The Art of Constructing the Clinical Narrative

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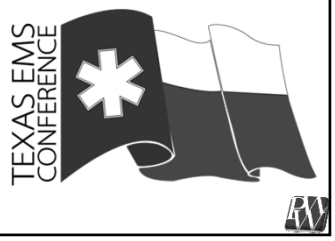

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Documentation is a skill

It can be taught, learned, practiced and improved

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Ethics in EMS Documentation

- All EMS documentation must be accurate, timely and complete
- This is both a ***legal*** and ***ethical*** responsibility

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Documentation is a fundamental part of patient care

Every EMS practitioner has an ethical duty to do it well.

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Ethics in EMS Documentation

- The first job of EMS practitioners is to provide effective patient care
- A PCR is a ***Patient Care*** Report
  - Vital part of the patient's medical records
  - Documentation is an integral part of patient care

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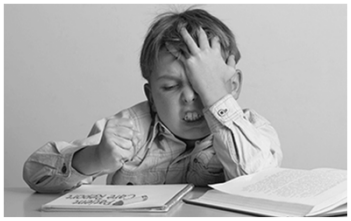
It Is Your Job!

- Documentation is an essential job function of the EMT and Paramedic
- Good documentation is not just ***important – it is an essential part of patient care!***



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The truth about being a street medic is this:

It's about helping people, *in their own time and on their own terms.* Mostly, helping people is *work*, and there's a reason we call it that.
It mandates the desire to be a caregiver, and that requires special gifts. Gifts like intelligence, compassion, patience, gentle kindness, humility and perhaps a sense of humor.

Thom Dick, "People Care"

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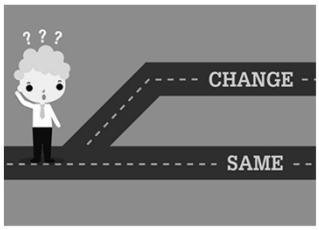
To Improve Clinical Documentation, We Must First Foster an Attitude Change!



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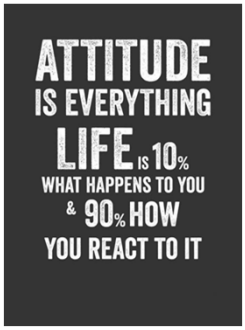
Reducing Risk and Improving Clinical Documentation Is All About …



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The Value of "Gratitude"

- Gratitude is a powerful motivator
- Grateful patients are loyal patients
- Gratitude reduces our own stress levels and increases job satisfaction!

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Benefits of a Positive Attitude

Positive Attitude

- Good Patient Care
- Good Patient Satisfaction
- Good Documentation and
- NO LAWSUITS!

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Ethics in EMS Documentation

- EMS practitioners are entrusted with the care of vulnerable patients
  - Not only ***medically*** vulnerable, but ***financially*** vulnerable
  - A serious medical crisis can be devastating financially

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Ethics in EMS Documentation

- EMS practitioners are entrusted with the care of *vulnerable* patients
  - Inadequate documentation can leave the patient financially responsible to pay bills that insurance would have otherwise paid for medically necessary services
  - Can exacerbate the suffering of the patient – that is not good patient care!

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Document *Completely*

- Ensure all relevant information is captured
- Capture operational, clinical and financial documentation
- Obtain necessary signatures
  - Crew members
  - Patient or responsible party (if patient cannot sign)
  - Receiving facility representative

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Document *Accurately*

- Honesty in all aspects of documentation
- Accuracy in dosages and measurements
- No purposeful omission of relevant information
- No documentation of information that is not true
- No misrepresentations for the purposes of reimbursement, liability or any other reasons

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Document *Timely*

- Comply with all state EMS requirements for timely completion of patient care reports
  - Example: Some states have specific timeframes in which EMS agencies must submit completed PCRs to emergency departments/receiving facilities

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Document *Timely*

- Ensure that necessary information is communicated to receiving facility at time of patient transfer of care
  - Even if the final PCR is not yet completed
  - Some EMS systems use field notes, a preliminary report or "rip and run" sheet for this purpose
  - Most systems do not require that field notes be retained, but check your system's policies

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What is a Clinical Narrative?

- A first person story written by an EMS practitioner that describes a specific patient encounter

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What is a Clinical Narrative?

