



College of Paramedics of Manitoba		
Practice Direction Name: Documentation	PD Number: PD-8	Total # of Pages: 10
Original Approval Date: December 21, 2022	Last Revision Date:	Next Revision Date: December 2025

PURPOSE

A registrant of the College of Paramedics of Manitoba must comply with the Regulated Health Professions Acts, the College of Paramedics of Manitoba General Regulation, and any practice directions produced by the College.

Regulated Health Professions Act

Member must comply with Act, etc.

86 A member must comply with this Act and the regulations, by-laws, standards of practice, code of ethics and practice directions for the member's health profession.

College of Paramedics of Manitoba General Regulation

Patient's record

5.4(1) A member must document, in a record specific to each patient, the care they provided to the patient.

5.4(2) A member must

- (a) sign and indicate the abbreviation of their title for entries on the record (ex. Jane Doe, ACP)
- (b) document the care provided by the member in the patient's record as the care is provided or *as soon as practicable after the care is provided.*
- (c) document the care provided by the member in the patient's record with enough detail for another member or health care professional to be sufficiently informed of that care; and
- (d) ensure the record is legible and accessible to maintain continuity of care.

5.4(3) When making a change to a patient record, a member must

- (a) ensure that the original entry remains identifiable and legible.
- (b) record the identity of the member making the change and the date of the change; and
- (c) document the change as soon as practicable after the reason for the change is identified.

5.4(4) A member must ensure that they comply with any other requirements relating to patient records under the Act, *The Personal Health Information Act* and any other enactment, by-law, standard of practice, code of ethics and practice direction with which a member must comply.



DOCUMENTATION

Patient Care Reports (PCR), either written manually or via electronic PCR (ePCR), are a record of the professional activities, clinical decisions, and interventions in the form of a professional, medical, legal document. It is a document that is included as a permanent part of a patient's medical record.

Documentation impacts:

- Continuity of patient care as subsequent clinical decisions may be based on care provided and documented on the PCR
- Education as data from PCRs can indicate the need for review of clinical skills
- Administration as a means of determining the need for equipment purchases
- Quality Assurance to ensure competent application of the scope of work and/or practice
- Research and contribution to best practice
- Patient Safety
- Public health monitoring, preventative measures, and public education

The Patient Care Report is not only a reflection of professionalism, but also a document which can be used to measure clinical competence, the fulfillment of professional responsibilities, and as evidence in a legal and/or conduct process. ***To misrepresent information on a PCR is fraudulent.***

The PCR will become a part of the patient's permanent health record, and may be reviewed for future care planning, legal considerations, quality assurance and program improvement initiatives, billing, research, and education. ***It is a legal requirement that the paramedic record be complete and accurate and contain all relevant information.***

The paramedic will complete the PCR, and any other documentation required by employer policy, immediately after patient hand off ***as soon as practicable after the care is provided.*** A copy, either electronic or printed, will be left with /provided to the receiving facility prior to paramedic departure from that facility or ***as soon as practicable after transfer of care.*** Any documentation provided by a facility to be transported with the patient will be included with the documentation and left with the health care professional assuming care for the patient or stored in a manner consistent with employer policy, and accessible to health care professionals who may be involved in the patient's care. Those working in a non-transport environment (ex. community paramedicine) will follow employer policy regarding documentation of patient care and storage of that documentation.

Note: Documentation principles must adhere to the [Personal Health Information Act](#) and verbal reporting must be done in an environment that ensure confidentiality is preserved.

The paramedic will ensure that all information contained on the PCR is accurate, complete, concise, and legible. The PCR, and the information it contains, is protected by the Personal Health Information Act (PHIA). The paramedic must ensure that the information is protected from



inadvertent disclosure by securely storing the PCR and /or documentation at all times according to **employer policy**. Any breach of PHIA, either electronic or a written document, must be reported to the employer as soon as it has been discovered. The paramedic must also maintain confidentiality by ensuring discussion of the patient's health information is not done in an area where others may be privy to information protected by PHIA and done in the context of patient care.

