Ontario Ambulance Documentation Standards

Version 3.0
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Emergency Health Services Branch
Ministry of Health and Long-Term Care

Ontario

To all users of this publication:

The information contained herein has been carefully compiled and is believed to be accurate at date of publication.

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3.0	March 29, 2016	April 1, 2017	Finalized version

Table of Contents

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Version 3.0

Part 1 - General

1

Part 1 – General

General

Paramedics shall comply, and ambulance service operators shall ensure compliance, with the following provisions respecting all reports required under the Documentation Standards:

1. Reports shall be made in either written or electronic format provided that such reports contain all of the information required by these Standards.
2. Reports shall be prepared in such a manner as to remain legible and readily accessible for review for a minimum period of five (5) years from the date of the documented event.
3. Information contained in reports shall be of a completeness and quality suitable for use as evidence in an investigation or legal proceeding.
4. Reports shall not contain false or misleading information. Where a report contains information that could identify a person who is a patient, the report and the information contained therein is subject to the confidentiality provisions of the *Ambulance Act* and the *Personal Health Information Protection Act, 2004*, and shall be secured from unauthorized access.
5. Paramedics shall complete reports as soon as possible following the event and shall complete reports prior to the end of the scheduled shift or work assignment during which the documented event occurred.
6. A paramedic who participates in the completion of any required report shall sign the report.

Part 2 – Incident Reporting Requirements

2

Part 2 – Incident Reporting Requirements

Incident Reporting Requirements

1. An operator who receives a complaint relating to the operator's service shall complete an Incident Report outlining the specifics of the complaint.
2. When an investigation relating to the operator's service is conducted by the operator or under the operator's authority for any reason, the operator shall complete an Incident Report.
3.
    a. An Incident Report shall be completed with respect to an unusual occurrence, including but not limited to, the following:
        i. An unusual response or service delays that may have negatively impacted the provision of patient care;
        ii. A delay in accessing a patient that may have negatively impacted the provision of patient care;
        iii. An excessive amount of time on scene that may have negatively impacted the provision of patient care;
        iv. Cases of suspicious or unexpected death that may be likely to result in a coroner and/or police investigation;
        v. Any circumstance that resulted in harm to a patient or any other person being transported in an ambulance, including equipment deficiencies;
        vi. Any circumstance which resulted in a risk to, or endangerment of the health or safety of, a patient, or any other person being transported in an ambulance.
    b. An Incident Report shall be transmitted to the appropriate Field Office of the Emergency Health Services Branch within the specified time frame per incident Level of Assessment to which the Incident Report applies.

Level of Assessment Tool

Table 1. Level of Assessment Tool

Level of Assessment	Description	Submission Timelines to Field Office
5 – Minimal	Not serious - does not involve an operational risk, no performance standards were compromised and no impact to patient outcome.	90 calendar days
4 - Minor	Limited risk - an incident with potential to impact patient care outcome or compromise performance standards but no actual impact. (*e.g.* avoidable delay that did not breach standards or only marginally breached, but should not have occurred in normal operations.)	15 business days
3 - Moderate	Moderate risk - an incident that impacted patient care, patient outcome, or paramedic safety but without known risk to life or significant or long lasting impact on safety; or that impacts the system by consuming unusual levels of resources. (*e.g.* an unusually long delay but without patient impact.)	5 business days
2 - Significant	Significant risk - impacted patient care, outcome or paramedic safety, with either serious impact or a near miss from serious impact, but does not include death or probable death. May have had significant systemic impact or could have systemic impact. (*e.g.* detection of willfully damaged paging equipment, patient care equipment or failure to respond to an urgent call that impacts patient outcome.)	2 business days
1 - Major	Known, serious negative impact to patient outcome or paramedic(s) safety. Involves a grave risk to life of paramedic(s) and/ or patient – a serious misuse or lack of operational practice or policy that could present a grave risk to life; or that impacts the system in a major way by consuming unusual levels of resources.	As soon as possible – within 24 hours

4.

