Guide to Effective Documentation

I. Essential Information

A. Date of call
B. Identification of department, unit, and personnel
C. Location of emergency
D. Type of response (i.e. emergency or non-emergency)
E. Times
    i. Call into center
    ii. Dispatch
    iii. Enroute
    iv. On-Scene
    v. At patient
    vi. Left scene
    vii. Arrived at Hospital
    viii. Clear
F. Name, age, and gender of patient
G. Type of call (illness / mechanism of injury)
H. Initial assessment of scene
    i. Position of patient
    ii. Impression of patient
    iii. Patient level of consciousness
        1. If using AAOx4 and patient is not x4 state what they are alert to (i.e. pt AAOx1, alert to person only)
        2. Describe the patient. Avoid ambiguous terms like “lethargic”
        3. Identify problems with short and long term memory if they exist
    iv. Does patient respond to questions appropriately?
    v. Any significant characteristics of the scene
I. History of present illness (HPI)
    i. Patients have **ONE** chief complaint (CC)
    ii. However patients can also complain of (c/o) other things
    iii. Be sure to differentiate between the **CC** and the **associated complaints**
    iv. Put the complaints in the patients words if possible
    v. You should attempt to have the patient qualify and quantify the complaint
    vi. Utilize OPQRST in interview and documentation
    vii. What does the patient think the cause is?
J. Events leading up to the present illness
    i. Was this a sudden or gradual event?
    ii. What was the patient doing when it occurred?
    iii. What factors aggravate or alleviate the condition?
    iv. What has the patient done to treat or mitigate the condition?

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K. Past medical history (PMH)
   i. Include any significant past medical history
      1. Cardiac
      2. Respiratory
      3. HTN
      4. Diabetes
      5. Infectious disease
      6. Any other significant illness
   ii. Medications and compliance or lack thereof (all meds should be indicated somewhere on the call report)
   iii. Family and social history as applicable

L. Complete assessment and physical exam
   i. Airway
      1. Patent?
      2. Foreign matter?
      3. Obstructions
      4. Methods of airway control (if done)
   ii. Breathing
      1. Relative rate, rhythm, quality
      2. Qualify and quantify respiratory effort
      3. Use of accessory muscles and/or retractions
      4. Condition of the chest wall
         a. Symmetry
         b. Abnormal movement
         c. Crepitus/bony instability
         d. Discoloration
      5. Ability to complete sentences
      6. Anterior neck (JVD, tracheal deviation)
   iii. Circulation
      1. Pulse
         a. Relative rate, rhythm, and quality
         b. Locations (compare carotid and radial)
         c. Does it match the monitor? (may be deferred until the monitor is applied)
         d. Quantify the pulse (1 – 2+ scale)
      2. Skin color, temperature, and moisture
      3. Cap refill
      4. Major external hemorrhage
      5. Heart tones and murmurs (if done)
         a. Tones present and clarity
   iv. Abdomen
      1. Intake and Output
      2. Discoloration (signs of trauma or internal hemmorhage)
      3. Auscultation (bruits, bowel sounds, etc)
      4. Palpation (shallow and deep)
         a. Soft, rigid, etc
         b. Painful response (i.e. non tender, tender etc)
         c. Where was the painful response?
         d. Masses (pulsitile, non-pulsitile)
         e. Organomegally

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f. Specific signs and findings
    i. Fluid waves
    ii. Rebound tenderness
    iii. Rovsing's sign
    iv. Psoas sign
    v. Cutaneous hyperesthesia

v. Pelvis
1. Stability x3 axis
    a. Always push in first if you suspect pelvic Fx!!

vi. HEENT
1. Head and Face
    a. Presence of trauma
    b. Hemorrhage
    c. Symmetry
    d. Bony instability
2. Eyes
    a. Discoloration
    b. PERRLA
    c. Consensual reflexes
    d. Extraoccular movements
    e. Nystagmus
    f. Presence and description of visual disturbances
        i. Diplopia
        ii. Blurred vision
        iii. Scotomata
        iv. Hemianopsias
        v. Vision loss
3. Ears
    a. Presence and description hearing disturbances
    b. Drainage
4. Nose
    a. Drainage
    b. Signs of trauma
5. Throat
    a. Any abnormal findings if exam is indicated

vii. Neurological exam
1. Presence of gross motor and sensory function
    a. Lower extremities
        i. Dorsiflexion and plantarflexion of the foot
        ii. Extension and flexion of the knee
    b. Upper extremities
        i. Grip strength (medial nerve)
        ii. Finger abduction (ulnar nerve)
        iii. Thumb opposition (radial nerve)
        iv. Flexion and extension of elbow

