ALBERTA COLLEGE OF PARAMEDICS

DOCUMENTATION GUIDELINE

Effective: January 2026

This document is intended to guide regulated members on the appropriate, consistent and legally compliant documentation of patient care records provided by Emergency Medical Responders (EMRs) and paramedics in Alberta.

PURPOSE

This guideline outlines documentation best-practices for regulated members of the Alberta College of Paramedics (College). This guideline is intended to:

1. Promote consistent, high-quality, timely and accurate documentation practices regardless of the format of documentation (paper or electronic).
2. Align with the College's Standards of Practice and Code of Ethics.
3. Apply to EMRs and paramedics across all practice settings, including but not limited to emergency medical services, industrial work, community paramedicine, interfacility transport and clinical or remote roles.

LEGISLATIVE AND PROFESSIONAL FOUNDATIONS

Documentation practices must align with the following:

- *Health Professions Act* (HPA)
- *Health Information Act* (HIA)
- Health Professions Restricted Activity Regulation (HPRAR)
- Paramedics Profession Regulation (PPR)
- The College's Standards of Practice and Code of Ethics

SCOPE

This guideline applies to all regulated members of the College, including Emergency Medical Responders (EMRs), Primary Care Paramedics (PCPs) and Advanced Care Paramedics (ACPs). It applies to all settings in which patient care is delivered.

CORE PRINCIPLES OF DOCUMENTATION

For EMRs and paramedics, documentation is a critical professional responsibility that serves as the legal record of care provided. Ensuring accurate and thorough documentation is essential for patient safety and professional accountability. The following principles guide EMRs and paramedics in their documentation practices:

- **Accuracy and Factuality**: Record all observations and care provided with precision and only include verifiable information.
- **Timeliness and Contemporaneousness**: Document care as soon as possible after delivery to minimize errors and ensure a clear record of events.
- **Clarity and Conciseness**: Use simple, straightforward language that is free of ambiguity, ensuring that the documentation is comprehensible to others.
- **Confidentiality and Security**: Protect patient information by adhering to privacy laws and securely handling all documentation.
- **Objectivity**: Focus on the facts without personal opinions or biases, maintaining a neutral and professional tone.

DOCUMENTATION REQUIREMENTS

These requirements help establish the foundation for the documentation of patient care or services provided. The following criteria outlines how regulated members are expected to fulfil each domain pertaining to proper documentation records. Keep in mind, these requirements are a guideline, and each regulated member must follow their employer's policies and procedures when completing documentation.

1. Accountability

- Document only the care personally provided or observed, unless acting as a designated recorder.
- Authenticate all entries with your legal signature and/or unique electronic identifier. This includes signing all documentation using your first name or initial, full legal surname, protected title and registration number (i.e. J. Smith, ACP, RO599999).
- Do not pre-chart or document care that has not yet occurred.
- Identify and label any late entries clearly.
- Never alter or delete another regulated member's documentation.

2. Timeliness

- Document care as close as possible to the time it was delivered. This enhances the credibility and accuracy of the record. This ensures your documentation is completed contemporaneously.
- Ensure each entry/act of care provided is dated and time stamped.
- Late entries must include the original date and time of the event, the date/time of the late entry being documented and be clearly labeled "Late Entry". Document late entries only when able to accurately recall the event and/or care provided. Include any additional employer requirements when documenting late entries (i.e. reason for late entry).

3. Completeness

- Each patient care record should include, but is not limited to:
    - Date and time of entry
    - Patient identifiers
    - Presenting concern or issue (chief complaint)
    - Assessment findings
    - Interventions and treatment provided
    - Clinical reasoning or rationale for decisions made
    - Patient's response to care
    - Ongoing or future care plans

4. Communication

- Document relevant communication with:
  - Patients or their substitute decision-makers
  - Healthcare team members
  - Supervisors or medical control
- Include names, titles and outcomes of discussions when appropriate.

