EMS Lawsuits and Documentation Issues

EMS DOCUMENTATION
Case Studies, Compliance and More!

University Hospitals
EMS Training & Disaster Preparedness Institute

Presented by:
J.R. Henry Consulting Inc.

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Disclaimer

• The consultant is not an attorney and does not provide legal advice. The information contained in this presentation is not intended and should not be construed as legal advice or direction.

• The consultant plans to share knowledge and practical experience with the attendees.

• All attendees are advised to obtain professional legal advice from an attorney before implementing any material change in their billing, administrative or operational polices or any other matter which is governed by law or regulation.

Seminar Topics and Agenda

• Welcome and Introductions
• Key Area of EMS Liability
• Negligent Documentation
• Documentation
• Legal and Compliance Issues
• Case Reviews
• Questions and Answers

Key Areas of EMS Liability

• Patient Care Issues
  – Airway management issues
  – Spinal immobilization issues
  – Inadequate training and policies

• Equipment Failures
• Refusals (Abandonment)
• Billing (Fraud and Abuse)

Medical Record Documentation

“If it isn’t documented – It didn’t happen!”

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How Do You Reduce Risk of Getting Sued?

• Maintain Good Documentation and Compliance
• Improve Communications Skills
  – Patients
  – Employees and Co-workers
  – Company Wide
• Good Policies and Training

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**Negligent Documentation**

May, 1995

DeTarquino v. Jersey City, plaintiff suffered injuries as a result of an alleged assault by a Jersey City police officer.

An ambulance was called and responded with two EMT's

During transport, the patient apparently vomited, but the trip sheet did not indicate vomiting.

In fact, the check box on the PCR indicated it was negative!

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**Case Facts**

- The hospital apparently concluded that patient was not seriously injured.
- The patient was discharged from the hospital and taken back to the county jail by police.
- A few hours later – Patient has an episode of seizures.
- Declared brain dead on May 11, 1995
  - Cause of death: epidural hematoma

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**NJ EMS Immunity Law**

- NJ Immunity Provision (NJSA 26:2K-29)
  - “No EMT . . . shall be liable for any civil damages as the result of an act or the omission of an act committed while in training for or in the rendering of intermediate life support services in good faith . . .”

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**Initial Verdict**

- Trial Court:
  - Dismissed the lawsuit against the EMT's
  - Found that NJ immunity statute protected them from liability

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**Outcome of the Appeal**

- Superior Court - June 28, 2002
  - The court held that the NJ immunity statute, for rendering intermediate life support, *does not include immunity for negligence in the preparation of a report* on those services.
  - What are the limitations of your immunity laws??

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**PCR Completion**

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**DOCUMENTATION FORMATS**

**C.H.A.R.T.**
- Chief Complaint
- History
- Assessment
- Rx or Treatment
- Transport

**The Patient Care Report (PCR)**

*Your Substituted Memory!*

**Documentation**

- Vehicle Checks are important!
- PCR should reflect YOUR independent findings!
- Don’t just copy or re-write the wording of a PCS or information found in other medical records!

**Critical Areas of Concern**

Paramedic to be fired for falsifying documents

*a nonworking defibrillator and a man’s death are at the center of the Clearwater case.*

By JACOB H. FRIES - Published June 27, 2006

CLEARWATER - City officials said Monday they plan to fire a veteran paramedic for falsifying records about a man he couldn’t revive with a defibrillator because its batteries were dead.

**Medical Record Documentation**

- **Chronological Recording of:**
  - Dispatch Information
  - Pertinent Facts and Observations
  - Past and Present Illness and Treatments
- Important Communication Tool
  - Continuity of Care
- Legal and Risk Management
  - Memorializes the standard of care provided
  - CQI, Quality Assurance, Research and Education
- Foundation for Reimbursement and Compliance

**Vital Sign Examples:**

- **Pulse equals 83**
- **Blood pressure equals 125 / 99**
- **Blood pressure equals 68/86**

Don’t rely solely on TECHNOLOGY; THIS IS A STILL A **“HANDS ON” PROFESSION**

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Documentation should include:

- All Pertinent Findings
- All Pertinent Negatives
- Every Action Taken

Sample Narrative

- Chief complaint: 911 Delta response to above location for 57 male patient involved in MVC earlier today, now unresponsive in cardiac arrest.
- Present illness: Bystanders present denied the victim complained of anything prior to him collapsing. No one witnessed the collapse, they found him, summoned 911 and began CPR. XYZ EMS on location, report received from crew, BLS measures being taken and AED did not fire.

