Documentation

Presented by Buxton Fire-Rescue

What and Why?

“Material that provides official information or evidence that serves as a record”

- Legal Document
- Detailed
- Accurate
- Professional
- Protection

Protection

- Most lawsuits against EMS are for negligence
- Lawsuits can also be for endangerment, malfeasance, failure to treat/intervene, negligence, abandonment,
- Reports are legal documents that are weighted heavily in court

Perez vs Bay State Ambulance February 1986

- 1800hrs: Male in his 70s with a fever x3-4 days. Family calls 911, transport to local hospital.
- Dr soon discharges him with diagnosis of UTI
- 2100hrs: Patient brought home by ambulance crew
- 0200hrs the same crew is called back to the residence with the request to be transported solely for filling the prescription, family feels he is worse.

Perez vs Bay State cont.

- Family has an interpreter present, and are given two refusal forms in both English and Spanish. Since there are no significant changes in vitals and the patient is still stable the EMTs sign the patient off.
- At 0630hrs the ambulance company is called again, this time the patient is apneic with no pulse. CPR is preformed and the patient is pronounced dead at the hospital at 0730
- Family states that EMTs are responsible as it is their job to tell the hospital the new patient condition

***The only reason that these EMTs had their charges dropped, is due to documentation and use of medical control.

Healthcare Provider?

1. Applicability of G. L. c. 231, Section 60B, to Bay State Ambulance. A provider of health care is defined as "a person, corporation, facility or institution licensed by the commonwealth to provide health care or professional services as a physician, hospital, clinic or nursing home, dentist, registered or licensed nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, or acupuncturist, or an officer, employee, or agent thereof acting in the course and scope of his employment." G. L. c. 231, Section 60B. *The plaintiff correctly notes that the EMTs were not included in the Legislature's list of "provider[s] of health care."*

***The only reason that these EMTs had their charges dropped, is due to documentation and use of medical control.

Rahily vs North Adam's Regional Hospital

August 1988

-5 month old difficulty breathing, artificial respirations being given by father on scene

-30 minute response- couldn't find the house. On arrival "limp, pale, RR 4"

-Intubation is in the esophagus for an unreported amount of time

-No CT at the initial hospital

-Flight crew did not bring transfer paperwork with them

-Cause of death: "Anoxic brain damage. Intracranial Hemorrhage. Aspiration Pneumonia."

-Lawsuit against: North Adam’s Regional Hospital, Baystate Ambulance, New England Life Flights Inc, and specific hospital staff

-Paramedics and staff on New England Life flights are not able to be tried as healthcare providers of this patient due to the precedent of Perez vs Baystate Ambulance, must undergo medical tribunal first. In this tribunal the delay, intubation verification, reassessment of the patient, and basic patient care were called into question. Lead paramedic lost their license, and the others had theirs suspended.

DeTarquino vs Jersey City May, 1995

-Patient suffered injuries from an alleged assault by police officers, EMTs called to evaluate patient.

-During the transport the patient vomited, however, nowhere on the run sheet is this documented. In fact, it is marked as “negative”.

-The hospital releases the patient based on the reports of EMS and their assessment.

-2 hours later, the patient has a grand mal seizure and is declared brain dead.

• NJ Immunity Provision (NJSA 26:2K-29) – “No EMT . . . shall be liable for any civil damages as the result of an act or the omission of an act committed while in training for or in the rendering of intermediate life support services in good faith . . .”

Due to this statute the EMT’s charges were dismissed. During the appeal, a judge determined that this does not include immunity for negligence or neglect **during the preparation of a report.**

Protect Yourself

Use your documentation to keep yourself safe in the case of a lawsuit or complaint against you.

Parts of your Report

DROP DOWN

- Vital signs
- Medications given
- Times
- Procedures
- Signatures
- Incident Information

NARRATIVE

- Dispatch Information
- What you were told
- What you see
- What you did/Assessed
- What you think is the problem
- An overview of care
- What the patient stated/what you stated to the patient

Criteria For a Well-written Report

- Third person perspective
- Details (RN names, family names, statements of bystanders, weather, house-type or challenges at the house, on scene delays)
- Use approved abbreviations
- Written the same way every time

- SOAP
- Modified SOAP
- CHART
- DCHARTE
- Use complete sentences
- Use punctuation
- Do not corner yourself
- Write ONLY what you see and do

SOAP

S (Subjective) should include: dispatch, weather, response delay, scene delay, what bystanders and patients state, safety information, circumstances surrounding situation.