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2. Evaluation of cranial nerves
3. Evaluation of speech and memory
4. Evaluation of spinal nerves
5. Evaluation of reflexes (should be quantified on 4+ scale)
6. Any specific findings
    a. Presence of ataxic gait
    b. Positive Romberg test
    c. Presence of pronator drift
    d. Hemipareses / Hemiplegia
    e. Point to point testing
    f. Presence of dysdiadochokinesis
    g. Babinski reflex

viii. Extremities
1. Obvious signs of trauma
2. Discoloration
3. Any swelling or deformity
4. Dependent edema
    a. Pitting vs non-pitting
        i. Edema to what level?
        ii. If pitting quantify with 4+ scale
    b. Pt Hx of edema and relation to presentation
    c. Recent change in edema
5. Presence of needle marks
6. Range of motion
7. Motor strength (0 – 5 scale) and symmetry

ix. Anterior neck and back
1. Obvious signs of trauma
2. Discoloration
3. Nuchal rigidity
4. Point tenderness
5. Range of motion
6. Pain
7. Spine
    a. In-line?
    b. Deformity?
    c. Step-offs?

M. Vital signs
i. Every 15 mins on non-emergency patients, every 5mins on emergency patients
ii. One set is worthless, must have a minimum of two
iii. Palpated BP should rarely be used and only in extreme circumstances
iv. Count the pulse; do not rely on the monitor. They can differ
v. Count the respirations, do not “guesstimate”
vi. Vitals are only valuable when accurate and seen as a trend

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N. Impression
    i. What do you think the patient's problem is based on your exam?
    ii. This justifies your treatment
    iii. Use the terms "Field impression", "Field Dx", "Differential Dx", etc. to indicate what you are treating.
O. Scene Treatment
    i. What did you do?
    ii. Be accurate, clear, and concise with all treatment descriptions
    iii. If you place treatment into a specific category of your report (rather than documenting in a chronological form of "I found this and did this, I found that and did that"), be sure to indicate when each treatment was performed
        1. For example: If the patient presented with an airway compromise, and your treatment description follows your physical exam documentation, be sure to include a statement such as "airway controlled by XYZ procedure immediately upon arrival". If not it may be misconstrued that you waited until you completed your entire exam before you treated anything you found.
    iv. Include any diagnostic tests and their results
        1. Monitor
        2. Pulse Ox (may be included in the assessment)
        3. Glucometer
    v. Include the flow rate and delivery method for all oxygen therapy
    vi. Include the size, location, type of fluid, and rate for all IV's
    vii. Include the concentration, dose, and route of all medications
    viii. Include equipment used in immobilization
        1. The statement "pt placed in spinal immobilization" is full of holes for an attorney.
        2. Specify that a C-collar, CSID, and LSB were used to close those holes
    ix. Include methods used to verify treatment was correct
        1. For example, how did you know the ETT was placed correctly and was not displaced during treatment and transport?
    x. Any other procedures or treatments performed
    xi. Any specific responses (expected or otherwise) to specific treatments
P. Patient response to treatment
    i. What was the general patient response to your treatment?
    ii. Did the patient improve or deteriorate?
    iii. What did you do based on the patients response?
Q. Transport mode and destination
R. Patient condition enroute - did any changes take place?

S. Treatment enroute
    i. What did you do?

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ii. One of the most common errors in documentation is to end it with a statement such as: “Patient transported to XYZ ER”. This gives the impression that you did nothing for the patient enroute. This is seldom the case. Be sure to document this phase of the call. You may simply state “continued to evaluate and monitor patient enroute without further change in condition or complaints” This at least shows you were still caring for the patient.
iii. Include any therapy and response to therapy (use the same guidelines as the scene treatment section above)

T. Transfer of patient care and belongings
i. Who did you transfer the patient to?
ii. Include their name and level (RN, MD, etc)
iii. Was a verbal report given?
iv. Who took possession of the patient’s belongings?