76 year old female

Pt had no complaints
Pt being transferred to dialysis facility for treatment of renal failure

Legs – weak

What is missing?

Is she bed-confined?

“Bed confined” means that the patient must be:

1. unable to get up from bed without assistance; AND
2. unable to ambulate; AND
3. unable to sit in a chair or wheelchair

Note: All three of the above conditions must be met in order for the patient to qualify as bed confined.

Can she walk? If no, Why?

What is the degree and cause of weakness in her legs?

Is she unable to sit in a chair or wheelchair? Why?

If yes, can she maintain an erect sitting position in a chair for a time needed to safely transport her to the destination?

Does she have a Grade II or greater decubitus ulcers on buttocks or sacral area?
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- Obesity or other condition which requires additional personnel/equipment to safely handle patient?
- How was she transferred to stretcher?
- What was her CONDITION and vital signs during treatment and transfer?
- Did she present with: Headache, Condition of Shunt site?; Abdominal Pain; Cramping; Nausea; Vomiting; Hypotension; etc.

Sample Narrative

- Arrive on location, long inclined, very icy driveway caused EMS to hand carry equipment to the residence.
- C-spine stabilization taken, endotracheal intubation with 8.0, 22 cm at lips. Placement verified by auscultation, visualize tube passing chords, 15 CC inflate, lungs clear, abdomen quiet, thick yellow mucus noted in ETT. (Proper Tube placement verified and confirmed by MD upon arrival at ED)

Other Required Documentation

- Signature Authorization Form:
  - Billing Authorization and Release of Records
  - ABN or Waivers
- Insurance and Patient Information:
  - Name, Date, SS #, Primary and Secondary Insurance, Group Number, Responsible Party, Etc.
- Hospital or Facility Insurance Records:
  - Face Sheet
  - Patient’s Medical Records
  - List of procedures or tests performed

Emergency Dispatched Calls

- Documentation of Dispatch Information
  - Response Priority
  - Patient’s reported condition at “time of dispatch”
- Documentation if a Paramedic Assessment was performed by an ALS crew, if applicable

Non-Emergency Transports

- Did you transport the patient to the nearest appropriate facility?
- What is the medical reason for transfer to other facility?
- What tests or other treatments were or will be performed?

Specific Issues

- All crew members should sign and indicate their certification level
- Correct pickup and destination points
- Mileage (Odometer) readings
  - Tenths of miles?
- Obtain a properly completed PCS Form on selected transports

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Medical Record Documentation

To some degree, Everyone has a photographic memory...

Some just don't have any film!!

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These are actual notes from patient charts...

• The patient has no past history of suicides.
  • Patient had waffles for breakfast and anorexia for lunch.
  • She is numb from her toes down.
  • Occasional, constant, infrequent headaches.

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Sample Narrative

• Dispatched for a male pt with dehydration. Found pt lying in bed. Asked how long pt was in this condition. The naber said that she comes over twice a day. The pt's room was about 100 degrees fairenet. The pt was tiered and wanted to go to sleep. We decided to move the pt fast. Took pt to ambulance via stare chair. Attendant 1 did asset of vitals. Pulse – 125; Resps 16; B/P 111/74

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Sample Narrative

• EMS called for a 21-year-old male patient with back pain. Upon arrival patient found walking towards the ambulance stating that he feel six weeks ago and now his back hurtz and he dissent have a ride to the ER for treatment. Patient received 16 gauge IV line in left-hand.

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“Spelling and the Use of Proper Grammar are Important and Essential Elements”

Always Double Check what you write!

Documentation is the foundation for your defense in any major event

(accidents, injuries, incidents, investigations, lawsuits)

“Can We Change the Chart”

“Can we change the chart once we turn it in?”

