Approacheses for ePCR narratives

EMS Clinical Practice courses

Quality assurance for Paramedic Documentation

9/5/2019

Scenario

Ambulance-1 was dispatched to a residence for a 76-year-old male complaining of chest pain. Ambulance-1 responded emergent and arrived on scene without incident. Upon arrival, the patient was found sitting upright in a recliner in the living room with his wife present. The patient states he began having substernal chest pain at approximately 0730 along with pain radiating down his left arm, rating it as 7/10 chest pain. Per dispatch instructions, he took 325 mg of aspirin. The patient appears normal in color with acutely moist skin and no signs of obvious respiratory distress. His past medical history only includes a prior hip surgery and hypertension, with related prescriptions. The patient was taking all of his prescription medications this morning.

Can you imagine walking through the front door to find this patient sitting on a recliner? This is just the start of a story, not the entire narrative. This narrative adequately describes the patient and an initial impression.

.

Common patient care narratives

SOAP, CHART single paragraph (and only a single paragraph) and chronological are common formats for patient care.

SOAP narrative

SOAP narratives often take the shape of four distinct paragraphs that start with an identifier like "S" or "Subjective," which helps to indicate that you're following a SOAP format.

The **Subjective** portion of the narratives includes history of the incident. What you're told, how the patient describes their symptoms, dispatch information and your perception of the scene.

Objective comments are then added in, which include your assessment findings, vehicle damage observations, patient positioning, vital signs and other non-opinionated facts.

Your differential diagnosis, then takes form in the **Assessment** section, which basically outlines what you believe you're treating or ruling out.

Lastly is the **Plan** portion of the narrative, which depicts what you did to treat your patient. Establishing an IV, giving medications, relaying what was done prior to your arrival and what you did on-scene versus in transport.

CHART narrative

CHART narratives also follow a visual layout based on the letters in the acronym.

Starting with the chief **Complaint**, the **History** of the present illness, along with the patient's past medical history, is outlined.

Assessment findings are then documented, along with **Rx** (prescriptions) that the patient is prescribed.

Lastly is the **Treatment** section, which outlines what you've done for your patient, much like the plan section on SOAP.

ICHART is used for EMS documentation.

I

Incident

- Brief details of the incident, including location and reason for dispatch
- Time on scene and location of patient
- How the patient was found

C

Chief Complaint (Cx)

- Patient's age, gender and chief complaint
- Documenting sources of information from family members, friends or bystanders with quotation marks
- Reason EMS was called

H

History (Hx)

- Brief history of events leading to the incident
- Mechanism of injury (MOI), if applicable
- SAMPLE

A

Assessment (Ax)

- AVPU and OPQRST

- Important findings and results of physical exam
- Vital signs

R Treatment (Rx)

- List of treatments in chronological order

T Transportation (Tx)

- Why the patient required transportation by ambulance
- Where the patient was transported and if any changes were noted en route

ICHART Example

(Ix) M9312 Dispatched to a private residence for a medical aid. U/A at 1325, pt sitting on the couch in a tripod position. Pt's spouse standing next to him.

(Cx) 65 Y/O M C/O of tightness in Cx and SOB. Pt's spouse states, "John was mowing the lawn when he started to clutch his Cx and complain of not being able to breathe." Pt states, "The pain is getting better, but my Cx feels tight and I can't seem to catch my breath."

(Hx) Pt states, "I felt a sharp pain in my Cx and couldn't breathe, so I stopped what I was doing and came inside to sit down." Pt C/O Cx tightness and SOB. (-) to any numbness or tingling. Not taking any Rx other than OTC multivitamins qdx1. Allergic to Penicillin.

(Ax) Appx. 1330, B/P 140/100, P 72, RR 23. Skin is pale, cool and diaphoretic. HEENT: C/O dizziness, (-) ear, neck, throat or eye pain. No evidence of trauma. Cx has equal rise/fall, L/S clear bilaterally, C/O dull chest pain. The pain started when pt was mowing the lawn and feels sharper when pt breathes in. Pain is otherwise dull and radiates out to entire Cx. Pain is 6/10 and started at appx. 1315. Abd is soft, non-tender and no masses. Pelvis is intact and no pain.

(Rx) Appx. 1331, pt placed on 02 @ 15lpm via NRB and IV 18G to L AC. Administered ASA 162mg chewable PO, NTG 0.4mg SL, and NTG ointment 1″ to L Cx. ECG Sinus tach @ 101 and stable. Pt transferred from couch to gurney with assistance and Tx to ACME Medical Center. Pt's spouse followed in POV.

