The PCR Under the Microscope

A Practical Workshop on Clinical and Legal Quality Review of EMS Documentation

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Two Lenses, One Chart

The Legal Lens

Frank Robert Flaspohler, Attorney

- EMS Legal Services, LLC
- Outside general counsel to Missouri ambulance districts and 911 centers
- Reads charts after something has gone wrong

The Clinical Lens

Joshua Stilley, MD

- Board-certified emergency physician
- Medical director for multiple ambulance districts
- Reads charts to make the next patient's care better

Same chart. Different alarm bells.

The Worst PCR We've Ever Seen

Clinical: The chart that almost hurt a patient

What was written? The words on the page

What was missing? The words that weren't

What did it cost? The patient, the clinician, the district

Legal: The chart that lost the case

What was written? The words on the page

What was missing? The words that weren't

What did it cost? The patient, the clinician, the district

The chart is the only witness that never forgets and never gets a second chance to explain.

Start With a Question

When you review a chart, what are you actually looking for?

What we usually hear:

Tables: 60 seconds

- Missing boxes?
- Protocol compliance?
- Someone to correct?

The better answer: Whether this chart can survive every reader who will ever pick it up.

Every PCR Has Four Audiences

The Next Clinician

Continuity of care: what happened, what was given, and how the patient responded

The Biller

Medical necessity, level of service, and required signatures

The QI Reviewer

Protocol adherence, trends, and education needs

The Lawyer

What you did, when you did it, and whether you can prove it

"Many people will read each report. Professional documentation is expected." — PHS Documentation Policy

Today's Roadmap

HOUR ONE — How to Read a Chart Like a Reviewer

Reviewer's Mindset	Review Worksheet	Table Exercise #1	Just Culture Findings	Hour One Wrap
7 min	12 min	15 min	12 min	4 min

HOUR TWO — Selection, Protection, and Escalation

Sampling Plan	Federal Shield	Table Exercise #2	Finding to Fix	Ten Commandments	Q&A
10 min	10 min	15 min	8 min	4 min	3 min

Our promise: two structured chart reviews, and a take-home toolkit you can use Monday morning.

SEGMENT 2 • 12 MINUTES

The Review Worksheet

A repeatable method for reading every chart the same way, every time

Freelance Review vs. Structured Review

Freelance Review

- Depends on who reviews, and what kind of day they are having
- Catches whatever the reviewer happens to care about
- Findings vary from chart to chart
- Hard to defend when someone asks, "Why this finding?"

Structured Review

- Same instrument, every chart, every reviewer
- Catches more, and catches it faster
- Findings are comparable and trendable
- Holds up when the review itself is examined

Freelance review produces freelance results.

Anatomy of the Review Worksheet

1. Review Identification
2. Administrative Completeness
3. Times and Response Data
4. Assessment Documentation
5. Interventions and Reassessment
6. Protocol Adherence
7. Refusal Documentation
8. Disposition
9. Narrative Quality
10. Findings and Just Culture Class
11. Review Disposition
12. Escalation Screen

Clinical focus

Administrative, legal, and program

Twelve sections. One pass.

Clinical Checkpoints

Complaint matches assessment

The impression is supported by what was actually examined

Intervention → reassessment

Every treatment is followed by a documented response

Pertinent negatives

What was ruled out, not just what was found

Narrative matches flowsheet

Times, doses, and findings agree everywhere

Vital sign intervals

Frequency matches patient acuity

Protocol adherence

Followed, or the variance and reasoning are documented

The Standard We Review Against

2 sets
of vital signs for every patient transported

15 min
maximum interval for stable patients

5 min
maximum interval for unstable patients

24 hrs
chart locked — ideally by end of shift



Interventions: procedures (including CPR), medications, infusions, and ventilator or CPAP settings — with initial settings and every titration.



A vital sign believed to be wrong: replace it, remove it with a note, or leave it with an explanation. Never delete it silently.

The Narrative Should Paint a Picture

Pick a format:

- SBAR
- DRAATT
- CHART / LCHART
- Chronological

S — **Situation:** Dispatch reason, response mode and why, delays, where the patient was found

B — **Background:** History source, chief complaint in the patient's words, history, at least 4 objective elements

A — **Assessment:** Relevant exam and vital sign findings — especially those that drove decisions

Rx — **Treatment:** What, why, and the response; how moved and secured; reasoning for any variance

No interpersonal or derogatory statements. Ever.

Legal Tripwires

Response Times

Do times reconcile with CAD?

Are gaps explained?

Objective Language

Observed facts, not labels or conclusions

Refusal Elements

Capacity, risks explained, alternatives offered, signature

Signatures and Crew

All crew listed; signatures obtained or absence explained

Late Entries

Dated, attributed, explained.

Never overwritten or deleted.

Written in the ambulance. Read in the courtroom.

Write What You Saw, Not What You Concluded

Conclusory	Objective
"Patient was drunk."	Odor of an alcoholic beverage, slurred speech, unsteady gait; states he drank "a few beers."
"Patient was combative."	Swung a closed fist toward EMT; two crew members held arms during transfer to cot.
"Patient refused."	Alert and oriented x4; told refusal could result in death; states understanding; signed refusal.
"Patient fine on arrival."	Ambulatory, speaking full sentences, skin warm and dry, GCS 15.