- Allows the EMS practitioner to describe complex and sometimes contradictory facts in a manner that can be easily understood by others
  - Example: *"The patient denies any chest pain today, but patient's spouse reported that Pt complained of severe chest pain approximately 30 minutes prior to our arrival"*

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Purpose of Clinical Narratives

- Document the complete story of the call - in chronological sequence
- Capture all *relevant* information about the patient's condition and treatment

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What a Good Narrative *Should* – and *Should Not* Do

23

A Good Narrative Should "Paint a Picture"

A clinical narrative should be a *visual exercise*

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What a Good Narrative Should Do

- Above all, the clinical narrative must be an ***accurate*** and ***complete*** record of the patient's condition and care provided
- The narrative has ***clinical***, ***operational, financial and legal*** significance

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A Good Narrative Should *Not* Be an Incident Report

- Do not use the clinical narrative to report information that is not germane to the call or patient care
- Example:
  - *"After the transport, when backing the unit into the station, the passenger side mirror was inadvertently knocked off"*

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A Good Narrative Should *Not* Be Used to Lay Blame

- Example:
  - *"First responders on scene had misapplied the extrication collar and admitted they were unfamiliar with its proper use"*
  - *"Ambulance crew was not monitoring airway properly and the ET tube became dislodged"*

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A Good Narrative Should *Not* Omit Information

- Never purposefully omit information that does not support reimbursement
  - Example:
    - Documenting: *"Patient was transferred from bed to stretcher"*
    - What really happened: *"Patient met us at the front door with suitcase in hand and walked down the steps toward the ambulance without any assistance…"*

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A Good Narrative Should *Not* Leave Out Supporting Details

- Never fail to document information that would support reimbursement
  - Example:
    - Documenting *"Pt walked from bed to stretcher"*
    - What really happened: *"Pt was seated on edge of bed, was very weak as we stood him up and he had to be supported under his arms by both crew members as he shuffled a couple of feet to the stretcher"*

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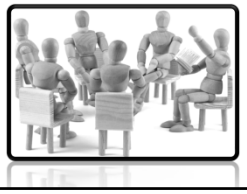
Data vs. Narrative

- ePCR data ***drives*** analysis and decisionmaking

- ePCR narratives ***persuade*** and tell the story



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Data Fields

- Are in important aspect of PCR documentation
- Do not replace the narrative
- Both must be complete and accurate
- Narrative and data fields must be consistent

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Example - Inconsistency

- Data portion says this:

EYES OPEN	BEST VERBAL	BEST MOTOR
☐ SPONTANEOUS– 4	☐ ORIENTED-5	☐ OBEYS COMMANDS-6
☐ TO VOICE – 3	☐ CONFUSED-4	☐ PAIN/LOCAL-5
☑ TO PAIN- 2	☑ INAPPROPRIATE.-3	☑ PAIN/WITHDRAWAL-4
☐ NONE –1	☐ GARBLED-2	☐ PAIN/FLEXION-3
	☐ NONE-1	☐ PAIN/EXTENSION-2
		☐ NONE-1

- BUT Narrative says:
  - *"Patient is alert and oriented x 4…"*

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Narrative and Data Consistency

- ePCR applications are largely data driven and include data capture for virtually all aspects of operations, assessment, treatment and transport
- Data fields and narratives service distinct purposes and both are important components of the PCR
- Both must be *complete*, *accurate* and *consistent*

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Narrative and Data Consistency

- Virtually every retrospective reviewer of a PCR will focus on *the narrative*
  - Other healthcare providers furnishing care to the patient
  - Attorneys investigating potential malpractice
  - Auditors reviewing medical necessity
  - Investigators evaluating potential false claims cases
  - They may compare the data fields and narratives

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"Double Documentation"

- Question:

  To what extent must the clinical narrative repeat information that is documented in the PCR data fields?