5. Refusals

When a patient refuses assessment, treatment or transport, regulated members must respond professionally by ensuring the refusal is informed and voluntary. It is essential to clearly explain the risks, benefits and alternatives, and thoroughly document the discussion with the patient. This includes recording:

- the information provided to the patient,
- the patient's understanding,
- the final decision,
- direct quotations from the patient and
- the names and titles of other involved healthcare professionals or supervisors.

Registrants must follow employer guidelines precisely, using approved forms, mandated statements and appropriate signatures and timing as required to ensure records are clear, accurate and compliant with policy.

6. Adverse Events/Outcomes

An adverse event is one that results in unintended harm to the patient and is directly related to the care/services provided rather than the patient's underlying medical condition. An adverse outcome refers to a deterioration of the patient's condition that is unexpected based on the plan of care. If either occurs, make sure to:

- Document the event, your actions, any notifications made and the patient outcome.
- Ensure follow-up steps are recorded.

7. Use of Abbreviations

- Use only employer-approved abbreviations. Avoid abbreviations that could be misinterpreted or cause confusion.

8. Language and Legibility

- Documentation must be clear, legible and in English.
- Avoid slang, subjective statements or disrespectful language.
- When citing the patient, clearly document this by indicating that the statement is a direct quotation from the patient and enclosing it in quotation marks.
- When documenting on a paper patient care report/record, ensure that you are using permanent ink.

CONFIDENTIALITY AND SECURITY

EMRs and paramedics safeguard patient health information by ensuring privacy and confidentiality, adhering to relevant legislation, professional standards and employer protocols, including those specific to pre-hospital care. They do this by:

- Complying with the *Health Information Act* (HIA) and employer policies.
- Maintaining the privacy and confidentiality of all patient information.
- Using only your own login credentials for electronic health records.
- Logging out of systems when not in use.
- Not storing patient information outside of approved systems or documentation platforms.

DOCUMENTATION ERRORS

- If an error is made:
    - Paper records: Draw a single line through the incorrect entry, write "error," add your initials, the correction and the date/time.
    - Electronic records: Follow the system's correction protocol to add a new entry.
        - If the electronic patient care record (ePCR) has been finalized already, do not delete the original entry. Instead, complete a late entry addition, identify the error made and include the correct information.

LEGAL AND PROFESSIONAL IMPLICATIONS

- The patient care report is a legal document and may be used in investigations, audits or legal proceedings.
- Incomplete or inaccurate documentation may be considered a failure to meet professional standards.

Remember: If it wasn't documented, it didn't happen. This includes ensuring that pertinent negatives and associated findings are captured. Alternatively, if an assessment or intervention was documented (i.e. a PCP signs the PCR saying they administered a restricted medication that only an ACP can give) – but it didn't actually happen – the patient care report, as a signed legal document, will hold more weight than member testimony during an investigation or legal proceeding. Do not sign a patient care report until you have thoroughly reviewed and verified the contents.

RESOURCES

- Alberta College of Paramedics: Standards of Practice
- Alberta College of Paramedics: Code of Ethics
- *Health Professions Act*
- *Health Information Act*
- Paramedics Profession Regulation
- For more guidance, contact the College or your employer's clinical practice lead.

REFERENCES

College of Licensed Practical Nurses of Alberta. (n.d.). *LPN policy: Documentation (ID 90281)* [PDF]. https://www.clpna.com

College of Registered Nurses of Alberta. (2022). *Documentation standards* [PDF]. https://www.nurses.ab.ca/docs/default-source/document-library/standards/documentation-standards.pdf

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Government of Alberta. (2000). *Health Information Act, RSA 2000, c H-5*. https://www.canlii.org/en/ab/laws/stat/rsa-2000-c-h-5/latest/rsa-2000-c-h-5.html

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This document is intended to support regulated members in meeting professional expectations. For clarification or practice support, contact the College directly.