# Narrative and Events Documentation 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. The patient care record events and procedures charts will provide a complete list of attempted procedures, obtained or imported vital signs, and assessments completed. **Narrative and events documentation should describe and support medical decision-making by EMS providers throughout the call regarding assessment, treatment, transport, and transfer of care.**

## GUIDELINES

The intent of writing a narrative documentation is to tell a story that can be thoroughly understood by those not present at the scene. Narrative documentation should provide an unbiased, factual, clear and concise yet thorough explanation of what occurred. Document an unbiased and factual description of the call. Events and procedures should be documented chronologically and thoroughly in their appropriate sections or tables. Available device data should be imported into the patient PCR record. Make sure all check boxes or electronic screen choices, as well as procedures and events listed, match documentation made in the narrative section of the PCR. A good PCR should be written with the same systematic approach used for the patient assessment. Include critical information which supports medical decision making throughout the call.

## NARRATIVE STRUCTURE

Several formats for narrative documentation exist to provide good structure for your narrative:

- SBAR: Situation, Background, Assessment, Treatment
- SOAP: Subjective, Objective, Assessment, Plan
- Chronological: Outline call as happened, broken into paragraphs
- DCHARTE: Dispatch, Complaint, History, Assessment, Rx/Treatment, Transport/Transfer of Care, Exception
- DISPATCH: Dispatch, Impression, Scene, Pt Statements, Assessment, Treatment, Changes/Responses, Handoff
- DRAATT: Dispatch, Response, Arrival, Assessment, Treatment, Transport
- *OEM **does not recommend** auto-generated narratives for **complete** narrative details*

**DCHARTE** format will be used to demonstrate information for inclusion into narrative documentation.

## DISPATCH

- Dispatch information, EMD code, responding agencies/units
- Response mode (use of lights & sirens)
- Specific dispatch instructions (CPR, delivery in progress, meet security)
- Scene summary (scene description, patient location and position)

## COMPLAINT

- Age, gender, race patient identifies with
- Notation for unknown identity or approximate age
- Chief complaint as indicated by the patient *or* observed by the paramedic
- Document sources of information: family member, friend, bystander, MD
- Primary reason patient is seeking medical care (provider judgment)

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| **HISTORY** | • Events leading to incident, last known well date and time<br>• Mechanism of injury if applicable<br>• History of present illness (OPQRST & SAMPLE )<br>• Past medical history (may be general if detailed in medical history section) |
| **ASSESSMENT** | • Assessments, primary and secondary<br>• Important physical exam findings<br>• Associated symptoms<br>• Pertinent negatives and positives<br>• Vitals sign interpretation, diagnostic findings (12-lead)<br>• Primary suspected problem, differential problem list |
| **Rx TREATMENT** | • Interventions in chronological order, including any prior to EMS arrival<br>  ▪ may be general or referenced, if detailed in events/procedures list<br>• Patient response to interventions<br>• Adjustments to treatments (repeat, modify, or discontinue) |
| **TRANSPORT**<br>**TRANSFER of care** | • Patient movement to ambulance<br>• Changes in patient condition<br>• Transfer of care at destination |
| **EXCEPTIONS** | • Any exception to call such as weather, road travel, unexpected delay in accessing patient<br>• Details of any refusal of transport conversation with patient/family |
| **MEDICAL DECISION MAKING** | • **Throughout your narrative, document medical decision making for all aspects of care** |

Here is a checklist of questions EMS providers should answer before submitting a patient care report (PCR):

- Are your descriptions detailed enough?
- Are the abbreviations you used appropriate and professional?
- Is your PCR free of grammar and spelling errors?
- Is the chief complaint correct?
- Is your impression specific enough?
- Is medical decision making clearly stated and supported?
- Are all other details in order?