II. Tricks and Traps, and Common Errors

A. Tricks
i. Write the report as soon as possible while information is fresh in your memory
ii. Make sure your report is thorough
1. Your documentation should accurately describe the scene, patients behavior, appearance, and S+S
2. What is documented should lead to a logical end (history and physical should support your treatment
3. Your report should somehow indicate the chronological order of events that took place
iii. Your report **MUST BE** readable and grammatically correct
1. Your documentation speaks of you, your professionalism, and your care
2. Often your report is the only representation you have either medically or legally
3. Sloppy or incomplete documentation is equated with sloppy or inadequate care
4. Spelling, punctuation, and sentence structure **DO MATTER!**
5. A report that is not readable by others is of no medical use, and can weaken your defense in a legal situation.
iv. History and Physical
1. Describe the patients appearance, age and sex
2. Describe anything pertinent and specific about the patient’s position, statements etc.
a. In a respiratory distress call it is important to note that upon arrival the patient was in tripod position with full use of accessory muscles in respiratory effort.

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   b. The chest pain patient who tells you that this pain feels just like his last MI should have that statement documented.
3. Aggravating and relieving factors, and any treatment prior to your arrival
4. Use your five senses to report findings. (be careful with the documentation of the presence of ETOH)
5. Document normal findings as well as abnormal findings. Be careful with words like unremarkable and negative without supporting documentation
6. Use pertinent quotes (patient, family, bystanders)
7. Document changes in patient condition

v. Treatment
   1. Indicate the order in which treatment was performed and who performed it. (a chronological narrative is always your safest bet)
   2. Identify every individual who performed care and what they did
   3. Treatment should be in accordance with established standard of care
      a. Treatments outside standard should be justified in your documentation and should include which physician you spoke, what facility they were at, and the time the procedure was performed
   4. Documentation should include the patients response (either positive or negative) to your treatment

vi. Before submitting your report ask yourself the following questions:
   1. Does my documentation adequately describe what I saw, what I did, and why to someone who was not on the call?
   2. Does my report contain all the necessary information needed by others who may need to rely on in alone?
   3. Does my report adequately state all of my observations about the patient?
   4. Does my report support or prove all the medical information presented?
   5. Does my report list all the treatment provided to the patient?
   6. Does my report contain sufficient information to enable me to reconstruct the entire situation and defend my actions if need be? (possibly years later)

vii. Sign the report legibly

viii. Changes and Addendums
   1. Noted in supplemental report if original has already been submitted
   2. Needs to reference the original report
   3. Needs to contain a reason for the addendum
   4. Must be dated and signed by the author

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B. Traps
   i. Avoid subjective or value laden statements
      1. State only the facts of what you saw (no opinions or bias)
      2. Subjective statements are easily used to weaken your personal credibility and treatment
   ii. Use of the words appears, seems, etc
      1. These are easily challenged
      2. Can be used to question your treatment
      3. Gives the appearance that you did not know what your were doing, what you were treating, or why
   iii. Documentation of ETOH
      1. ETOH is a colorless and odorless liquid
      2. Documenting you smelled ETOH will destroy your entire report in a legal situation
      3. The odor of alcoholic beverages is a result of the distilling or fermentation process
      4. Therefore, correct documentation should state “There was an odor of an alcoholic beverage about the patients person”
      5. Do not state “on the patients breath” Something may have been spilled on them and they may not have been drinking the beverage.
      6. Do not state a patient was intoxicated or drunk. Your training to be able to do that will be called into question in court. State the patient was exhibiting behavior consistent with intoxication.
      7. You do not know what is in a container unless you test or taste it. Therefore do not assume the Jack Daniels bottle in the car was half full of Jack Daniels. Instead you saw a Jack Daniels bottle half full of a brown liquid.
   iv. Mistakes
      1. Documentation
         a. Draw **ONE** line through the mistake and initial it.
         b. Never obliterate an error, you will be questioned about “what you are trying to hide”
         c. It is better to have someone know you made a spelling error that to have your credibility and treatment questioned
      2. Treatment
         a. Identify and take ownership of the mistake
         b. Document what happened and what was done to mitigate it
         c. Document which physician was notified of the error
         d. Hiding a mistake in treatment can have serious personal and professional repercussions

