NARRATIVE DOCUMENTATION FOR PCR
Operational Policy

POLICY: The patient care record narrative will provide a complete picture of the patient presentation, pertinent findings, pertinent negatives, ongoing development of the patient care event, care and treatment provided and condition at end of call.
GUIDELINES: The intent of writing a narrative documentation is to tell a story that can be completely understood by people who were not present at the scene. Narrative documentation should provide a, clear and concise, yet thorough explanation of what occurred at the scene of the call. Document an unbiased and factual description of the call. Make sure all check boxes or electronic screen choices match documentation made in the narrative section of the PCR. Use a systematic approach, a good PCR should be written with the same systematic approach that is used for the patient assessment. Include critical information and document care chronologically.

Sample guideline for Narrative Documentation:

1. Found (age & sex of patient) in (position) complaining of_____.
2. Since (duration).
3. States chief complaint began (time).
4. Precipitating factors
5. List interventions by patient/family & results
6. Describe signs & symptoms and assessments which are not mentioned previously in record.
7. Describe treatments not already mentioned in record: patient treated with _____ or treated as above.
8. List responses to treatments if not already mentioned.
9. Document any reassessments done besides initial assessment.
10. List any problems which may have occurred as a result of your interventions.
11. Patient transported in (position) to what hospital and with/without lights/siren, if not already mentioned.
12. List status of patient during transport.
13. Document status of patient upon admission to emergency department. Include comments of any "significant findings" which the patient was treated for, ex: Upon admission to ED, patient _____.
14. After narrative is written it – READ IT. Check for accuracy AND consistency.

A narrative in conjunction with other data fields in the PCR should clearly provide the patient assessment information below:

Guidelines for Assessment/Interview:

1. Name:
2. Age:
3. Chief Complaint:
4. Onset/Duration:
5. Precipitating Factors:
6. Interventions by Patient:
7. Associated Symptoms:
8. Medical History:
9. Allergies/what kind:
10. Vital Signs - Blood Pressure, Pulse and Respirations:
11. Breath Sounds:
12. Pupils:
13. Skin:
14. Neck Veins:
15. Mental status:
16. Initial Physical Exam:
17. Decide on what Primary Impression is and how the patient will be treated.