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"Double Documentation"

- Answer:
  - *If the data field communicates a complete fact for which no additional context is required, it need not be repeated in the narrative*
  - *If the data field does not provide sufficient context, it must be included in the narrative*

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Example 1

- Data field:

VITAL SIGNS			
TIME	BP	PULSE	RESP
1647	140/96	92	24

- Data stands on its own and does not require additional context to be clearly understood
- No need to repeat the vital sign data in the narrative
  - *"At 1647, BP was 140/96, pulse was 92 and respirations 24"*

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Example 1

- Data field:

VITAL SIGNS			
TIME	BP	PULSE	RESP
1647	140/96	92	24

- Include additional observations that are relevant to the data in the narrative, such as:
  - *"Radial pulse was bounding and irregular, and the respirations were shallow and labored…"*

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Example 2

- Data field:

CHIEF COMPLAINT:	Chest pain

- Provide context in the narrative:
  - *"Pt states that pain is located in the center of chest, slightly to the right of the left nipple. Pt describes pain as 'sharp' and 'stabbing' and radiates to the lower jaw and down the left arm…"*

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"Double Documentation"

- Refusing to write a narrative to avoid ***inconsistencies*** between the data fields and the narrative is just an ***excuse***
- ***Proofread*** the PCR thoroughly to find inconsistencies and verify accuracy

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Clinical Narrative Templates

- Clinical narratives must be specific for *that* patient and *that* date of service
- Do not copy and paste narratives from one patient to another – or from one call to another
  - Even if it is for the same, repetitive patient
  - The PCR must document an independent assessment of each patient encounter

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Clinical Narrative Templates

- But having an organized, consistent approach to completing a narrative can help ensure accuracy and completeness
- For example, the "SOAP," "CHART" or "DRAATT" formats (Lesson 2B)

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Auto-Generated Narratives

- Some ePCR programs may use an auto-generated narrative feature
  - Based solely on the information entered in the data fields
  - Can only be as good as the information entered – or not entered – in the ePCR data fields
  - Must be reviewed and edited to ensure it is complete and accurate

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Seven Core Principles of a Good Clinical Narrative

- Complete
- Objective
- Specific
- Dispassionate
- Professional
- Descriptive
- Chronological

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Complete

- Contains all *relevant* information
- Does not purposefully omit relevant information
- Captures all aspects of operations, assessment, treatment, transport and patient disposition

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Complete Means *No Assumptions*

- Do not omit important documentation about assessment or treatment just because it is considered "routine"
- If it's something you always do, it should be something you always document - when it is ***relevant*** to patient care or safety

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Complete Means *No Assumptions*

- Examples:
  - "*Secured patient in a semi-Fowlers position with four cot straps"*
  - *"Post-intubation, verified tube placement with auscultation of breath sounds in all fields and end-tidal CO_2 monitoring…"*

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Case Study

Documentation – Not Assumptions

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Case Study

- An ALS ambulance is dispatched for a case of respiratory distress at a Chinese restaurant
- Upon arrival, you find a patient in severe respiratory distress
- The patient's husband tells you his wife is allergic to peanuts and must have come in contact with peanuts used in the food

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Case Study

- By the time the patient is loaded into the ambulance, she is not breathing effectively on her own
- The crew intubates the patient and transports
- Upon arrival at the hospital, the E.D. physician determines that the ET tube is in the patient's esophagus instead of her trachea and re-intubates the patient who dies shortly after transport

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Case Study

- One year later, the family files a lawsuit against the ambulance service for negligent care
- The PCR does not document any steps taken to verify placement of the ET tube following intubation (auscultation of breath sounds, end tidal CO_2, etc.)

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Case Study

- The medic on the call testifies at his deposition:
  - *"I don't make a practice of documenting things that I do routinely. Verifying tube placement is standard practice, it's something you do every time. It's just assumed so I don't write it down when I do it"*

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Case Study

- The insurance company decides to settle the case for $1.5 million, citing – in part – the medic's decision not to document steps taken to verify correct placement of the ET tube following intubation

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"Complete" Means Document Pertinent Negatives

- What negatives are pertinent depends on the patient's condition and chief complaint

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"Complete" Means Document Pertinent Negatives

- Example:
  - If patient's chief complaint is a possible ankle fracture due solely to a trip and fall and the patient is young with no significant PMH, "*denies chest pain"* would not be a pertinent negative that requires documentation

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"Complete" Means Document Pertinent Negatives

- Example:
  - If chief complaint is shortness of breath, then *"denies chest pain"* is a pertinent negative that should be documented as part of the assessment, as chest pain often accompanies shortness of breath

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Complete

- Being complete also means telling the full story of important details – such as a visual description of the initial patient encounter

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Example

- Incomplete:
  - *"Pt was found supine in bed"*
- More Complete:
  - *"Pt was found in a hospital bed in the bedroom, supine, 30° upright calmly speaking to his son, skin pale but in no obvious distress…"*