O (Objective) should include: Assessment findings, what you see, abnormalities, reassessment

A (Assessment) Assessment findings

P (Plan) should include: overview of events and patient care, anything you state to the patient, and the plan for the patient that you are signing off.

D	**Dispatch Information**	The dispatch information given to the crew at the time of the call. EMD Codes Specific/Specialized Instructions
C	**Chief Complaint**	Why the patient/ healthcare provider called 911? What the patient/family member/caregiver told you was the current problem. Some situations require that you make a judgment call as to the primary reason the patient is seeking medical care.
H	**History**	History of the present illness (HPI – This would include mnemonics such as OPQRST, SAMPLE, MOI, AEIOUTIPS) Past Medical History (If not obtained in the patient medical history section of the PCR) Any statement regarding the present event or pertinent past events
A	**Assessment**	How and where you found the patient upon your arrival. Specify who and when for any information given to you by first responders about their assessment. Your primary and secondary assessment of the patient. Include pertinent positive and negative findings. Include the findings/results from any treatment and diagnostic findings. The patient's primary suspected problem, and a differential problem list.
R	**Treatments**	All treatment and interventions performed (This can be a general overview if the specific information was captured elsewhere in the PCR) Record the patient's response to the medication or treatment If adjustments were made to a medication drip the reason and adjustment needs to be recorded
T	**Transport/Transfer of Care**	Who at the receiving facility you gave verbal report to and accepted the patient. Any changes in the patient condition during transport. Time you transferred care to another healthcare provider.
E	**Exceptions**	Any item that you felt was an exception to the call such as weather and road travel, unexpected delay in accessing the patient, or other exceptions can be documented here.

If the field is highlighted with blue, it is an addition to CHART formatting and is optional

High Risk Patients

-Sign offs

-AMA sign offs

-Special Populations (Geriatric, Bariatric, Pediatric, Mentally or physically challenged)

-”Run of the mill” calls

Common mistakes

“Per protocol”

“Followed ACLS protocol”

Typos

Discrepancies between drop down and narrative information

Personal Opinions

Common Spelling Errors

- Semi- Flowers→ Semi-Fowlers
- Conscience→ Conscious
- Cholestral→ Cholesterol
- Orianted→ Oriented
- Numonia- Pneumonia

Tips For Success

1. Be consistent
2. Write it down- all of it
3. Do not repeat yourself between drop down and narrative. Vitals do not need to be listed → typos can discredit your entire report
4. Document mistakes honestly and professionally
5. Don’t Wait
6. Proof read and double check everything

Ways to improve your narrative...

- You are painting a picture with your words, be very descriptive

"Pt's left lower leg was found to have a fracture below the knee. Fracture splinted in place with pillow splint and tape"

"Assessment of Pt's left lower leg showed a probable angulated fracture of the tibia/fibula below the knee. Distal circulation was found to be slowed but present with capillary refill approx. 7 seconds with no palpable pedal pulses and colder skin distally. Unable to straighten Fx due to severe pain and resistance to manipulation. Fracture splinted in place with pillow splint and tape due to the above.

-Plan what you are going to write

-Think about documentation on the call

-You made decisions, so put the information that lead you to that decision in your report.

-Organize the order of your information

Examples

Disclaimer: If your report is found within this presentation, please take it as an opportunity to learn. No names have been attached to these reports aside from one written by the author of the presentation.

“Pt is evaluated and stable. Pt reported he took his meds and it took care of the issue. Pt was advised that we can transport however he was stable and had an appt about his condition and to wait and go to his appt was the best way to treat this issue. Pt agreed no transport. “

Examples cont.

“I was dispatched to [such and such address] for a possible code. When i got there my partner told me to get the monitor and I started CPR. I saw that the patient was still pink and warm. I gave 50 compressions and then my partner said to pause for two breaths. A new person started CPR and then I tried to get an airway. After I looked for an IV. But I couldn’t find it. So then we put an IO in. The husband says she was gasping for air and that he called 911. The monitor advises a shock. Then we followed the CPR protocol. Patient pronounced dead after paramedic arrives.”

Service Defined Questions

Narrative

S: Dispatched for a 72 year old female cancer patient with low oxygen levels. On arrival patient was in hospital bed in her family member's home, overweight, some difficulty breathing, dizzy, lightheaded, confused.

O: Patient laying in bed. Patient talking to EMS slowly. ABCs: low oxygen levels, Conscious, somewhat confused but alert, Eyes; PERL, -stroke scale, patient complained of being dizzy and uncomfortable, unable to obtain BP in the field, home nurse had taken it at 122/72. original SAo2 at 82% SAo2 93% at 15L on a non-rebreather mask. Patient had taken Oxycodone/acetaminophen prior to EMS arrival for pain related to Multiple Myeloma.

