DOCUMENTATION LEGAL LIABILITY

By Michael K. Anderson 2/20/2023 **Published in JEMS: https://www.jems.com/administration-and-leadership/documentation-legal-liability/**

I'm sure you are "sick and tired" of hearing that accurate, complete, and timely documentation is your best defense against allegations of professional and civil negligence. Well, despite your reaction to hearing it, this is a true statement. Documentation of patient care is an essential component of patient care and an invaluable risk management tool from a defensive perspective.

EMS and Healthcare providers will tell you documentation is one of their least favorite parts of their job. However, it is the most important thing we as EMS and Healthcare providers need to do. Many EMS and healthcare providers do not appreciate the critical purposes served by their patient care documentation. Some see their patient care reports as documents casually tossed and ignored and eventually will be used against them in a quality assurance improvement review and/or civil litigation. There are five critical areas that are extremely important to legal liability when it comes to patient care documentation: clinical, operational, legal, financial and compliance.

Documentation serves an extremely important legal and liability purpose. In the event of a civil litigation against you, your documentation will be one of the first things reviewed by the attorneys. The issue in a malpractice and/or negligence case, will be whether the EMS and Healthcare providers met the applicable standard of care. The patient care report will be the best defense the provider will have, as long it's accurate and detailed. A well-documented patient care report is more reliable than a provider's memory when sitting on a witness stand years after the fact.

Plaintiffs' attorneys in any EMS malpractice and/or negligence case is to review the patient care documentation written by the EMS and Healthcare providers. Most often, this review will occur in consultation with an expert witness in EMS documentation, such as myself retained to help guide the attorney through the clinical appropriateness of the documentation. If an EMS patient care report is thorough, well-documented of the appropriate standard of care being satisfied, a reputable expert witness may well advise the attorney that there is no viable case to be had against the EMS providers. It is unlikely that a good patient care report will deter a plaintiff's attorney, it is a possibility, especially when coupled with the hurdle of legal immunity for acts of ordinary negligence that EMS providers in most states enjoy.

From the legal perspective, EMS patient care documentation should be used as the provider's primary remembrance then that of their memory. For example, in Washington State, the plaintiff has three years from the date of the injury to initiate a lawsuit, (see RCW 4.16.080). This period is set forth in the statute of limitations. Different states have their own statue-of-limitations for personal injury lawsuits. Memories can fade quickly though, and recollections of specific patients can blend together-especially after a few hundred calls. A well-documented patient care report that creating a clear picture of the incident can refresh your memory of other important details of the call.

Even if a lawsuit has been commenced immediately after an incident, it could still be years until the case goes into the discovery phase, where you as the provider is likely to be giving a deposition and/or testifying in court. When testifying months or years later and trying to prove your actions and/or treatment met the applicable standard of care, your documentation will often be the only thing you can rely on to help you paint that picture for a judge and/or jury.

The importance of the patient care report as a legal document, is a vital to the integrity of the report. Documentation long after the fact can raise many troubling issues when you must defend yourself on a witness stand.

There are six principles of documentation for liability:

- **Accurate Report –** Your report needs to be truthful, detailed, complete and concise.
- **Medical Record –** Your patient care report will be part of the patient's medical record throughout their treatment process.
- **Quality Assurance and Improvement -** Your patient care report is used by your agencies and/or department's Q&A review. This is where your Q&A officer reviews your report for any areas for remedial training and/or potential liability issues that need to be addressed by the legal department.
- **Billing –** The patient care report is used by the billing department for billing the insurance companies and/or the patient. This is why it's so imperative that your report is very accurate, truthful, detailed, complete and concise. If any of these elements are missing, it could cause billing issues and the insurance companies and/or the patient will not pay.
- **Research –** The patient care report can be used for medical research. Depending on the type of call and the illness and/or injury presented by the patient, researchers can use that information in assisting in coming up with different diagnoses and/or treatments.
- **All EMS Providers are Responsible for the Report –** All personnel that had any direct patient contact, i.e., taking vital signs, administering oxygen, assisting in packaging the patient for transport etc., names and titles should always be included in the patient care report.

A complete patient care report should include the following for liability reasons:

- **Dispatch and Response Summary –** This should be very brief, i.e., what you were dispatched too, and any other pertinent information relayed to you by dispatch.
- **Scene Summary –** What you observed on arriving on scene, any pertinent observations should be noted. This also includes any pertinent information from witnesses and/or bystanders.
- **HPI and Physical Exam –** This is your basic physical exam and medical history from the patient. Make sure, if possible, obtain all patient demographics for your report.
- **Interventions –** What did you do for the patient, i.e., medications, oxygen, splinting etc.
- **Status Changes –** Any changes in the patient's condition during interventions and/or preparing patient for transport or during transport. This is one area, where I see EMS providers forget to document on the patient care report.
- **Safety Summary –** This is where you will document any safety concerns with the patient and/or Fire/EMS personnel. This is another area where I don't see Fire/EMS personnel documenting on their patient care report. This is very important that if there were any safety issues, they should be documented for legal reasons.
- **Disposition -** What was the outcome of the patient, i.e., transported, AMA or ROR.

An interesting case from New Jersey points out the need for accurate and timely medical documentation on the patient care record (PCR) and in spite of the fact that there was essential documentation missing from the report, the court ruled in favor of the EMS providers indicating there was qualified immunity related to their treatment it did not include the documentation. A 22-yearold male was struck in the head by a police officer and succumbed to his injuries five days after the incident. The patient was transported by ambulance and had vomited but no notation in EMS report and/or verbal report indicated the patient had been vomiting. In De Tarquino v. City of Jersey City,

352 N.J. Super. 450, 452 (App. Div. 2002) the court granted plaintiff's motion for leave to appeal to determine whether the immunity N.J.S.A. 26:2K-29 confers upon "EMT-intermediate[s]" for negligence "in the rendering of intermediate life support services" extends to negligence in the preparation of the report provided to the hospital where an emergency patient is brought for treatment. The court concluded that N.J.S.A. 26:2K-29 only provides immunity for negligence in connection with the actual rendering of life support services.

The Court reversed the summary judgment in favor of defendant Jersey City Emergency Medical Services (Emergency Medical Services), an ambulance service company, and two of its employees, defendants Pedro Reyes and Arafat Saab, which dismissed plaintiff's claim that defendants negligently failed to record on an ambulance "run sheet" that her son, a head trauma victim, had been vomiting, and that this negligence was a contributing cause of his death."

This case, although finding in favor of the EMT's demonstrates the necessity of complete, through and accurate documentation.

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