Documentation

Why your narrative is important:

Patient continuity of care

Provides a clear picture for all hospital staff involved in the care of the patient.

Legal protection

Your PCR narrative is a legal document that reflects the quality of care provided to your patient.

It will also protect you and your agency from potential lawsuits.

Quality assurance

It helps the agency to evaluate the effectiveness and find ways to improve protocols.

Reimbursement

It is essential for proper reimbursements from insurance providers and other government providers like Medicare.

It is vital for any audits and financial compliance.

Choosing a Style:

It is better to pick one style of narrative and stick with it for every call.

C.H.A.R.T.

Chronological

S.O.A.P

No matter which style you choose to write, remember:

Avoid jargon

Be objective

Prioritize critical information

Include interventions and the way patient responds to them

Paint a picture of the scene and the condition of the patient

Check grammar and spelling

Our Grading System

There is a grading template that Greg uses to review our narratives. These requirements MUST be met. When Greg QA's your EPCR, he reads your narrative and checks off to see if you have missed anything, this is not meant to cause embarrassment or "get you in trouble", it is only a system to advise how to better your documentation.

Our Template

General: The following section includes what is reviewed for every narrative

- Mental status
- General impression (XABCD)
- Skin Condition
- SAMPLE and OPQRST
- Related symptoms/ secondary assessment
- Quality of lung sounds and work of breathing
- Interventions for complaints/ findings with success or failure of intervention. If you choose not to intervene with any interventions, you MUST document why!
- Patient securement to the cot and how you placed him on the cot.
- At least 2 sets of vital signs or a legitimate reason why you did not.
- Continued vitals at appropriate intervals.
- Changes in your patient's condition.
- ER delays for transfer of care.

Chest Pain/ STEMI:

- 12-lead within 10 minutes of patient contact. If you are unable to get this done for some out of the ordinary situation, document it.
- Transmitted if it is a suspected STEMI.
- <15 minutes on scene for STEMI (after confirmation).
- Include OPQRST in your narrative.

Stroke:

- Last known well time
- Is the patient on blood thinners
- Onset of symptoms
- Blood Glucose Level
- Which stroke assessment did you use
- A documented time of when Code Stroke was called including the C-STAT score

Refusals:

- Decision making capacity
- Lack of drugs, alcohol, or major injury that could impact decision making capacity.
- Clear explanation of risk.
- No advice given outside of the scope of practice.
- A documented passing grade for the Mini-Mental Status Exam (State EMS Guideline).
- A witness

Trauma:

- Mechanism of injury.
- For penetrating trauma include type of object: caliber of bullet, knife, etc.
- For blunt trauma include what: fall, struck. Include findings of bruising, crepitus, etc.
- Head to Toe findings.

Cardiac Arrest:

- No avoidable delays in CPR.
- Resuscitation performed on scene.
- Correct timing of pulse/ rhythm checks.
- Correct timing of medications administered.
- Advance airway placed during compressions (plus airway section).
- Bicarb only if indicated.

Airway:

- Positioning with adjunct.
- Bag compliance.
- Confirmed effect of sedative/ paralytic if used.
- Immediate securement of tube.
- Depth and confirmation types of successful intubation.
- ETCO2/ SPO2/ EKG as applicable.
- Continued sedation at appropriate intervals.
- Confirmation of tube placement after patient movement/ transfer of care.
- Signature of who confirmed tube placement at time of transfer of care.

Vent Transfers:

- Documented tube size, depth, securement device, and more than 2 confirmations.
- Monitored for at least 10 minutes prior to transport.
- Vent settings must be documented including Mode, TV, Rate, PEEP, FiO2
- Vital signs at appropriate time intervals.
- Signature of who confirmed tube placement at time of transfer of care.

Childbirth:

- Length of gestation.
- High risk pregnancy and why.
- Gravida/ Para.
- Prenatal care.
- Meconium present?
- APGAR scores if applicable.

A well written narrative will help jar your memory if you ever have to go for a deposition. We all know that they usually happen years after the call.

<u>Auto-generated AI S.O.A.P. narrative is not sufficient information.</u>

IF YOU DIDN'T DOCUMENT IT, YOU DIDN'T DO IT!

A well written narrative

Opening of your narrative:

The first opening statement of your narrative should reflect the Med Unit responding.

The address you are responding to

The chief complaint of the patient

How you did or did not respond with explanations

Opening: ***(Example)***

Greene County Med 3 responded immediately to 719 Kramer St. for report of a 35-year-old male patient complaining of chest pain with shortness of breath. We were unable to respond emergency due to inclement weather, high winds and storms.

Painting a picture of your scene

This next paragraph should be a detailed scene size up

It should include how you find your patient

It should include your XABC's, SAMPLE, and OPQRST

It should include any obstacles that challenge you with this patient

You should document who and why you were called, and what was going on at the time of the call.

Make sure you get a name so the document shows that you are not making assumptions of your own.