A: field impression: having difficulty perfusing oxygen

P: arrived on scene, made contact with patient. Patient requested to be transported by suggestion of doctor. Patient was put on a nasal canula at 4L, this did no help O2 levels, switched patient to NRB at 15L, O2 levels came up, patient stated she felt less dizzy. Patient transported, report given to receiving team.

Spell-Check | Save | Clear

Narrative

Dispatched for a motor vehicle accident with airbag deployment. Patient was seatbelted and ambulatory. Minor damage to the front right bumper of the vehicle. Car was traveling approximately 10mph. Patient stated that he hit the gas instead of the break. Front airbag deployment only, patient stated he did not want to be evaluated by EMS.

Patient- 47 year old male COAx4, ambulatory, ABCs in tact, No apparent cspine issues, was wearing seatbelt, stated he did not want any evaluation or transport. Patient had already walked home and back to the accident with insurance paperwork and was acting appropriately. Patient advised by multiple providers to call 911 if any changes happen, or to at least seek medical attention.

Primary Impression: no apparent injury

Arrived on scene, patient contact made. Patient refused any assessment due to no injuries being presented. Patient advised to either call 911 or seek medical attention if his condition changed. Patient signed off.

Narrative

S: Dispatched to [redacted] for a 62 year old female who was experiencing abdominal pain.

O: Arrived on scene; 62 year old female sitting on couch. Patient COAx4, -ABCs, -Cspine, Female stated that 4 weeks ago she had her left ovary removed and a part of her ureter . Since then she had been having issues with bowl movements and had been taking a suppository as needed. Around midnight she had experienced severe pain in her LLQ of her abdomen. After taking a suppository she had a large bowel movement. After that she experienced extreme diarrhea and nausea. Later on in the morning she began vomiting in small amounts. Patient called 911 after she was unable to keep any water down. Patient walked to the ambulance. Vitals taken: BP 136/90, HR 105, SAO2 90% Temp 97.6F. Enroute patient experienced jolting and stabbing pain in her LLQ 8/10 when going around corners and over bumps, however, the pain subsided after a few seconds.

A: Primary impression: Patient is experiencing abdominal pain due to surgery and bowel movement issues.

P:Arrived on scene, patient contact, patient stated she had been vomiting and experiencing abdominal pain, requested to be transported to Maine Medical Center, patient stated she had undergone surgery a month prior, patient walked to ambulance and was transported, vitals and pain monitored enroute, full report given at arrival of MMC, patient care transferred.

Narrative

Dispatched 911 to a 61 yr old male with chest pain.

S- Pt stated that he was on his way to bed when the pain started. Pain started approx. 1 hour prior to EMS arrival. Pt. complained of a burning pain in the lateral aspects of his chest, with radiation starting down the arms and into the back. He did admit to a cardiac history of a prolapsed mitral valve. He stated that he did not have any falls recently, no known allergies to drugs, medications were aspirin, and atenolol, and rated the pain 6/10, denied that anything would make the pain better or worse, stated that he felt "hot," denied any SOB, stated that dispatch told him to take aspirin, which he took but swallowed not chewed, denied taking NTG,

O- Pt was sitting in a semi-fowlers position, with a damp washcloth on his forehead. Skin was pink and warm, no difficulties breathing, No abnormal lung sounds, vitals were BP 160/110, SPO2 97%, HR 80, R 18. Pt was in obvious pain.

A- Pt was having chest pain, non-traumatic chest pain. Not triggered or brought on by overexertion.

P- Wait and transfer care to Saco FD to transport Pt to hospital to have chest pain further investigated.

*Was unable to get Pt. signature

Why?

Why did you do/not do something? Why do you think the patient seems (insert emotion here)? Why is your impression what it is?

Narrative

Dispatched for a patient at the quick care with dizziness. Patient reports dizziness, SOB, and blurry vision.

Patient presenting alert and oriented to person, place, time, and event. ABCs intact, skin PWD, chest rise and fall equal with clear lung sounds bilaterally. Vital signs WNL, abdomen soft/nontender, patient denies pain/nausea. No findings produced in physical assessment.

Assessment finding suggest dizziness from an unknown cause.

