Purpose of Document

This document is to explain the reasons behind thorough narrative writing, requirements, and examples of EMS and ER Narratives. Specifics on narrative formats will be reviewed during lecture.

Details on accessing Fisdap and populating clinical data will be reviewed during lecture by your instructor and podcast by EMT-IV Director Mr. McCullough.

Competence Disclaimer

It is the intent of this document to be used as part of a formal EMT training program under the direct supervision of qualified instructors. The information provided herein is based on currently accepted clinical practice; however, they cannot be considered absolute recommendations. It is the responsibility of the reader to become thoroughly familiar with the task and associated theory for the task. Consult with your instructor if you have any questions. We do not assume responsibility for the reader’s misunderstanding of the text.
Requirements

EMS Field Clinical Shifts

You are required to schedule and attend 5 EMS Field (ambulance) shifts during the semester commencing on February 7, 2013 and finish prior to final exam on April 21, 2013.

For each patient contact, a Fisdap Record must be created entering all pertinent patient information, demographics, vitals, skills performed, treatment, assessment, and a written NARRATIVE. Therefore, if 8 patient contacts were made there should be 8 patient contacts in Fisdap along with 8 Narratives, one for each contact.

The Field Sites available to EMT Interns are: Dickson, Giles, Hickman, Lawrence, Marshall, Maury EMS, and Nashville Fire.

Emergency Room Clinical Shifts

You are required to schedule and attend 3 ER Clinical shifts during the semester commencing February 7, 2013 and finish prior to final exam on April 21, 2013.

For each patient contact a Fisdap Record must be created entering all pertinent patient information, demographics, vitals, skills performed, treatment, and assessment. The difference with ER Narratives is only ONE narrative is to be submitted highlighting “Best Experience”, “Worst Experience”, and “Questionable Practices Observed”.

As such, if 8 patient contacts were made there should be 8 patient contacts in Fisdap and just 1 narrative. This SINGLE Summary Narrative of the shift can be entered in any one of the 8 patient contacts under Narrative Tab.

The ER Clinical Sites available to EMT Interns are: Nashville General, and Maury Regional.
Narrative Writing

Several formats exist to assist in organizing the information expected in the written narrative – CHART, DCHART, SOAP. These will be reviewed during classroom lecture.

At a **minimum** the following information is **required** to be documented within the narrative:

- Dispatched information: What dispatched for.
- Response: How responded to call emergent, non-emergent and where responded from.
- General Impression of Patient when found: Where/How found, LOC, Level of Responsiveness (AVPU), Primary Assessment (ABC’s), Chief Complaint.
- How was patient loaded onto stretcher: ambulatory, ambulatory with assistance, draw sheet, etc. If patient requires to be moved via draw sheet, must state why moved via draw sheet.
- How was patient secured for safety onto stretcher: Rails x2, Straps x3 or x5.
- Vitals: Minimum of 2 required; 3 are preferred. All must be written in narrative.
- Assessment: Secondary assessment (head to toe exam) and findings, negative or positive findings.
- Treatments: IV, O2, Medication. Must document results of treatment whether positive, negative, or no change.
  - When describing IV must state gauge of catheter, who performed the IV if not the author of narrative, location of IV, number of attempts, fluids or saline lock, amount of fluids infused while under EMS care.
  - If medications given, must state route, dosage, by what authority (protocol, verbal orders stating Doctors Name).
- Where was patient transported.
- How was patient transported – emergent, non-emergent.
- Condition of patient during transport, same or state any changes.
- How was patient moved from stretcher to bed, chair.
- If moved to hospital bed, it’s good practice to raised rails and state “rails x2 raised”.
- Document the name and title of person verbal report and care released to. Ie. RN, Jane.
- Document what and who patients’ personal property released to.
Why Thorough Documentation

1. One of most important things EMS can do.
2. Used in Five critical areas
   i. **Clinical**: For the record
      1. Records assessment and patient care.
      2. Informs the Emergency Room Doctor and Nurses about the scene, condition of patient when found, assessment and treatment.
      3. Becomes part of patients medical record.
      4. Plays role in subsequent treatment in an ED.
      5. Can be held negligent in your documentation.
      6. QA and QI processes.
   ii. **Legal**: CYA
      1. First thing reviewed in alleged malpractice suits.
      2. Should be written at or as close to time of incident.
      3. Reflects the standard of care provided and can help avoid a case against EMS if done well.
   iii. **Operational**: Data Drivers
      1. Track performance measurements such as response times, call-to-intervention times, on-scene times, transport times and other such assessments.
      2. Data used for policy making, staffing, deployment, peak-demand utilization.
      3. QA/QI, training and continuing education.
   iv. **Financial**: The Bottom Line
      1. Role in billing and reimbursement.
      2. Medicare makes payment decision.
   v. **Compliance**: Following the Law
      1. Verifies The Organization is operating with all applicable contracts and local, state or federal laws.
3. **Tips from an Expert Witness**
   a. The narrative must be an accurate reflection of what happened. It details the accounts from when EMS arrives on scene to when the patient is turned over to the next higher level of care. Where found: surroundings, and assessments.
   b. Ensure a fully complete PCR. Incomplete or unchecked boxes invite questions.
   c. If you don’t write it down, you didn’t do it or it didn’t get done.
   d. Don’t be misled that if you don’t write it, they can’t get me. False!
   e. Poor spelling multiple times relays a sense of ignorance or apathy. Illegible raises questions.
   f. When in doubt reference national standards.
g. Need multiple set of vitals to determine if patient is stable.

h. Blood pressure by palpation provides incomplete information about patient’s perfusion.

i. Repeated vital signs are rarely the same.

j. Narrative must make sense.