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Objective Not Subjective

- Objective
  - Facts
  - Unbiased
- Subjective
  - Opinions
  - Unsupported conclusions

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Examples

- Subjective:
  - *"Pt appears to be intoxicated at the present time."*
- Objective:
  - *"Pt has noticeable odor of alcohol on breath. Pt's eyes are blood shot and speech is slow and slurred. Pt admits drinking 6 beers in the past 30 minutes"*

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Objective

- The patient may report subjective information
- You document the fact of what the patient reported
- Example:
  - *"Pt states that it feels like an elephant is sitting on his chest"*

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Objective

- Whenever possible, be *quantitative* as well as *qualitative*
- Quantitative:
  - Specific numbers or values
- Qualitative
  - Fact-based descriptions

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"Pt describes the pain as 'sharp' and 'stabbing'. Pt rates pain an 8 on a 1-10 scale"

63

"Pt describes the pain as 'sharp' and 'stabbing'. Pt rates pain an 8 on a 1-10 scale"

Qualitative Quantitative

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Examples of Qualitative Descriptors: *Pain*

- Sharp
- Dull
- Stabbing
- Hot
- Burning
- Tearing
- Squeezing
- Aching
- Cramping
- Stinging
- Shooting
- Deep

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Specific

- Specificity is required both:
  - Geographically – where in the ***world***?
  - Anatomically – where on the ***patient***?

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Geographic Specificity

- At home?
- At work?
- At school?
- At a healthcare facility?
- In a public place?
- At a shopping center?

- *"Patient fell from standing position…*

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Geographic Specificity

- At home?
- At work?
- At school?
- At a healthcare facility?
- In a public place?
- At a shopping center?

- *"Patient fell from standing position…while entering a grocery store. Pt reported she tripped on a rubber mat that was not taped down and was sticking up on one end…"*

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Anatomic Specificity

- ***Specificity:*** Use clinical terminology to anatomically landmark the body position
- ***Laterality:*** Use *patient's* left/right

- Distal
- Proximal
- Anterior
- Posterior
- Left/Right

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Examples: Specificity

Non-Specific

"Patient fell, complains of pain in right shoulder"

Specific

"Patient was at work at an industrial warehouse when patient fell off a ladder from a distance of approximately 4 ft. Patient has noticeable abrasions and red skin on right anterior shoulder area as well as right posterior scapular area, approximately 2" from top of shoulder. Pt reports a sharp pain in posterior scapular area and rates the pain an 8 on a 1-10 scale"

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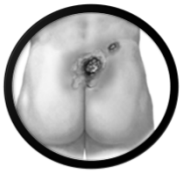
Examples: Specificity

Non-Specific

"Pt has decubitus ulcer on R buttocks"



Specific

"Pt has approx. 4" decubitus ulcer on upper right side of buttocks, located approximately ½" distally from sacrum. According to SNF staff, wound is Stage 3 and Pt experiences severe pain on movement, making it impossible for Pt to sit in a chair or wheelchair"

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Examples: Specificity

Non-Specific

"Pt complains of abdominal pain since 8 a.m. this morning"

Specific

"Pt complains of abdominal pain since 0800 today. Pt states pain is in the right lower quadrant and is "sharp" in nature and radiates to all quadrants. Pain was intermittent for first few hours, and then became constant. Pt describes pain as very severe at 10 on a 1-10 scale. Pt denies nausea, vomiting or fever. Abdominal inspection reveals no discoloration, all quadrants are extremely tender to even minor touching. No pulsatile masses noted. Pt states last BM 3 days ago"

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Specificity: Avoid Vague Words and Phrases

- Some words and phrases commonly used on PCRs are not sufficiently specific on their own and require additional context
- Putting words in context helps paint a complete and visual picture of the entire patient situation

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"Weakness"

- Additional information should be documented
- What are the clinical manifestations of that weakness?
  - Can the patient stand?
  - Is the patient capable of safely ambulating or sitting?
  - What is the patient's grip strength?
  - Is the weakness bilateral or focused on one side?

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"Transported Without Incident"

- Meaningless phrase
- Was the patient monitored during transport?
- Was there any material change in the patient's condition during transport?

