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Epidemiology

More errors with electronic vs paper ambulance call reports

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By Rob Goodier

NEW YORK (Reuters Health) - Researchers found more than five times as many errors in electronic ambulance call reports as in traditional paper reports by Canadian paramedics.

The study of nearly 33,000 reports from a one-year period found that 3.3% of electronic reports had missing or inaccurate information, compared to only 0.6% of the paper reports.

The 2.7% difference was statistically significant. And most of the errors - 70% of the electronic reports and 69% of the paper reports - were in the clinical information sections of the forms.

Adeel Ahmed from the Southwest Ontario Regional Base Hospital Program in London, Ontario and his team presented the findings January 13 at the annual meeting of the National Association of EMS physicians in Tucson, Arizona.

Ambulance call reports provide information such as call history, patient assessments and care provided. Doctors in the base hospital program use the reports to assign medical duties to the paramedics, and medical staff at the hospitals can refer to the reports as they provide further care.

"Documentation of patient care in EMS is important for many reasons. Results from analyses such as these can be used by EMS administrators and medical directors to understand limitations within their own system and for the development of quality improvement initiatives to decrease documentation errors," Jon Studnek, Director of Prehospital Research at Carolinas Medical Center in Charlotte, North Carolina, who was not involved in the study, told Reuters Health by email.

"It is not clear why this occurred," the researchers wrote in their abstract for the meeting. "It may be that the use of electronic ambulance call reports increases the number of documentation errors, despite vendors' claims to the contrary."

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