– Yes, authors can change entries or add additional information after initial submission
  • Should be appropriately noted and dated
  • Should be properly marked as an amendment or additional entry
– Written errors should always be corrected with strikeout lines, initials and date – (No white-out)
– Supplemental pages can be used if more space is necessary
– Computer software should log and track amendments and changes

“Can We Change the Chart”

Chronology of Care Documentation

– How was patient found? (supine, in bed, bed rails up, seated, standing, etc)
– How was patient moved? (two-person sheet lift; standing pivot; walked to stretcher; ambulatory with assistance to stretcher)
– How was patient transported? (on stretcher; were chemical/hard restraints used; in captain’s chair, etc)
– Was patient monitored enroute? (vitals; change in condition; positioning; response to treatment; etc.)
– Where was patient delivered? (to hospital bed, room number, MRI table, wheelchair, etc.)

Legal Case Reviews

Presented by

Structure Fire

• Early January, 11:40 p.m., snowing and cold
• House Fire - 2 blocks from Trauma Center
• Fire Dept. rescues 3 unconscious, apneic patients within 10 minutes
• First E.M.S Unit is a Supervisor Vehicle - 3 minute response time
• Second Unit - ALS Ambulance sets up Triage with Portable O2 and other equipment
Structure Fire

- 4 year old, apneic, taken to triage area - Airway, O2, BVM
- While extricating to ambulance, 16 year old male, apneic, taken to ambulance.
- A second 4 year old is brought to triage by Fire Dept. Transported by a third Unit which was requested by Supervisor

Outcomes:
- 4 year old has acute brain damage
- 16 year old treated and released after 1 day
- 4 year old treated and released after 2 days
- Fire Dept involvement with ambulance service and family

What are the issues?
- Is this negligence or gross negligence?
- What would you have done?
- Why was the documentation important?

Structure Fire

- 2 patients in first Unit -
  - Supervisor, F.D. Captain - 1st 4 year old
  - Paramedic from Unit taking care of 16 year old
- Portable O2 runs out on 4 year old
- F.D. says he will go back to triage to get more (almost a block away)
- Supervisor says no and transports to Trauma Center 2 blocks away, bagging without supplemental O2 Transport Time <2 minutes
- Second Unit transports the other 4 year old twin
- Supervisor takes 1st patient to Trauma Room A
- Other patients taken to rooms B and C

Cardiac Arrest

- 3:55 am, Call received for a 65 y/o male patient with SOB
- Ice covered roadways – minor delay in response time – 9 minutes
- No patient update from Dispatch enroute
- Patient’s son meets ambulance about a block from the home very excited and agitated
- Ambulance positioned 10 yards from front door of residence

- Patient found in Cardiac Arrest!
- No equipment brought in except for O2 and ALS Bag
- Family begins “yelling” at ambulance to put O2 on patient
- No treatment (Defib, intubation, IV, etc) performed in house except intermittent CPR – Patient moved to ambulance
- ACLS performed in ambulance – 16 minutes after arrival!

- Two stops to check tube placement enroute
- Trip sheet and incident report contain:
  - Opinions which “blame” dispatch for not updating crew on the patient’s condition
  - Does not mention the two stops enroute to the hospital
  - Does not mention weather conditions or delayed response
  - “EMS Supervisor and other medics not able to arrive in time” for backup
  - Times were written incorrectly – ECG Monitor recording strip helped to clarify at trial

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Case Study - Refusal (under 18 years old)

• 16 y/o male CC: Leg Pain & Swelling while at an amusement park with 19 y/o sister and friends
• Friends went to get wheelchair to assist patient to car
• ALS personnel at park provide wheelchair and ask to examine the patient
• Upon arrival, limited patient history obtained, vitals and assessment performed
• Medic says that patient can’t leave since he is underage and no legal guardian is present
• Sister and friends all implore Medic to let the patient go home where meds and proper treatment can be administered by the mother

Case Study - Refusal (under 18 years old)

• Pt attempts to leave, Park Police are told by the medic to restrain him and a struggle ensues
• Medic command contacted instructs the Medic to release patient to his sister!!!
• No refusal form signed
• Case settled for less than $1m dollars
• What is the real issue in this case?

The Golden Rule:
DO NO HARM !!!

Problem Areas

• Personal Opinions and Biases
• Improper Abbreviations
• Illegibility
• Improper Correction of errors
• Omissions
• Poor Choice of Words

The “A B C D” Approach

✓ Adopt and Adapt!
  • Policies, Procedures and Training
✓ Be Nice!
✓ Consistent and Compliant
✓ Documentation!

Special Thanks to Dan Ellenberger and Dominic Silvestro
And to:
All of You for Attending!!!