All persons signing the PCR verify that the information contained within is complete and accurate. (Practice Direction: Registrant and Employer Responsibilities page 8)

Documentation needs to be:

- Clear
- Complete
- Concise
- Correct
- Consistent

Clear

Documentation should be legible (neat handwriting or printing if applicable), and appropriate sentence structure utilized (so there is clarity in interpretation). Abbreviations should be avoided, but if used, need to be universally recognized. (See employer policy regarding acceptable abbreviations) Avoid the use of profession-specific terms (example: use "collapsed" or "cardiac arrest" rather than "coded")

Complete

The documentation should capture all pertinent aspects of the patient encounter. **If it isn't documented, it didn't happen.** (See: <https://pbieducation.com/if-it-isnt-documented-it-didnt-happen/> for additional information)

Concise

Concise documentation is brief, recording the essential facts relevant to the events leading up to the call, the diagnosis or chief complaint, assessments performed, medically necessary clinical care and treatment, and the patient response and subsequent assessments.

Correct

Documentation must be correct, representing a truthful and factual reporting of patient care. Spelling and grammar errors directly impact the credibility of the document. If documentation is written, errors are corrected by drawing a single line through the error and include the initials of the documenter, followed by the correct word/information



Consistent

The documentation format used should reflect the professional level of assessment and care provided and allow other health care professionals to access the information in a timely manner. **A PCR is created for any individual patient for all circumstances.** (ex. transport, refusal, treat and release, etc.)

The paramedic shall keep the following standards in mind when completing a Patient Care Report:

- Document must be legible (Written PCR)
- Appropriate professional abbreviations and acronyms will be used
- Errors noted with a single strike-through and initialed (Written PCR)
- Must be written in an organized manner
- Blank spaces are lined out. (Written PCR)

Patient Care Report Components

Note: Patient Care environments vary (ex. Community Paramedicine, Vaccination Clinic, etc.) Registrants should use the documentation system provided by the employer and follow relevant employer policy regarding required content.

The following components must be included on a PCR /patient care documentation:

1. **Name of paramedics, registration (license) number and abbreviation of their title** who provided assistance and care to the patient
2. **The signatures** of registrants/other health care providers who witnessed medication discard
3. **Incident number** as assigned by MTCC and/or Dispatch agency and/or Employer policy
4. **Times** including Call Received, Enroute, Arrive Scene, Arrive Patient, Depart Scene, Arrive Hospital, Available, when care was transferred to another Health Care Professional, cancellation, discard of medication
5. **The names** of On-line Medical Support (and delegation documentation if applicable), and other health care professionals including all registrants (ex. Medical First Response personnel, additional paramedic resources) that contributed to care and/or accompany the patient (ex. physician, RN, RT on an IFT)
6. **The names** (when possible) of outside agency members that attended the incident including RCMP, Fire personnel, Midwife, etc.



Vital Signs

It is **strongly suggested** that a minimum of **two sets of vital signs** be obtained for each patient transport/encounter. Vital signs are an important component of assessment. The first set (baseline) and subsequent vital signs identify a change in acuity, evaluate response to an intervention, etc. Frequency should be guided by patient hemodynamic status and supported in the documentation. Vital signs, in addition to other assessments, should be done before and after administration of medication or procedures. If frequent vital signs are required which exceed documentation space (ex. written PCR), registrants should use the documentation process for these situations provided by the employer and follow relevant employer policy.

Narrative

Note: These are general principles that should be included in patient documentation. Documentation and practice mediums differ, and employer provided formats should be used.

The narrative includes the following:

- **Chief complaint** – why the patient/bystander requested ERS
- **Mechanism of injury** – if traumatic, include detailed information
- **History of Present Illness or Injury** – the events which took place which required ERS dispatch
- **Past Medical History** – record those related to reason for current ERS contact first
- **Medications** – including prescription and non-prescription and dosages, when possible, patient compliance
- **Allergies** – including medication, environmental, food

Observation

Note: Patient Care environments vary (e.g. Community Paramedicine, Vaccination Clinic, etc.) Registrants should use the documentation system provided by the employer and follow relevant employer policy regarding required content.