a. If an Incident Report is required as a result of an event occurring on an ambulance call and an Ambulance Call Report was not required then the Incident Report shall contain the following:
    i. Ambulance call number;
    ii. Pick-up Location and UTM Code as applicable;
    iii. Dispatch and priority code;
    iv. Ambulance service name;
    v. Date report was completed;
    vi. Date of incident requiring the report;
    vii. Time of incident requiring the report;
    viii. Vehicle number;
    ix. Names, EHS numbers and signatures of all paramedics;
    x. Description of the actions and events requiring the completion of the incident report;
    xi. A description of each EMA or paramedic's observations in relation to the event;
    xii. A description of each EMA or paramedic's action/procedures taken in response to the event;
    xiii. The names of involved parties other than the EMA or paramedics involved including and where possible the involved parties address, date of birth and sex;
    xiv. A detailed description of the scene;
    xv. Wherever possible, the names and identification numbers of any police officer/investigator on scene.
b. If an Incident Report is required as a result of an event occurring on an ambulance call and an Ambulance Call Report has been completed in accordance with the requirements of the *Ambulance Call Report Completion Manual* the Incident Report shall include the following:
    i. Ambulance Call Number;
    ii. Description of the actions and events requiring the completion of the Incident Report;
    iii. A description of each EMA's or paramedic's observations, actions and procedures not documented on the Ambulance Call Report in relation to the event;
    iv. A detailed description of the scene;
    v. A copy of the Ambulance Call Report.

5. In addition to section 4 above, where an item of patient care equipment has malfunctioned or failed, the following shall be recorded:
   a. Identity of the make and type of equipment, including any identifying number (i.e. model and serial number);
   b. A description of the nature and timing of the equipment failure or malfunction;
   c. Description of the impact, if any, of the equipment failure on patient care.
6. Where an event results in a risk or endangerment to the health or safety of a patient, paramedic(s), or any other person being transported in an ambulance, the following should be recorded:
   a. A description of the risk or endangerment;
   b. A description of the effect that the risk or endangerment had to a patient or other person;
   c. Actions taken by the paramedic(s) to deal with the risk or endangerment;
   d. The outcome of such actions documented in 6(c).

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Part 3 – Patient & Patient Care Documentation Requirements

3

Part 3 – Patient & Patient Care Documentation Requirements

Patient & Patient Care Documentation Requirements

1. An Ambulance Call Report shall be completed for each request for ambulance service where the paramedic arrives at a scene as directed by a Central Ambulance Communications Centre/Ambulance Communication Service (CACC/ACS), including where there is no contact with the individual for whom the request was made.
2. The paramedic who has made contact with, assessed, and/or provided patient care to an individual, shall be responsible for completing the Ambulance Call Report. A separate Ambulance Call Report shall be completed for each individual.
3. The Ambulance Call Report shall be completed according to the requirements set out in the *Ambulance Call Report Completion Manual*, as required by the *Basic Life Support Patient Care Standards*.
4. The Ambulance Call Report shall be completed as soon as possible and no later than the end of the scheduled shift or work assignment during which the call occurred.
5. Where a CTAS 1 or 2 patient or a patient on whom a controlled act has been performed is transported to a receiving facility, the paramedic shall:
    a. provide a verbal report to the receiving staff as outlined in the *Basic Life Support Patient Care Standards*;
    b. provide the receiving staff with printed copies of any associated biometric data of the patient; and
    c. make every reasonable effort to provide the completed Ambulance Call Report prior to leaving the receiving facility unless the paramedic can demonstrate that it was not possible to do so, and in such circumstance, the paramedic shall provide the completed Ambulance Call Report no later than the end of the scheduled shift or work assignment during which the call occurred.
6. Where a CTAS 3, 4 or 5 patient is transported to a receiving facility and the requirements in 5 above do not apply, the paramedic shall:
    a. provide a verbal report to the receiving staff as outlined in the *Basic Life Support Patient Care Standards*;
    b. provide the receiving staff with printed copies of any associated biometric data that may be clinically relevant for the assessment and continued treatment of the patient; and
    c. provide the completed Ambulance Call Report no later than the end of the scheduled shift or work assignment during which the call occurred.

7. Completed Ambulance Call Reports and the associated biometric data shall be distributed to the Base Hospital for quality assurance and medical oversight within forty-eight (48) hours of the end of the scheduled shift or work assignment during which the call occurred.
8. In the event that an individual refuses care and/or transport, the paramedic shall seek to have the individual or his or her substitute decision-maker, complete and sign the appropriate areas of the Refusal of Service portion of the Ambulance Call Report.
9. Where a Refusal of Service is to be documented, and only one paramedic is attending to the call, the paramedic shall request a witness to complete the appropriate area of the Ambulance Call Report or document this request on the Ambulance Call Report in the event that a witness declines to sign the Ambulance Call Report.