On scene portion: ***(Example)***

As we made our way into the residence, the patient's wife stated that he was in the back room. It did take a bit to access the patient due to the fact that they had been renovating and the hallway was cluttered with construction debris. As we made our way into the bedroom, we found the patient sitting on the side of his bed in the tripod position with heavy breathing while using his accessory muscles. He did try to tell us what was going on, but he was using short broken sentences with singed words. His wife stated that he was getting up to get ready for the day, and started complaining with chest pain and then became short of breath. She did state that he has a history of CHF and has had multiple stents and a recent CABG. Patient's pulse is rapid and bounding and he was immediately placed on the cardiac monitor with not only baseline vital signs obtained, but a 12-lead as well. We did request for additional help as the patient is approximately 275 pounds and the hallway is cluttered. Fire Department did arrive on scene and helped clean

out the hallway enough to get the stretcher closer to the patient as he is too dyspneic to walk. Once the stretcher was close to the patient, he was assisted up with 2 crew members, pivoted, and assisted down onto the stretcher. He was secured with rails up, straps over and across, in a high seated fashion, due to his breathing. Patient was then taken to the ambulance with the assistance of Fire Department due to mud and rain.

Inserting the SAMPLE: *(Example)*

- S: Dyspnea, Tachypnea, Tripod position, Short-singed word sentences, chest discomfort.
- A: Lisinopril, IVP Dye
- M: Aspirin, Amiodarone, Atorvastatin, Furosemide, Nitroglycerin, Metoprolol, Spironolactone
- P: Angina, CABG x 2, CHF, Hyperlipidemia, Hypertension, Obesity
- L: Cereal and coffee this morning at 07:30
- E: Went to eat breakfast this morning and walked back to his bedroom where he became severely short of breath. He also stated that he has missed his medicines for the past 4 days, as he is out.

Insert the chief complaint:

This is important so the hospital and insurance biller knows what you are treating the patient for. It is wise to include a differential-diagnoses, as well, if there is one.

Insert the OPQRST: *(EXAMPLE)*

- O: Suddenly after a mild bit of exertion.
- P: Exertion and position.
- Q: Dull pressure.
- R: Does not radiate.
- S: Severely distressed with a pain scale of 8 out of 10.
- T: 08:30 this morning

Documenting interventions:

Once you have your patient in the ambulance, you should document your interventions and medications you administered.

If it takes multiple attempts for a particular intervention, you should document why and how many attempts it took.

You should also document if the medications have helped improve the condition of your patient.

If you choose to not treat your patient, as some do, you must provide a legitimate reason why you did not. We just don’t give rides for no reason!

Treatments in ambulance: ***(Example)***

Once inside ambulance, patient was placed on oxygen via end tidal capnography, due to his increased respiratory rate. Due to the fact that we may have to assist the patient with respirations, IV therapy was initiated at the left AC using an 18-guage int, it did take 2 attempts, and there were no signs of infiltration noted and the site flushed with ease and was secured appropriately. Since the patient is hypertensive and has wet lung sounds, he was administered a DuoNeb treatment, as well as a sublingual NTG, to avoid flash pulmonary edema. Patient was administered 40 mg. Furosemide with emergency transport initiated to the facility where his cardiologist is located. During transport, patient was administered 125 mg. Slu-Medrol and there was no change is his respiratory rate as he is very anxious. Did administer 1 mg. Lorazepam for the anxiety and placed patient on C-Pap at its designated level, continued monitoring patient. A second sublingual NTG was administered, as the first one was helping with his hypertension. A second 12-lead was obtained and showed no difference than the first one. An albuterol treatment was administered, with the C-Pap left in place, this provided greater improvement in the patient's condition. Patient is now stating that he is breathing easier and he was continuously monitored.

Documenting Vital Signs:

This is the only section that I inform the reader that they must look at the chart to see the vital signs and to tell that there was improvement.

Documenting a reason for Ambulance:

Even though you have been dispatched on an emergency call, it is wise to report what you did for the patient and if it showed improvement.

Reason for Ambulance: ***(Example)***

> **Interventions done:** ALS assessment, 4-man assist to stretcher, Cardiac monitoring due to hypertension and tachycardia, 12-lead EKG to rule out STEMI, IV therapy for medication administration, Med neb treatments, end-tidal capnography, C-Pap with improvement, emergency transport to hospital, 4-man sheet transfer to hospital bed.
>
> **Medications administered:** NTG x 2, Furosemide 40 mg., DuoNeb 2.5 mg. with Improvement, Solu-Medrol 125 mg., Albuterol 3 mg. with improvement, Ativan 1 mg with improvement in the patient's anxiety.

Ending your narrative:

> The ending of your narrative should reflect the following:
>
> - What facility you transported to and why.
> - A list of medication and therapies provided and if it provided any relief.
> - Documenting that your therapies are still in place.
> - Who you gave report to and their qualification.

- Signature of that person with a typed name.
- A name, signature and level of qualification of someone that confirmed airway adjuncts.
- End your report by writing your name and level of training, at the end of your narrative.

Ending: ***(Example)***

Patient was transported emergency to Johnson City Medical Center, an out of county higher level of care facility, where he is established with cardiology. Upon arrival, patient was taken to AC-1 and sheet transferred to hospital bed. IV site was checked and showed no signs of infiltration. A full report of interventions and medications were given to the RN. A list of medications administered and handed to her and she was informed that all had improved the patient's condition. Signature was obtained from Janis Joplin, RN.

This narrative was written by EMT-P Kenneth Lawrence, CADS