**COMPLAINTS AND WORKING ASSESSMENTS, documentation to consider in narrative or appropriate distinct fields:**

Altered mental status

- Last known well (LKW) military time
- Baseline mental status
- Multiple Glasgow Coma Scale (GCS) assessments
- Stroke assessment BEFAST & LVO
    - All pts with AMS should have stroke assessment obtained within 10 minutes of EMS arrival
- Blood glucose reading
- Interventions by law enforcement, health care providers, bystanders
- Trauma or medical events leading up to AMS
- Presence of seizure activity

Stroke:

- Last known well (LKW) military time
- Multiple Glasgow Coma Scale (GCS) assessments
- Stroke assessment BEFAST & LVO
    - Stroke assessment should be obtained within 10 minutes of initial EMS arrival
- History of any previous stroke and residual effects
- Anticoagulation use
- Activation of STROKE alert
- Reason for hospital destination (STROKE specialty, closest facility, patient preference)

Chest pain or ACI symptoms:

- Acute coronary syndrome symptoms (description, location, duration of symptoms)
- Time and interpretation of all 12 lead ECGs
    - All pts with suspected ACS symptoms should have 12 lead obtained within 10 minutes of capable unit arrival
    - ALS confirmation of ECG interpretation
- Interventions prior to EMS arrival including pts ASA & nitro
- Regular assessment of pain score
- Pain interventions and results, with goal of pain score zero, including any contraindications
- If given, total of fluid bolus
- Signs of congestive heart failure
- Activation of STEMI alert
- Reason for hospital destination (STEMI specialty, closest facility, patient preference)

Respiratory complaints:

- Level of respiratory distress (mild, moderate, severe)
- Interventions prior to EMS arrival including pts own treatments or oxygen adjustments
- Initial SPO2, post-intervention SPO2
- Signs of obstruction, bronchospasm, pulmonary edema, aspiration
- Breath sounds, use of accessory muscles, severity score, signs of poor perfusion
- Coaching required by EMS during therapies
- Escalation of therapies, CPAP, PEEP, ventilation assistance and advanced airway placement

Trauma

- Details of penetrating or blunt trauma, including weapon or instrument causing harm
- MVC - vehicle speed, intrusion, pt position in vehicle, restraints, airbags, ejection
- Falls – estimation of fall height or stairs
- All injuries identified on full evaluation
- Medical decision making for chosen destination

Resuscitation or deceased persons

- Last known well, bystander CPR or AED, movement of patient by family or EMS
- Assessment of rigor mortis, dependent lividity, signs of death
- Trismus or other barriers to airway placement or ventilation
- Completion of CARES section (required for all arrests including EMS-witnessed)
- Initial rhythm, reassessments, and notable rhythm changes
- Contact with OLMC, live streaming
- Explicit criteria confirmation for TOR, time of discontinuation of resuscitation
- Medical Examiner notification, disposition of body

OB/GYN

- Current gestational age (months or weeks)
- Total pregnancies and live births
- Status of prenatal care, complications of pregnancy, high risk concerns
- Bleeding, cramping, fluid leakage
- Contractions? Haw far apart and for how long
- Individual EMS for mother, another for newborn infant if delivered (parent last name, ‘infant’ first name)

Pediatric

- Primary caregiver or guardian
- Acting normally per caregiver?
- Signs of distress or poor perfusion
- Any medication given prior to EMS arrival
- If infectious presentation, vaccination status
- Patient weight reported by patient or caregiver, or Broselow determination

Remember the importance of painting a picture. The first thing that a medical director, quality assurance reviewer or a lawyer will read is your narrative because it sets the pace. Your narrative indicates your thoroughness, it implies your competence, and it links your findings with your actions. In addition, whether device-imported or manually entered, all events should be detailed into the charting section of the ePCR and not just referenced in the narrative. Procedures performed charting should include all applicable: location, type, size, route, setting, number of attempts, success yes/no, specific medication, and total given. Your narrative interpretation of findings, combined with charting of events and procedures, should support medical decision making for all aspects of care.