SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

DOCUMENTATION OF PREHOSPITAL CARE

PUBLIC COMMENT NOVEMBER 2026

EFFECTIVE DATE: x/x/xx ***POLICY REFERENCE NO: 6050*** ***SUPERSEDES: 10/1/20***

1. PURPOSE

1.1. To establish documentation standards for the purposes of medical record keeping and quality improvement practices.

2. DEFINITIONS

2.1. Patient Care Report (PCR): is a legal document created by prehospital emergency care providers to record all aspects of a patient's medical care, from the initial dispatch to the handover at a medical facility.

2.2. California Emergency Medical Services Information System (CEMSIS): State administered, centralized electronic system that collects and standardizes data on EMS incidents across California. CEMSIS integrates with NEMSIS.

2.3. National Emergency Medical Services Information System (NEMSIS): National database and data standard for collecting, storing, and sharing emergency medical across the United States.

3. POLICY

3.1. Patient Care Documentation Standards

3.1.1. An agency-approved CEMSIS/NEMSIS compliant Patient Care Report (PCR) shall be completed for all patient contacts (patient as defined in Policy #4040 Section 2.5).

3.1.2. PCR's should be completed as soon as operationally possible but no later than end of shift, or within twenty-four **(24) hours**, whichever comes first.

3.1.3. A copy (paper or electronic) will be provided to the receiving facility.

3.1.4. For patients transported Code 3, providers should complete and transfer the PCR prior to departing the hospital, unless prevented due to technical issues or EMS system demand.

3.1.5. For prehospital births, a separate PCR must be completed for the birthing parent and each newborn.

3.1.6. The person primarily responsible for directing patient care on scene and during transport is responsible for completing the report.

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3.1.7. All procedures noted on the PCR shall be accompanied by the identification (state paramedic number) of the paramedic who performed the procedure.

4. NON-TRANSPORTING EMS PERSONNEL

4.1. Non-transporting Personnel (ALS or BLS) shall document findings, assessment, interventions, times, and other relevant patient care activity on an agency- approved first responder form (paper or electronic).

4.2. The form shall be made accessible to transporting providers and receiving facilities as soon as feasibly possibly, or by end of shift, whichever comes first.

4.2.1. Provider agencies shall retain a copy of the form in accordance with medical record regulations.

4.2.2. Patient refusals completed by non-transporting providers shall be documented on a PCR, in accordance with Policy #4040.

5. DOCUMENTATION REQUIREMENTS:

5.1. All data fields as mandatory or required by CEMSIS

5.2. Providers shall make all effort to obtain, at minimum, the following information:

5.2.1. Initial Response Fields

5.2.1.1. Dispatch-generated Incident Response Number

5.2.1.2. The date and estimated time of incident

5.2.1.3. The time of receipt of the call

5.2.1.4. The time of dispatch to the scene

5.2.1.5. The time of arrival at the scene

5.2.1.6. The time of first medical contact by an EMS provider

5.2.1.7. The location of the incident

5.2.2. Patient Demographics and Care Fields

5.2.2.1. Name

5.2.2.2. Age

5.2.2.3. Self-reported gender

5.2.2.4. Self-reported race

5.2.2.5. Weight (mandatory for pediatrics, may be estimated or caregiver-reported)

5.2.2.6. Address

5.2.2.7. Primary Impression

5.2.2.8. Chief complaint

5.2.2.9. Vital signs (Intervals: 10-15 minutes if stable, 5 minutes if unstable)

5.2.2.10. Physical assessment

5.2.2.11. Any emergency care rendered and the patient's response to such treatment

5.2.2.12. Barriers to care (e.g. Language barrier, unsafe scene etc.)

5.2.2.13. Patient disposition

5.2.3. Transport and Transfer of Care Fields

5.2.3.1. The time of departure from scene

5.2.3.2. The time of arrival at receiving facility (if transported)

5.2.3.3. The time of patient care transfer to a receiving provider

5.2.3.4. The name of receiving facility (if transported)

5.2.3.5. The names of the transporting Paramedics and/or EMTs

5.2.3.6. Signatures of the transporting Paramedics and/or EMTs

5.3. If a provider is unable to obtain the minimum required documentation listed above, the circumstances shall be documented in the narrative section of the PCR.