k. If subpoena to court tips on how to testify
   i. Review your report before coming to court
   ii. Bring you report to court to refresh your recollection, if needed, on the stand
   iii. Wear a suit or uniform
   iv. Show up one half-hour early
   v. Do not discuss case in courthouse
   vi. Speak with loud and booming voice from the stand
   vii. Be confident, listen to questions, look at attorneys and jury
   viii. Answer ONLY question asked, don’t add information that is not asked
   ix. Don’t fill in awkward silences with testimony that is not called for by the question
   x. You may state that you didn’t hear a question when you didn’t hear it
   xi. Show respect to the attorneys from both sides
   xii. Don’t give equivocal answers, whenever possible
   xiii. Be definite when you are definite
   xiv. Don’t say, “to the best of my recollection”
   xv. Sustained = you may not answer a question. Overruled=have to answer
   xvi. Observations limited to treatment of patient.
Example of EMS Field Narrative

Immediate response with lights & sirens to a 911 call for a 43 YO F who had fallen and could not get up. Upon arrival at scene pt found laying supine in front of her couch. Pt awake, alert and oriented but in obvious distress/appeared to be actively seizing. Pt states history of dystonia, "3 or so" episodes of similar severity in the past 6 months. Pt’s speech and breathing labored but appropriate and intelligible. Pt placed on cot via 3 person lift and secured with straps x3, rails x2. Pt moved via cot to ambulance & loaded for transport. Departed scene emergent with lights. Pt provided med list which was given to medic; pt states allergic to morphine and "other drugs" on list given to medic. 20 g IV w/ saline lock established on pt’s R AC (15 ml NS flush); medic administered 1 mL of Ativan; pt states no change in condition. Medic administered another 1 mL of Ativan; pt condition seemed to improve somewhat but still in obvious distress. Continued to monitor pt status during transport; transport time too short for second set of vitals. Upon arriving at MRMC ED, pt unloaded from ambulance via cot and moved via cot to assigned ER room. Pt moved from cot to bed via 3 person lift & secured via rails x2. Medic provided full report and medical history/medication list to nursing staff and pt left in ER staff’s care. END OF REPORT.

Immediate response with lights & sirens to a 911 call for a 59 YO F who could not get out of bed. PTOA, FD on scene. FD reports pt's HR 115, weak & rapid. Pt found in bed, supine. PT opened eyes to verbal stimulus, responded to sternum rub, disoriented. Pupils sluggish and pinpoint. Pt skin presented cold, clammy, and pale. Pt had R leg amputated proximal to the knee when she was 7 years old according to family. Family provided medic with pt's bag of medications and list of allergies. Pt moved from bed to cot via 4-person lift with bedsheet and secured to cot via straps x3 rails x2. Pt moved to ambulance via cot and loaded into ambulance. 7 total IV attempts made, none successful (L hand 24 g; L AC 22 g x2; R AC 20 g x2; R hand 20 g x2). Vitals taken en route: BG 252; BP 80/30; HR 115, slightly irregular/slightly weak; RR 12 shallow; SPO2 49 on RA. Applied O2 to pt via NRB @ 15 LPM; SPO2 not improved; NP airway #7 inserted right nare & O2 via NRB @ 15 LPM re-applied. SPO2 improved slightly to 57. Upon arrival at MRMC ED, pt unloaded from ambulance and moved to assigned room. Pt moved from cot to bed via 3-person lift with bedsheet and secured with rails x2. Medic provided MRMC ED staff with full report, pt’s medications & history & pt left in care of MRMC ED staff. END OF REPORT.
D- Dispatched to scene of 49 yof complaining of severe abdominal pains.

C- Patient reported to EMS on 11-18-12 that she is having severe sharp abdominal pain in her lower left side and that she feels nauseous. When the tried to stand she became light headed and disoriented.

H-Patient reports that is having severe abdominal pain in the LLQ. Patient was lying in bed and has not been feeling well over the last few hours. Patient was difficulty breathing and began to feel sharp pains in her lower left side. Patient has a history of open heart surgery and an aneurysm. Patient state that she is allergic to Ibuprofin and Percocet. Patient did not state any further medical history.

A- Patient was sitting in the tri-pod position on the edge of her bed showing signs of labored breathing. Patient was placed on O2 15 l/pm NRB. Patients breathsounds were equal bilateral clear. Patient was assisted to the cot on her front porch. Straps x 3, Rails x 2. Palpated teh abdominal area to check for sensitivity. No signs of guarding was present. Patient reports pain severity to be a 10 on 1-10 scale.

Vital signs: BP-108/88,P-70 strong and regular,RR-24 slightly labored but adequate on NRB,Sa02 97%,Pupils-Pearl, Skin-Normal WD,

Vital signs: BP-118/80,P-78 strong and regular,RR-20,Sa02 100% on NRB, Pupils-Pearl, Skin-Normal WD,

Patient was AAOx3 during assessment and transportation.

R-Oxygen was provided by NRB 15 l/pm during assessment.

T- Patient was transported to Maury Regional Hospital with difficulty breathing improved. PCR was given to medical staff upon arrival. Assisted to bed rails x 2.
Example of ER Clinical Narrative

Best Experience: I would have to say my best experience was getting to see two broken bones. One lady had a bone disease ever since she was little and couldn't count the number of times she had broken a bone. She broke her humerus on the right arm. The second was a lady that was doing yard work with her family and a rope caught her feet and she fell and fractured her femur.

Worst experience: My worst experience would be when a lady started going off on my nurse and I when we tried to draw blood with a butter fly needle. I wasn’t doing anything wrong and she was trying to tell us we didn’t know what we were doing.

Bad practices: This time I didn’t really see any bad practices. Even the nurses I was use to seeing without gloves wore gloves.