Patient report taken from NP at quick care. Ambulance 4 requested for bariatric stretcher/lift system. During their response time a stroke scale, vital sign assessment, and interview are preformed. Patient ambulatory to stretcher with x1 assist. Vitals monitored enroute, 18G IV established prior to EMS arrival in the LAC by quick care RN Amanda. Full report given upon arrival, patient remained stable throughout. Care transferred in room 23.

63 yom Chest Pain

Dispatched for a 63yom complaining of chest pain. On arrival the patient reports that the pain started around 2200hrs and got worse and worse, is now an 8/10. Patient has had a previous MI but didn't know until after it happened and has never felt this pain before. Patient has taken 324mg ASA prior to arrival.

Patient presenting alert and oriented to person, place, time, and event. ABCs intact, skin PWD, pupils 4mm and PERRL. Chest rise and fall is equal, patient is breathing faster than usual. Patient is able to ambulate with no assistance. Vital sign assessment finds mild hypertension, all other vitals WNL. Pain does not radiate anywhere, positioning does not make it better or worse, and the patient is denying difficulty breathing/nausea/dizziness. Patient improves following nitro with a lower blood pressure and respiratory rate.

Assessment findings suggest possible cardiac related chest pain

Patient contact made, patient interviewed while ambulating to the ambulance. Assessment preformed including vital signs, 12 lead EKG, IV access. Oxygen administered at 2LPM via NC due to patients rapid breathing. 0.4mg of nitro administered SL with improvement in blood pressure, pain levels, and RR. Patient remains stable with no new complaints throughout transport. Upon arrival full report is given in traige 5 and patient care is transferred to A7.

unable to obtain patient signature due to testing upon attempt to obtain.

Narrative

Dispatched to assist PD with a male with a gunshot wound to the face. Upon arrival, two police officers report that the patient was shot with a bird shot shotgun. They report that he was initially completely unresponsive but has started moaning and moving around. Patient is found lying supine on the ground with his shoulders and head underneath his vehicle in the middle of the road. The driver's side door is open and the patient's head is directly under where the driver's seat is. No bystanders are present to answer demographic questions. Patient eventually is able to report that he knew the shooter, who was angry with him and shot him from about 20 yards away.

Patient presenting semiconscious and not alert. Airway is being maintained by the patient, who is vomiting but able to turn his head to the side to do so. Breathing is rapid and adequate. Circulation assessment finds multiple small entry wounds to the left side of the neck, face, and scalp. Bleeding is uncontrolled at the time of arrival. Patient has a strong, slow radial pulse. Skin is diaphoretic, warm, and pink. Chest rise and fall is equal and lung sounds are bilaterally clear- diminished in the bases due to rapid breathing. Abdomen is soft, lower abdomen is tender to palpation. No other findings produced in the physical assessment. Patient vomiting what appears to be swallowed blood upon arrival, after the patient becomes more alert he no longer vomits. Patient vital sign assessment finds bradycardia, and low oxygen saturations initially. Throughout transport his systolic blood pressure trends down. By the time the patient reaches the hospital he is notably more diaphoretic and shivering with multiple blankets on him with the heat on high. The patient has goosebumps and his teeth are chattering. Vomiting stops after oxygen administration.

Assessment findings suggest multiple gunshot wounds to the neck, face, and scalp with significant injury to the left eye.

Patient contact made, patient removed from underneath the vehicle. ABCs assessed, bleeding control initiated. Patient moved to stretcher via blanket lift with three people. Enroute to MMC vitals are assessed and reevaluated. 2 18G IVs established, one in each arm. Normal saline administered wide open (1L administered over transport time), oxygen administered via NC. Shock treatment initiated including heat retention, oxygen, and supine positioning. With the shock treatment the patient remains cold and begins shivering. Heat and blankets are unsuccessful in warming him. The patient was covered in sweat to the point that the tape securing the IVs were not sticking to his skin anymore. IVs are re-secured after drying the skin, and extra tape is applied to keep it from happening again. IVs flushed again to ensure that they did not dislodge from the vein. Upon arrival to MMC a full report is given in CC2, and care is transferred. Patient chemically sedated and intubated and is unable to sign.

Hospital unable to verify name at the time of transfer of care. Anonymous name entry for documentation purposes- to be updated at a later time. 28002 MCQUILLEN 0422 8/6/2017

Update of patient information and editing of report done on 8/6/2017 at 1235 hrs by Paramedic McQuillen, 28002.

So remember...

Documentation benefits you when done correctly

Keep it professional, to the point, and very clear

ALWAYS explain why

Ask yourself if you can read that report and remember all of the details 5-10 years later

Document everything!

Thank You!