NYS NEMSIS 3.5.0 | Educational Snip #2024-011

eHistory.05, .06, .08, &.12

Q: How have history fields changed under NEMSIS 3.5?

History taking drives prehospital clinical decisions. Additionally, accurate documentation of patient history is vital to continuity of care, effective assessments of system quality, and EMS research.

Often, patient history fields in ePCRs are completed using not values like "not applicable" or "not reported" instead of pertinent negatives like "none reported". NYS validation rules under NEMSIS 3.5 flag history fields as warnings when they are completed with not values. This means a provider can still lock their chart but there is consensus that there may be a better way to document.

Below we will give field specific information on appropriate history documentation.
Note, we will only list fields with validation rules in NYS

Advance Directives (eHistory.05)
Validation Rule for ALSFR & Transporting Agencies 2457

Advance directives must be documented when patient contact is made. When a patient doesn't have an advanced directive, the correct response is "none".

Allergies, Medications, & Past History

The following three fields document patient medical history. Below are the appropriate pertinent negatives (and when they are applicable) for these fields. Providers shouldn't use not values.

- **None Reported:** for use when a patient does not have the listed field (allergies, medications, medical history).
- **Refused:** for use when a patient refuses to answer the history question.
- **Unable to Complete:** crew members for reasons other than those available were unable to obtain this information from their patient.
- **Unresponsive:** the patient was unresponsive, hindering history taking ability.

1. **Medication Allergies (eHistory.06)**
   Validation Rule ALSFR & Transporting Agencies 2459

   Medication allergies should be documented when a patient is assessed.

2. **Medical/Surgical History (eHistory.08)**
   Validation Rule for ALSFR & Transporting Agencies 2460

   When a patient assessment is completed, a thorough history should be documented.

3. **Current Medications (eHistory.12)**
   Validation Rule for ALSFR & Transporting Agencies 27362461

   When a patient assessment is completed, a thorough medication history should be documented.