Documentation Tips

THE NARRATIVE

It is easiest and best to document from the start of the call to the end. Always follow the same pattern.

1. Dispatched to _____. (Note any difficulties encountered during the dispatch/response phase.)
2. Arrived to Find: Describe the scene, patient positioning, how s/ he got there (when pertinent). "The patient was found supine on the sidewalk; bystanders state that he was thrown from the vehicle."
3. SAMPLE history and OPQRST. Expand on the chief complaint that is noted separately. "Patient is complaining of chest pain, radiating down the left arm. Patient states pain is a crushing pain that came on while he was sleeping."
   - O – ONSET
   - P – PROVOKE
   - Q – QUALITY
   - R – RADIATION
   - S – SEVERITY
   - T – TIME (when, and does the pain come and go; did it ever happen before)

   HISTORY OF PRESENT ILLNESS – HPI – anything pertaining to the chief complaint and associated symptoms. Include anything that has not been documented previously. If you are writing about a symptom, cite the source of the information.
   a. Patient states that he felt dizzy.
   b. Patient's wife states that…
4. PAST MEDICAL INFORMATION – anything that might relate to the present problem or contribute to the outcome. If already documented in a separate section of the trip sheet, you may just write "as above".
5. PHYSICAL EXAM – PE – must be done on all patients. If only a focused exam is completed, document "focused exam reveals…" Document the detailed exam in a head to toe fashion. List pertinent negatives. For example, if the patient is complaining of chest pain, document the presence or absence of respiratory difficulty.
6. TREATMENT IN PROGRESS – TIP – should be listed in the care flow chart, including times and response to treatments. This is where you should document any of the times you assist the patient with his/her medication. Make sure you document the time, dose, route, medication form and expiration date as well as the patient's response to the treatment. Any orders from medical command may be documented here also, as they are completed.

Time	P	R	BP	Rhythm	Treatment	Provider ID	Response/Comments
1300	88	22	120/62	Regular	O2 15L NRB	A1	No relief from chest pain
1308	88	20	120/60	Regular			

7. Document the patient's condition at the time of the transfer and anything else that your service requires in the narrative.

Your service may have other requirements or guidelines. Always follow your service's guidelines first, as long as those guidelines will provide the necessary information.

Important things to Remember

1. Midnight is 0000.
2. A patient will be either a medical or a trauma patient. If a medical problem caused the trauma, document it as a medical patient.
3. Vital signs must be documented if patient contact was made. If a patient refuses to allow vital signs to be taken, document this in the narrative. If you are unable to measure a vital sign, do not mark it as "000".
4. Refusal of Treatment:
   a. Make sure patient is Alert and Oriented
   b. Make sure patient understands risks
   c. Explain that patient can refuse now, but can change their mind at any time
   d. Make the patient sign the refusal immediately after explanation, especially when they refuse a specific treatment.
   e. Document, document, document.

TRAUMA SAMPLE

CHIEF COMPLAINT	Pain in right ankle
CURRENT MEDICATIONS	None
ALLERGIES (MEDS)	None
PAST MEDICAL HISTORY	None
NARRATIVE	

Dispatched to incident location for a fall. ATF: Rescue/QRS 666 arrived to find a class 3, 27 year old male complaining of pain in his right ankle. Patient is at base of a ladder. HPI: Patient states that he was approximately two feet up on a ladder, when he slipped while climbing and fell. Landed on feet. Denies symptoms before fall. PE: CAO. Skin warm and dry. Denies neck or back pain. PEARL. Lungs clear and equal. Abdomen soft and non-tender. Pelvis stable. Moves all extremities other than right leg strongly and without pain. Right ankle swollen. Good pedal pulse. Denies any other pain or deficit. PMH: None. TIP: Exam, vitals. Right ankle splinted with pillow and cravats. Ice pack applied. Good pulse, motor and sensation before and after splinting. Transported via litter in position of comfort.
Transported to RHMC. No change in patient condition. Patient care transferred to ECU staff after report.

Time	P	R	BP	Rhythm	Treatment	Provider ID	Response/Comments
1620	72	22	128/74	Regular	Exam, pillow splint, ice pack	A1	
1648	78	22	124/p	Regular	Re-eval	A1	Pedal pulse still present

MEDICAL SAMPLE

CHIEF COMPLAINT	Abdominal Pain
CURRENT MEDICATIONS	Pepcid, Plavix, Hydrocodone with APAP, Albuterol, Vitamins
ALLERGIES (MEDS)	ASA, PCN
PAST MEDICAL HISTORY	TIA, GERD, Arthritis, COPD
NARRATIVE	

Dispatched to incident location for chest pain. Ambulance 666 arrived to find a class 3, 71 year old male complaining of abdominal pain. HPI: Pain started four hours ago. Patient states that he has been unable to move his bowels for six days. States that pain comes and goes and feels like a cramp. Can't stand it anymore. Wife states he has not been eating or drinking normally for last few days because of constipation. Pain is in both lower quadrants. Abdomen is soft, but slightly tender on palpation. PE: Skin hot and dry. Lungs clear and equal. Denies chest pain or respiratory distress. MAE equally and strong. TIP: Exam, vitals. O2 initiated 4 lpm via NC.
Transported to RHMC. No change in patient condition. Patient care transferred to ECU staff after report.

Time	P	R	BP	Rhythm	Treatment	Provider ID	Response/Comments
0240	92	20	168/88	Regular	Exam, oxygen 4 lpm	A2	
0252	96	20	170/88	Regular		A1	