The observation includes the following:

- The age of patient
- A brief scene assessment (who was there, where/how patient was found),
- Assessment findings,
- Treatment provided (medications and/or procedures),
- A brief explanation on how the patient was taken to the ambulance and where/what position they were transported)



- Ongoing assessment (as determined by assessment finding, treatment/procedures provided, and patient response),
- Patient status on arrival at destination.

Treatment Provided

Including medications, procedures, assessment results (ex. glucometry, 3 lead ECG)

Treatment/Assessment Provided Prior to ERS Arrival

Including Medical First Response (if a documentation mechanism exists for MFR it should be attached to the primary PCR and include the names and registration number (if applicable) of MFR personnel), bystander first aid providers.

The documented information should create a picture of the patient contact/assessments/care implemented/response or change in status from the time of arrival to the time care was transferred to another qualified provider. Documentation of patient care must “stand on its own”.

A word about pertinent negatives: – In medical documentation, the rule is generally “if you didn't write it, you didn't do it”. “Pertinent Negatives” is a term used when documenting a medical assessment that indicates a registrant **checked/assessed for something and didn't find it**. For example, if in an assessment the registrant listened to a patient's heart and found that it was normal, documentation should be “regular rate and rhythm, no murmur, rub, or gallop” instead of “heart sounds normal”. The pertinent negatives are the lack of arrhythmia, murmur, rub, or gallop (pathologic findings). Documenting this way ensures that anyone reading the PCR knows that the paramedic **checked for these pathological findings**. If the documentation only includes “the exam was normal”, another health care providers won't know whether the pathologic findings really were absent, or if the paramedic didn't remember to look for them.

Pertinent negatives also help to identify a potential differential diagnosis. For a patient who complains of burning with urination, pertinent negatives may include lack of blood in the urine, lack of new sexual contacts, lack of fever, and lack of back pain. Without these findings, a paramedic can consider a simple UTI rather than pyelonephritis, kidney stones, and sexually transmitted infections.

Disagreement of Care Provided

If a paramedic, while reviewing the PCR for completeness and accuracy, disagrees with what is documented, the expectation is that the conversation between paramedics to correct/revise the error/documentation will be professional and respectful. If the disagreement cannot be resolved, an addendum with the alternate account of events (those in dispute) should be attached to the PCR and include the signature and registration number of the person who created it. (Please follow employer policy regarding the addendum format and procedure in this situation.)



No Transport Situations

- **Cancelled prior to Arrival** – include documentation of time and who issued the cancellation
- **No Patient/Incident Found** – use only if no incident found and/or patient had left the scene prior to ERS arrival. (ex. a drive-by 911 for a vehicle in the ditch which was empty as occupants left before ERS arrival)
- **Handled by Other Agency** – identify agency and details of the situation. (ex. RCMP transported the patient under the Mental Health Act prior to ERS arrival) Note: if a paramedic performs an assessment on a person, they become the responsibility of the paramedic (patient), and this option cannot be used.
- **Patient Refusal** – include assessment, pertinent details of the situation, advice provided to patient (Please follow employer policy/procedure regarding refusal documentation requirements)
- **Treat and Release** – include documentation of care provided, pertinent details of the situation, advice provided to patient. Depending on the practice environment, this may also require a patient signature on the PCR. Please follow employer policy/procedure and documentation format)
- **Agency Standby** – where ERS is requested to accompany another response agency (ex. structure fire)
- **Special Event** – where ERS is contracted to stand by at an event
- **Deceased at Scene** – where patient is deemed to be deceased, or resuscitation has been discontinued on scene

DOCUMENTATION FORMATS

Note: Practice Directions speak to all registrants not ones that have just entered practice