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Examples

- *"Transported without incident"*
- *"Continued to monitor patient's condition during transport. Patient remained A & O x4 and complained of some pain, but no significant change in condition during transport…"*

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"Abnormal Labs"

- This finding alone does not describe a patient's clinical condition
- What are the specific findings that necessitate transport by ambulance?
- Is the patient experiencing any symptoms?
- Why was lab work performed?

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Dispassionate

- Not influenced by passion or emotion
- Non-judgmental
- Rational and impartial

- *"Dispatched by 911 for SOB at 03:00. AOS to find a 75 y/o female shuffling around kitchen with absolutely no complaints. Pt says she has a cardiac history and was SOB earlier in the day but feels fine now. Pt did not need an ambulance, no way, no how. This was a waste of my time. Walked Pt to stretcher and transported to ABC Medical Center, transport uneventful"*

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Professional

- Correct spelling
- Proper grammar
- Within the EMS practitioner's scope of practice
- Clinically appropriate abbreviations

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A Note on Abbreviations

- EMS agencies should have policies regarding standard abbreviations to be used by EMS practitioners in that agency
- Some local or state EMS oversight agencies have approved abbreviation lists
- Sample abbreviation list included in course materials

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Professional

- PCRs must be completed using appropriate and accurate clinical terminology

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Example

- Not Professional:
  "Pt has possible broken leg"
- Professional:
  "Pt has possible fracture of right distal tib/fib. Severe contusions and abrasions anteriorly approximately 5" above the ankle. Lower leg angulated toward midline at approximately 40°, pedal pulse present"

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Descriptive

- Use vivid, descriptive words to paint a complete and accurate picture of the patient's condition

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Example

- Non-Descriptive:
  Pt has altered mental status"
- Descriptive:
  "Pt was extremely drowsy and lethargic and could be aroused only by shouting loud verbal commands. Oriented only to time, but not place or person…"

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Example

- Non-Descriptive:
  "Pt has difficulty breathing"
- Descriptive:
  "Pt was bolt upright on the side of the bed in a tripod position, with labored breathing, gasping for air. Respirations were rapid and shallow"

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Example

- Non-Descriptive:
  "Pt has a cut left arm, bandaged"
- Descriptive:
  "Pt has an appx. 3-inch incisional type laceration to the left anterior forearm appx. 2 inches above the wrist. Dark red blood oozing, with appx. 30 cc blood loss. Bleeding controlled with 4x4 dressing and pressure bandage"

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Bad Documentation Will Hurt You, Good Documentation Can Be Like A "Shield of Protection"

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What Do You Document?

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You Could Write…

- "Person found at bar appeared to be intoxicated"
  - That is a subjective conclusion with no factual support
  - Does not fully describe what you see in an objective, unbiased manner
  - Remember: "ETOH" is not a chief complaint

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A More Accurate Description…

"An approximately 25 year old male found sitting at a bar with his head resting on his forearms and eyes closed with what appears to be an alcoholic beverage still in his hand. Glass contains approx. 2 oz and is half full with ice. There is a standard size open bottle of whiskey about 2/3 full on the bar next to pt's right arm"

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What Do You Document?

91

You Could Write…

- "Elderly male found in bed"
  - That is not a complete description of the patient or his surroundings

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A More Accurate Description…

"An approximately 70 year old male found in a hospital bed in the family room. Patient was supine on bed elevated 30° upright covered in a blanket with a nasal cannula in place. Skin was pale, and patient appeared to be in no respiratory or other distress. Patient was calmly speaking to a middle aged male"

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The OPQRST Narrative

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OPQRST Narrative

- *"Pt reports chest pain which began at approximately 0545 today. Pt was laying in bed when pain began and was not physically active at the time. Pt states that pain is not affected by movement and there is no position that makes it better or worse. Pt describes the pain as "achy" and "hot". Pt reports that pain is located in the center of the chest, approximately 2" below nipple line and does not radiate. Pt rates pain as a 6 on 1-10 scale. Pt reports that pain was intermittent for the first hour then became constant."*

95

OPQRST Narrative

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O P Q R S

100

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O P Q R S T

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Conclusion

- The clinical narrative is a "visual exercise" – it should paint an accurate picture of the patient in the reader's mind
- When *data* does not provide sufficient context, the *narrative* helps make the data complete
- Clinical narratives should always satisfy core principles such as accuracy, completeness and objectivity

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