

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RETENTION AND DISPOSITION OF** (EMT, PARAMEDIC, MICN)
PREHOSPITAL PATIENT CARE RECORDS REFERENCE NO. 608

PURPOSE: To outline the appropriate procedure for retention and disposition of Prehospital Patient Care Records which includes but is not limited to the following paper formats: EMS Report form, Base Hospital Form, MCI EMS Report Form, MCI Base Hospital Form, EMS Report Form Page 2, Base Hospital Form Page 2, Advanced and Life Support Continuation Forms, Triage Tags, base hospital radio contact logs, base hospital medical control audio recordings, and private provider agency basic life support (BLS) patient care records.

AUTHORITY: Title 22, California Administrative Code, Sections 100128, 100169
California Welfare and Institutions Code Section 14124.1
California Health and Safety Code section 1797.98(e)
Health Insurance Portability and Accountability Act of 1996

PRINCIPLES:

1. Prehospital patient care records contain patient information which is protected under the Health Insurance Portability and Accountability Act (HIPAA) and shall be maintained in accordance with HIPAA regulations.
2. Prehospital Care Providers and Base Hospitals have an obligation to ensure the security of confidential patient information.
3. Personnel responsible for all aspects of prehospital patient care record maintenance (including data entry personnel) shall receive appropriate training related to patient care record confidentiality.
4. Prehospital patient care records shall be maintained in a secure location with access limited to authorized personnel.
5. Provider agencies and base hospitals are responsible for maintaining the original copy of prehospital patient care records.
6. Original patient care records of all patients shall be retained for a minimum of seven years. Original patient care records of minors shall be kept for at least one year after such minors have reached the age of 18, but in no event less than seven years following the provision of service.
7. Records shall be accessible for audit review by EMS Agency personnel.
8. All records related to either suspected or pending litigation shall be held for an indefinite period of time.

POLICY:

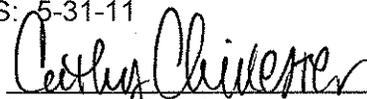
- I. Paper Provider Agency Prehospital Patient Care Records:
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EFFECTIVE: 09-23-76

REVISED: 02-01-14

SUPERSEDES: 5-31-11

APPROVED:


Director, EMS Agency


Medical Director, EMS Agency

- A. EMS Report form, MCI EMS Report Form, EMS Report Form Page 2, Advanced Life Support (ALS) Continuation Form are utilized as applicable for all ALS and 9-1-1 patients (ALS and BLS) and are distributed as follows:
1. White (Original) - Retained by the EMS Provider Agency that initiates the form.
 2. Red (Receiving Hospital) - Left with the receiving facility for transported patients. This copy becomes part of the patient's medical record at the receiving facility. If the patient is not transported, disposition is at the discretion of the EMS Provider Agency that initiates the form.
 3. Yellow (EMS Agency) - Sent to the Emergency Medical Services Agency within 45 days of the last day of the preceding month. The EMS Agency shall retain until the data has been entered into the Trauma Emergency Medical Information System (TEMIS) database.
 4. Blue (Supplemental Form) - Presented to the County pharmacist at the assigned County pharmacy in accordance with Reference No. 702, Controlled Drugs Carried on ALS Units, for replacement of controlled drugs administered to a patient in the field. County pharmacies will only accept the blue copy of the EMS Report Form with the original imprinted sequence number. Crossed out or hand written sequence numbers are not acceptable for controlled drug replacement. If the blue copy is not needed for controlled drug replacement, disposition is at the discretion of the EMS Provider Agency that initiates the form.
- B. Private provider agency specific non-9-1-1 prehospital patient care records are completed for all BLS patients and are distributed as follows:
1. Original copy - Retained by the private provider agency that initiates the form.
 2. Duplicate copy – Left with the receiving facility for patients transported to a healthcare facility. This copy becomes part of the patient's medical record at the receiving facility. If patient is not transported to a healthcare facility, disposition is at the discretion of the private provider agency that initiates the form.
- C. MCI EMS Report Form are distributed as follows:
1. White (Original) - Retained by the EMS Provider Agency that initiates the form
 2. Yellow copy - Sent to the EMS Agency within 10 business days of the incident for an MCI of greater than 5 victims. The copy shall not be separated. The EMS Agency shall retain until the data has been entered into the Trauma Emergency Medical Information System (TEMIS) database.
 3. Gray copy - Used at the discretion of the EMS Provider

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4. Red copy - Individual sticker is separated will remain with the patient, if transported, and become part of the patient's medical record at the receiving facility.
 - D. Triage Tags - In the event of a multiple casualty incident where triage tags are utilized, the original triage tag will remain with the patient, if transported, and should become part of the patient's medical record at the receiving facility. If the patient is not transported, the triage tag is to be retained as the original medical record.
- II. Base Hospital Records: Base Hospital Form, MCI Base Hospital Form, and Base Hospital Form Page 2 are utilized, as applicable, for all patients requiring base hospital contact and/or medical control and are distributed as follows:
- A. White (Original) - Retained by the Base Hospital that initiates the form.
 - B. Yellow (DHS) copy - Sent to the EMS Agency within 60 days of the incident unless approved by EMS Agency not to submit.
 - C. Red (Complimentary) copy - Used at the discretion of the Base Hospital.
 - D. Black (Complimentary) copy - Used at the discretion of the Base Hospital.
- III. Maintenance of Prehospital Care Patient Records
- A. Prehospital patient care records shall be maintained in a secure location that is accessible only to authorized personnel.
 - B. Prehospital patient care records shall be delivered to the EMS Agency in a manner that ensures form security and patient confidentiality.
 - C. Prehospital patient care records in paper format, may be stored electronically upon written approval of the EMS Agency.
- IV. Destruction of Prehospital Care Patient Records
- A. Prehospital patient care records that are eligible for destruction shall be disposed of in accordance with all applicable laws.
 - B. Complimentary and supplemental copies of prehospital patient care records must be disposed of in accordance with all applicable laws.

CROSS REFERENCES:

Prehospital Care Policy Manual:

Ref. No. 602, **Confidentiality of Patient Information**

Ref. No. 606, **Documentation of Prehospital Care**

Ref. No. 607, **Electronic Submission of Prehospital Data**

Ref. No. 702, **Controlled Drugs Carried on ALS Units**