the prices. If you do the math, the conference is cheaper if you are an IMESA member. If you are not already a member, simply pay the membership fee when you sign up for the conference, then you can instantly take advantage of the discounted conference registration price! The membership fee and the IEMSA membership conference registration fee combined are still less than the non-member conference registration fee. Also, when you become a member, you can get your own copy of this newsletter and you won't need to "borrow" it from the station next time.

We know that most of you come back year after year for the education, so we have worked hard to ensure that there are quality options for everyone. The pre-conference workshops begin Thursday November 10th with offerings that include an off-site, hands-on rescue & extrication class (participation is limited so sign up early for this one!). Classes in EMS Management & Leadership, EMS Education, a 12 lead refresher, "ALS for the BLS Provider" and, of course, an entire track of CCP topics are also available. Following the pre-cons is the Welcome Reception in the Vendor Hall – your chance to meet with the vendors without having to run to a class.

Don't forget the annual board meeting on Thursday evening. This is a great opportunity for IEMSA members (current and prospective) to learn more about our organization and what we do. After all, IEMSA is your VIOCE in EMS… Wouldn't you like to know what we are saying? After the meeting head to Pitchers at the Marriott to kick back and relax. Pitchers has been reserved solely for IEMSA's use that night and will be prepared for our arrival. Expect a lot of fun!

The 2005 conference also brings back some familiar names in EMS education. Thom Dick will kick off the conference on Friday with "Tricks of the Trade". Lisa Hollett, Mike Grill, Bill Raynovich, Bob Page and Heather Davis are just some of the other names you might recognize. We are proud to lend the podium to several great Iowa speakers as well!

If you have skipped the Friday night dance in the past, you may want to reconsider this year! In anticipation of their upcoming 20th Anniversary, Mercy One is pulling out all the stops and sponsoring a BIG event. There will be free food and great music along with several other surprises! It'll be a night to remember and who knows, there might even be a drink or two if you are so inclined. This promises to be a good time.

Great times, lots of vendors and great education, you'll find it all at the 2005 IEMSA Conference, so make sure to get your time off requests in early. We hope to see you there! ■

First EMS "Safety Net" SEMINAR A BIG HIT!

Over 60 attendees participated in a two-day Emergency Medical Services Conference in Chicago, June 8 through 10, on loss control and risk management. A variety of outstanding speakers presented a wide range of topics including the benefits of on-board monitoring systems, the latest trends in stretcher and ambulance design, EVOC and other training options for EMS staff, recent accident statistics and how to work with attorneys for a positive outcome on law suits and more.

The Seminar was sponsored by THOMCO, the EMS Underwriting Manager for the Zurich Insurance Company, which also co-sponsored the event. THOMCO recently acquired the American Agency, headed by Howard Handler, which has been insuring Ambulance Services for 25 years. THOMCO's President, Greg Thompson, mentioned "We are overwhelmed with the positive response to the seminar. Attendees seemed to feel that the Seminar provided useful information necessary to improve their operations. The Seminar met our goal of providing loss prevention services to the industry in addition to providing insurance coverage. We look forward already to next year's meeting, which has been tentatively schedule for June 7-9, 2006."

For more information on the seminar and the agenda, please contact Bill Leonard, THOMCO's Senior Loss Control representative for EMS, at whleonard@thomcoins.com For more information on THOMCO and/or its insurance program for ambulance services, Ambulance Plus, please log onto THOMCO's web site at www.thomcoins.com or call the American Agency Division's toll free number, 800-255-4301. ■