(Tx) Emergency Tx was necessary because pt is suspected to have a possible MI. Contacted ACME Medical Center to notify them of pt's arrival and condition. No changes to pt's condition en route. Pt care was transferred to Jane Doe, RN at ACME Medical Center at appx. 1358.

A single paragraph

The entire patient encounter is summarized into a single paragraph, often five to six sentences long. *Thus, in terms of today's documentation standards for quality assurance and reimbursement, simply isn't enough.*

Chronological narrative

Chronological narratives focus on outlining the call as things happened. To keep the documentation visually appealing and readable, sections are often broken into different paragraphs to denote a change in environment.

Starting with your dispatch notes, response findings and initial patient impression, you can then build into your next paragraph, which includes your on-scene events.

On-scene (next paragraph), document what you performed, what the patient told you about their condition and history, what injuries you assessed and what your overall differential diagnosis of the patient is.

Based on those findings, you then decide to transport your patient (next paragraph) and begin to outline your "in ambulance" events. This section may be fairly short, as the time between the home-to-ambulance, then ambulance-to-transport may only be a few minutes. In any event, this is the appropriate area to document what you did prior to transport, how the patient's condition changed from one scene to the ambulance and what any other pertinent scene findings may include.

On scene, vitals were assessed. IV access was obtained and a 12-Lead ECG reveals a sinus rhythm with ST-elevation noted in leads V2, V3 and V4. An anterior-wall infarction is suspected and defibrillation pads are placed on the patient, per protocol. The patient's shirt is removed and left on the scene with his wife. Lung sounds are clear bilaterally in all six fields. Nitroglycerin was considered, but not administered due to the patient's systolic blood pressure only being 110 mm Hg, along with the patient's recent prescription intake of metoprolol. SpO2 values were in the upper 90s, so oxygen was not delivered, per protocol.

In transport (next paragraph) you continue your secondary assessment, intervention follow-up, and description of new actions on your way to the hospital. Medications administered, changes in patient condition, and any new findings are all documented.

The patient was briefed on our findings and advised that transport to the closest cardiac-appropriate facility was recommended, and he agreed. City Hospital is contacted via phone with a Cardiac Alert and advised of a 10 minute ETA; no further questions were asked by the ED. The

patient was able to stand with assistance and pivot onto the EMS cot. He was secured in a semi-Fowler's position of comfort and transported to the ambulance.

In the ambulance, the patient had no deterioration in initial status. His chest pain remained at 7/10 and no new symptoms were present. Emergent transport was initiated to City Hospital.

In transport, fentanyl was administered for pain management. A second IV was established and maintained at TKO. The patient's wrists were shaved of excess hair and the patient's shoes and pants were removed. The patient began to complain of new-onset nausea, so ondansetron was administered as an anti-emetic. The patient's skin remained normal in color and moist. No significant changes were noted in the patient's blood pressure or SpO2 levels. The patient's pain level decreased to 4/10 after fentanyl administration. Repeat 12-Lead printouts reveal no new findings or changes. ETCO2 values were within normal limits and a capnography print-out revealed a normal box/plateau waveform. The patient remained otherwise calm and was explained, some potential courses of action that he may encounter while at the hospital.

Narratives, overall, don't need to be redundant. All vital signs don't need to be documented in the narrative, nor do all patient prescriptions or history findings. But, findings that require your follow-up action do need to be documented. If the patient's blood pressure is low, then it's appropriate to document "96/42 mm Hg" in the narrative, followed by the fact that you started and IV and administered a 500 mL normal saline fluid challenge.

As you arrive at the hospital (new paragraph), you continue or discontinue some of your initial interventions, then transport your patient into the emergency department. The patient is transferred to the emergency department bed and you complete your hand-off report. Necessary information is relayed, and you return to your ambulance with your necessary paperwork and crew.

Upon arrival at the ED, the patient was lifted from the EMS cot to the ED bed by EMS and ED personnel. Patient information was then relayed to the ED Physician and RN staff, and care was transferred.

As an addition to any form of narrative, it may be appropriate to add a disclaimer section that notates other various actions or findings from your call. What items were left with the patient at the hospital, who signed your HIPAA/privacy and billing documents and any time discrepancies that may be noted can also be explained in this section.

HIPAA/billing documents were signed by the patient and a Notice of Privacy Practices form was left with the patient at the ED. Patient belongings, including shoes, pants, wallet and watch, were left in the ED room in the patient belongings bag provided. Some documented times may be approximate and dispatch/report times may not be synchronized.

Own the report

Lastly, own and take pride in your report. Sign your narrative so that it is easily identifiable that you wrote it rather than relying on what the computer-generated portion assumes. Signatures may include your initials, your first and last name, a combination, your employee/license number or your provider level.