Late Entries, Amendments, and the Locked Chart

Do

- Label it clearly as a late entry or addendum
- Record the date and time the addendum was written
- State the reason and the source of the new information
- Identify the author

Don't

- Alter the original entry
- Add details you do not actually remember
- Backdate anything
- "Fix" a chart at a supervisor's request without documenting why

Lock the chart by end of shift — and never later than 24 hours.

TABLE EXERCISE #1 • 15 MINUTES

Review the Routine Chart

Sample PCR #1
A routine transport hiding six to eight clinical and legal deficiencies

Exercise #1: Your Instructions

1. Read

Sample PCR #1 once, start to finish, before marking anything

2. Work the Worksheet

Section by section, in order — no skipping

3. Flag

Mark each deficiency as clinical, legal, or both

4. Choose One

Pick the one finding your table will report

10:00

minutes of table work

We are circulating — flag us down anytime.

Debrief: One Finding Per Table

Clinical Catches

What would change the next patient's care?

Legal Catches

What would change how this chart reads in a deposition?



The deficiencies nobody caught are the reason the worksheet exists.

For each missed deficiency, what would have caught it?
If you had gone section by section?

SEGMENT 4 • 12 MINUTES

Documenting Your Review

Just culture feedback — and findings that are safe to write

Just Culture: Three Behaviors, Three Responses



Human Error

An inadvertent slip, lapse, or mistake

Console. Fix the system.



At-Risk Behavior

A choice where the risk is not recognized, or is believed to be justified. Policy drift

Coach. Examine the drift.



Reckless Conduct

Conscious disregard of a substantial and unjustifiable risk

Accountability action. Rare.

Sort the behavior before you characterize the deficiency.

Sort Before You Characterize

1 Was the act intended?

If not, start from human error.

2 Was the risk recognized?

Or had the shortcut become normal?

3 Substitution test

Would three clinicians with the same training/experience have done the same?

Check the system first:

- Staffing
- Workload
- Equipment
- Protocol clarity
- ePCR design

The Craft of Useful Feedback

- Specific
- Behavioral
- Tied to the standard
- Includes system context

A finding written the right way:

No reassessment of vital signs or pain documented after the second dose of nitroglycerin, as required by the chest pain protocol.

System context: single-medic transfer during a multi-call surge.

Write Every Finding as if It Will Be Read Aloud

No speculation | **No editorializing** | **No character conclusions**

Instead of…	Write…
"Medic was lazy and didn't bother reassessing."	No reassessment documented after second nitroglycerin dose.
"Probably missed the STEMI because he always rushes."	12-lead acquired at 14:32 meets STEMI criteria; no alert documented.
"This crew clearly doesn't care about documentation."	3 of 5 required narrative elements absent: response mode, history source, response to treatment.

The Finding Template

1	2	3	4	5	6
Finding	**Standard**	**Gap**	**Context**	**Classification**	**Action**
What the chart shows, or does not show	The protocol, policy, or expectation	The difference between the two	Contributing factors and system conditions	Human error, at-risk, or reckless	Console, coach, educate, or escalate

Context is not excuse-making. It makes the finding fairer and more defensible.

Hour One: What You Now Have

The Instrument

A worksheet that reads every chart the same way

The Practice

One structured review, completed at your table

The Discipline

Findings that are fair, factual, and safe to write

Coming Up in Hour Two

- Which charts to review — and how to prove the choice was fair
- How to protect your QI work under federal law
- What to do when a chart becomes a problem
- How to close the loop



Fifteen-Minute Break

Hallway questions welcome -> we aren’t going anywhere.

Up next: Selection, Protection, and Escalation

SEGMENT 6 • 10 MINUTES

What to Review

Building a sampling plan that fits your service — and holds up when questioned

The 100% Review Myth

Promising 100% review?

- Most services cannot sustain it
- Quality drops as volume rises — reviewers skim
- A written promise you do not keep becomes Exhibit A



Sample defensibly instead:

- **Mandatory Triggers**
- **Randomized Sample**
- **Documented Method**

= A plan that holds up

Mandatory Triggers: The Medical Director's List

Adult Vital Signs

GCS < 9; SBP < 70 or > 220; HR > 180 or < 50; RR > 30

Pediatric

GCS < 14, or any vital sign outside the normal range for age

Time-Critical Diagnoses

STEMI, stroke, and sepsis alerts; major trauma; every cardiac arrest worked

Procedures

Airways, CPAP, NRB, IO, defibrillation, cardioversion, cric, thoracostomy, delivery, any infusion

Medications

Ketamine, midazolam, epinephrine, racemic epinephrine, diltiazem

Other Triggers

Witnessed seizure; lights-and-sirens transport; MCI; protocol concern; exceptional care

Add the Legal-Risk Triggers

- Refusals and No-Transports
- Pediatric Calls
- Restraint Use
- Medication Errors
- Ambulance Crashes
- Any Call With a Complaint
- Records Requests and Subpoenas
- Escalations and Interfacility Upgrades

If a chart is going to leave the building, someone should review it first.