In Manitoba, different documentation mediums (written and/or ePCR) currently exist and formats vary according to employer policy. Regardless of the format used or required by the employer, the documentation of the care provided by a paramedic on the PCR must have enough detail for another member or health care professional to be sufficiently informed of that care, and all persons signing the PCR verify that the information contained within is complete and accurate. **If it isn't documented, it didn't happen.**

Systems Format:

Narrative information: (see above)



Observation information:

This format includes:

- The age of patient
- A brief scene assessment (who was there, where/how patient was found),

The body systems in order of priority assessment:

- **Primary/Initial Assessment:** Central Nervous System (CNS), Cardiovascular (CV), Respiratory (RESP)
- **Additional Assessment (order determined by Chief Complaint):** Gastro-intestinal (GI), Genital/Urinary (GU), Endocrine (ENDO), Musculo-skeletal (MS), Integumentary (INTEG)

A brief description of the method used to get the patient from where they were found to the ambulance.

Treatment provided and patient response.

Ongoing assessment by system (may be limited to the focused system but should include any system where an abnormality was found on assessment).

Condition upon arrival at the receiving facility.

Remember: The documented information should create a picture of the patient contact/assessments/care implemented/response or change in status from the time of arrival to the time care was transferred to another qualified provider.

SOAP or SOAPIER Format:

Subjective information (information reported by the patient or family member and is included in the narrative portion of the PCR)

Objective information (observations made by the Paramedic on arrival)

Assessment information (interpretations and conclusions made)

Plan (treatment)

Interventions (actual interventions)

Evaluation (patients' response to the interventions and plan)

Revision (changes in care based on the evaluation/response to interventions)



Remember: The documented information should create a picture of the patient contact/assessments/care implemented/response or change in status from the time of arrival to the time care was transferred to another qualified provider.

Chronological Format:

This is often referred to as a story-telling narrative and documents the call as things happened. The chronological format approach shouldn't be redundant i.e., stating interventions, vitals, etc., that have already been documented elsewhere on the PCR.

The observation includes:

- Initial impressions of the patient including the history of events
- More details of the chief complaint and what injuries/illness that was assessed
- What was done and how the patient responded
- What was done during the time with the patient in the ambulance
- The disposition of the patient at the end of the call (handoff to receiving facility and/or qualified medical personnel)

Remember: The documented information should create a picture of the patient contact/assessments/care implemented/response or change in status from the time of arrival to the time care was transferred to another qualified provider.



ADDITIONAL RESOURCES: Appendix A

Documentation Checklist

Consider using the following checklist to make sure you're meeting documentation requirements.

The PCR documentation:

- ✓ Reflects the application of paramedical care.
 - Assessment, interpretation of findings (analysis) and provisional diagnosis.
 - Includes subjective data (patient/bystander/witness perspective).
 - Includes objective data (paramedic's assessment/analysis).
 - Plan of care which takes into account the patient's needs, circumstances, preferences, values, abilities and culture.
 - Implementation of intervention.
 - Evaluation and modification of the care plan if patient status changes.
- ✓ Includes the required information for a patient refusal (follow employer policy).
- ✓ Includes communication with the patient's family or other significant supports.
- ✓ Uses permanent ink and is written legibly.
- ✓ Does not have blank lines.
- ✓ Records events in a format that creates a picture of the patient contact/assessments/care implemented/response or change in status from the time of arrival to the time care was transferred to another qualified provider.
- ✓ Records the date and time of each intervention/procedure.
- ✓ Documents as close to real time as possible in order to ensure accuracy of details and timely communication.
- ✓ Documentation was recorded at the time care was provided so that it is credible and accountable).
- ✓ Includes signature and designation (abbreviation of title) in both handwritten and electronic versions.
- ✓ Uses professional language and terminology.
- ✓ Avoids abbreviations as they may not be understood and can be misinterpreted.
- ✓ Includes notes of the care provided and follows employer policy when more than one caregiver is required to document.
- ✓ Does not include bias (only documented conclusions that can be supported by data).