5.4. The PCR should include findings, interventions, and other information related to patient care that was performed or obtained by another provider prior to arrival.

5.5. All procedures noted on the PCR shall be accompanied by the identification (state paramedic number) of the paramedic who performed the procedure.

5.6. Providers shall document base contacts with Base Hospital Physicians in the PCR, including time of contact and physician name.

6. SPECIAL CIRCUMSTANCES

6.1. Refer to the following policies for special documentation requirements:

6.1.1. Policy 4040 – Procedure and Documentation for Non-Transported Patients

6.1.2. Policy 4044 – Scene Management

6.1.3. Policy 4043 – EMS Use of Physical Restraints

6.1.4. Policy 7010 – Emergency Medical Services at Special Events

6.1.5. Policy 8000 – EMS MCI Policy

7. ARTIFICIAL INTELLIGENCE

7.1. Use of Artificial Intelligence (AI) tools integrated within a NEMSIS approved ePCR system is permitted subject to approval of EMS Provider Medical Director.

7.2. The integrated AI feature is a documentation support tool and does not replace the provider's, assessment, or responsibility for the completeness and accuracy of the final ePCR.

7.3. When using AI to generate fields within the ePCR system, providers should review, verify, and make necessary edits to confirm that the documentation accurately reflects the patient encounter.

7.4. EMS Personnel are ultimately responsible for what is documented, which includes any outcome of an AI-generated error.

7.5. The EMS Personnel shall disclose that AI tools were used.

8. AUTHORITY

8.1. California Code of Regulations, Title 22, Sections 100170 & 100171

APPENDIX A: NOTABLE DATA ELEMENTS

The following references highlight important patient care information for specific cases to promote thorough documentation and enhance quality improvement practices and research.

1. **Cardiac Arrest**
    a) Accurate intervention and medication times
    b) Patient response to interventions
    c) ROSC or termination time
    d) AED/CPR prior to arrival, bystander or name of provider
2. ~~**Chest Pain/Acute Coronary Syndrome**~~**/STEMI**
    a) Time of Aspirin administration
    b) ~~Detailed EKG findings~~ Field ECG Preformed
    c) 1st ECG Time
    d) Initial SpO2
    e) Time of symptom onset (in HH:MM format)
    f) Time of hospital notification for STEMI Alert
3. **Stroke**
    a) Cincinnati Prehospital Stroke Scale with score
    b) Blood glucose reading
    c) ~~Time of symptom onset~~ Last Known Well Time (LKWT) ~~(in HH:MM format)~~
    d) ~~Time last seen normal (in HH:MM format)~~
    e) Time of hospital notification for Stroke Alert
4. **Advanced Airway**
    a) Time of adjunct placement
    b) Reason for advanced airway placement
    c) Initial SpO2
    d) End tidal CO2 (waveform and ETCO2 number)
    e) Reconfirmation of adjunct placement after all patient movement
5. **Severe Agitation and Use of Restraints**
    a) Patient behavior that necessitated restraint usage
    b) Type of restraint or adjunct used
    c) Time restraint was applied
    d) Reassessment of patient condition every 5 minutes post-restraint
    e) Respiratory monitoring using end tidal CO2 (if chemical sedation performed)

a) Blood glucose reading

6. Opioid Withdrawal

a) Administration of naloxone/buprenorphine (route, dose, complications)
b) Initial and secondary COWS
c) Reason for non-enrollment (exclusion criteria)
d) Reason if non-transport of enrolled patient

7. Alcohol Withdrawal

a) Brief Alcohol Withdrawal Scale (BAWS) score