Randomized Sampling, Scaled to Volume

1,000-run district

Runs per month	≈ 83
Random sample	15%
Random charts per month	≈ 13

12,000-run district

Runs per month	≈ 1,000
Random sample	3–5%
Random charts per month	≈ 30–50

In addition to every mandatory trigger. Illustrative starting points — set yours by reviewer capacity and risk.

Random means random: use a generator, not a hunch.

Document the Plan Itself

Your sampling log should show:

- A written sampling policy
- The random-selection method used
- Which charts were pulled each month, and why
- Who reviewed each chart, and when

Systematic, not selective.



Show of Hands

- Who reviews 100% of charts today?
- Who has written mandatory triggers?
- Who could prove how a chart was selected?

SEGMENT 7 • 10 MINUTES

The Federal Shield

Protecting QI work as Patient Safety Work Product under the Patient Safety and Quality Improvement Act

How the Protection Is Built



Listed PSO

A relationship with a Patient Safety Organization listed by AHRQ

+



Defined PSES

A written Patient Safety Evaluation System for collecting and analyzing information

=



The Privilege

Patient Safety Work Product: privileged and confidential under federal law

No PSO. No PSES. No privilege.

Patient Safety and Quality Improvement Act of 2005 • 42 U.S.C. §§ 299b-21 – 299b-26 • 42 C.F.R. Part 3

What the Protection Does

Privileged

Not subject to subpoena or discovery in civil, criminal, or administrative proceedings

Beyond Public Records

Not subject to FOIA or the Missouri Sunshine Law

Licensing Shield

Not admissible in professional disciplinary proceedings (i.e. Bureau of EMS)

Confidential

Disclosed only as the Act and regulations permit

Preemptive

Applies regardless of any contrary state or local law

Enforced

Civil money penalties for improper disclosure; protection for good-faith reporters

What Patient Safety Work Product Is Not

Protected (inside the PSES)

- Analyses and deliberations within the PSES
- Reviewer findings developed for reporting to the PSO
- Root-cause and trend work
- Reports submitted to the PSO

Not Protected

- The PCR itself — the original medical record
- Billing and discharge information
- Information kept separately for licensing, mandatory reporting, or personnel use
- The underlying facts, from their original sources

The protection covers the analysis but not the facts.

Building It at Your Service

1. **Write a PSES policy**
   Define what enters the system, who handles it, and how it reaches the PSO
2. **Train reviewers on "drop out"**
   Information removed before reporting must be documented
3. **Segregate the files**
   Keep PSES materials apart from operational and personnel files
4. **Document the pathway**
   Be able to prove, later, that the privilege attached

Why It Fits Just Culture

The privilege creates the protected space where candid error analysis can happen.

In Your Packet

- Model PSES policy framework
- PSOs accepting EMS members

TABLE EXERCISE #2 • 15 MINUTES

The Problem Chart, Start to Finish

Sample PCR #2 — a refusal that ended badly

Exercise #2: Score It, Then Decide



8:00

- Score the chart
- Identify deficiencies
- Answer the four questions

Education issue, or performance issue?

Does anything trigger reporting to the Bureau of EMS?

Where does each document live?

Who gets told what — and when?

The Fork in the Road: When QI Stops Being QI

QI Review of the Problem Chart

- **Stays in the PSES:** Analysis, deliberation, and just culture classification
- **Drops Out: Personnel:** Facts for a performance action, documented through HR channels
- **Drops Out: Regulatory:** Information for a required report, through its own channel

The reviewer's file, when it is over:

Worksheet	Finding	Classification	Action taken	Date closed	What dropped out, and why

From Finding to Fix

1. Track in aggregate
2. Spot the trend
3. Targeted CE
4. Revise protocol
5. Re-measure

The 45-Minute Medical Director Meeting

10 min	Trigger-review highlights
15 min	Trend review
15 min	Action items and education
5 min	Open loops

Closing the Loop — Legally

The remediation paper trail:

- What was found
- What was done, and when
- Clinician acknowledgment
- Follow-up review showing the fix worked

Due process basics: where a public employee has a protected property interest, give notice and an opportunity to respond before significant discipline.



The Binder Problem

Once your QI data shows a pattern, the district is on notice.

A QI program that finds problems and doesn't fix them is worse, legally, than no program at all.

The Ten Commandments of PCR Review: Clinical

I. Thou shalt confirm the impression is supported by the assessment.

II. Thou shalt look for a reassessment after every intervention.

III. Thou shalt hold vital signs to the interval the patient's acuity demands.

IV. Thou shalt look for the pertinent negatives.

V. Thou shalt require a documented reason for every protocol variance.

The Ten Commandments of PCR Review: Legal

VI	Thou shalt use the same instrument on every chart.
VII	Thou shalt write findings as though they will be read aloud.
VIII	Thou shalt select charts by a documented method, not a hunch.
IX	Thou shalt keep protected analysis inside the PSES.
X	Thou shalt close every loop thou openest.

Questions From the Field

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