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Part 4 – Documentation Requirements

4

Part 4 – Documentation Requirements

Documentation Requirements

1. In instances where, prior to arriving at the scene, a call is cancelled while paramedics are en route to the call, an Ambulance Call Report is not required to be completed.
2. For each instance where paramedics arrive on the scene but no patient[1] is located, an Ambulance Call Report shall be completed and shall include the following information:
   a. Service Name
   b. Service No.
   c. CACC/ACS
   d. Call Number
   e. Call Date
   f. Pick-up Location or Sending Facility
   g. Pick-up Code
   h. Remarks – *if applicable*
   i. Vehicle Number
   j. Station
   k. Status
   l. UTM Code
   m. Dispatch
   n. Return
   o. Warning Systems – To Scene
   p. Incident History
   q. Call Received
   r. Crew Notified
   s. Crew Mobile
   t. Arrive Scene
   u. Depart Scene
   v. Paramedic 1 (Attending) No.
   w. Paramedic 2 No. – *if applicable*
   x. Name (Paramedic 1)
   y. Name (Paramedic 2) – *if applicable*
   z. Designation (Paramedic 1)
   aa. Designation (Paramedic 2) – *if applicable*
   bb. Signature No. 1
   cc. Signature No. 2 – *if applicable*

[1] As per the *ACR Completion Manual*, "patient" refers to an individual for whom a request for ambulance service was made and who a paramedic has made contact with for the purpose of assessment, patient care and/or transport, regardless of whether or not an assessment is conducted, patient care is provided, or the patient is transported by ambulance.

dd. Date of ACR Completion
ee. Time of ACR Completion

3. In addition to paragraph 2 above, for each instance where a paramedic transports remains of a dead person for the purposes of tissue transplantation, the following information shall be recorded on the Ambulance Call Report:
   a. Problem Code
4. In addition to paragraph 2 above, for each instance where contact with an individual is made, regardless of whether an assessment is conducted, patient care is provided or the individual is transported by ambulance, the following information shall be recorded on the Ambulance Call Report:
   a. Last Name
   b. First Name
   c. Physical Exam (General Appearance)
5. In addition to 2 and 4 above, where patient assessment is performed, whether or not further care is provided or the patient is transported by ambulance, the following information shall be recorded on the Ambulance Call Report:
   a. Age
   b. Sex
   c. Weight
   d. Date of Birth
   e. Mailing Address
   f. Date of Occurrence
   g. Time of Occurrence
   h. Chief Complaint
   i. Positive for FREI – *if applicable*
   j. MOHLTC DNR Confirmation Number – *if applicable*
   k. Problem Site/Type – *if applicable*
   l. Relevant Past History
   m. Medications
   n. Allergies
   o. Treatment Prior to Arrival – *if applicable*
   p. Cardiac Arrest Information – *if applicable*
   q. Physical Exam
   r. Clinical Treatment/Procedures
   s. Results
   t. Primary Problem
   u. Problem Code
   v. Deceased – *if applicable*
   w. Physician/BHP Name (if pronounced/TOR) – *if applicable*
   x. Date (Deceased) – *if applicable*
   y. Time (Deceased) – *if applicable*
   z. CTAS Arrive Patient
   aa. Base Hospital Name – *if applicable*
   bb. Base Hospital Number – *if applicable*

cc. Base Hospital Physician Name/No. (if Patch) – *if applicable*
dd. Patch Log No. – *if applicable*
ee. Patient Contact – *if applicable*
ff. Aid to Capacity Evaluation – *if applicable*
gg. Refusal of Service – *if applicable*

6. In addition to 2, 4 and 5 above, where patient assessment is performed, patient care is provided and the patient is transported by ambulance, the following information shall be recorded on the Ambulance Call Report:
   a. Health Insurance Number
   b. Disposition of Effects – *if applicable*
   c. Sp Trans Code – *if applicable*
   d. CTAS Depart Scene
   e. CTAS Arrive Destination
   f. Hospital Number
   g. Patient
   h. Sequence
   i. Warning Systems – To Destination
   j. Arrive Destination
   k. Transfer of Care (TOC)


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