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v. Sloppiness
    1. Write legibly (your report should exude professionalism)
    2. As stated above, a sloppy report indicates sloppy care and leaves “holes” in your defense in a legal situation
    3. Do not try to “jam” everything on one page if it will not easily fit. Use supplemental pages as needed
    4. Do not write in the margins
    5. Use standard medically accepted abbreviations only
        a. The fact that you “always” use XYZ abbreviation does not make it acceptable
    6. Avoid multiple authors on one report

C. Common Errors
    i. Mechanism of injury or illness not adequately described
    ii. Failure to document pertinent findings at the scene
    iii. Incomplete history and physical
    iv. Incomplete description of treatment
    v. Order of treatment not indicated giving appearance non critical treatment(s) were performed before critical treatment(s)
    vi. Failure to document dose and route of medications (and concentration if applicable)
    vii. Not indicating the patients response to treatment
    viii. Failure to indicate treatment performed enroute
    ix. Basis for treatment no clear or not identified at all
    x. Use of non-standard, or “local” abbreviations
    xi. Failure to include pertinent negatives in the history and physical
    xii. Use of the word(s) “negative” or “unremarkable” in lieu of documenting the findings of a physical exam (see explanation at the end of this document)

Use of the word(s) Negative and Unremarkable in Documentation

In an effort to shorten their documentation many new healthcare providers document systems as unremarkable to indicate there were not abnormal findings. While such a statement may seem benign, and self-explanatory to the author, they are actually very ambiguous and can lead to problems at a later time. Knowing the medical record (patient call report) has several functions; this will focus on the medical and legal functions.

The medical record serves as an important document to those who will be involved in a patients care long after you have left the hospital, potentially up to days and weeks later if the patient was admitted. As the pre-hospital medical professional you are the only person who had access to the patients initial presentation and findings on the scene. The treating physician may very well need access to information from the initial exam and circumstances on scene to assist in determining the patients progress or course of treatment. **Remember that data not recorded is data lost.** Suppose for example you documented the following: “The abdomen is unremarkable upon examination”, or “The

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abdominal exam is negative". This statement can have a different meaning to each person who reads it. You have given no indication of what you have actually evaluated or not evaluated. Did you only do a cursory visual exam and are saying there were no visual abnormalities, or did you also palpate the abdomen as well? If you palpated did you do shallow palpation, deep palpation, or both? Did you assess for the presence of abdominal masses or bowel sounds? The clinician who is now treating the patient has no way to know if what he or she is finding is new onset or has been present. This removes all possibility for the trending of patient progression from time of onset to take place. The same can be said for any body system. "Neurologic exam negative" essentially says nothing about the type of exam you did. Not only may future clinicians wonder what you did, but if you are ever asked to clarify it, you may yourself not be able to remember exactly what you did or did not assess. "Did I really do a complete sensory exam, or just ask the patient to squeeze my hands?" and a myriad of other questions can result from such an ambiguous statement.

The medical record also serves an important legal function should your care ever be questioned in a court of law. The statements used as examples above provide excellent material for a prosecuting attorney, but almost no material for a defense attorney. Picture the following scenario. You transported a patient with a fractured forearm to your local hospital. You had the patient squeeze your hands and determined that his bilateral grip strengths were equal. His pupils were equal, round, and reactive to light, his gait was steady, his speech was clear, and his thought process and memory were appropriate. In your report you documented that the neurologic exam was unremarkable. You have been called to court because the patient had impairment of the ulnar nerve secondary to the forearm fracture, which the physician found to be present upon arrival at the ER. The patient is suing you for inappropriate care, which caused his injury. While being question by the patient's attorney he asks you to describe your neurologic exam of patient and how you determined the nerve injury was not present upon your initial or subsequent assessments. Without documentation of what type of neurologic exam you performed you have no ability to testify to this question. All you can say is that it was unremarkable. The attorney would then ask you what you specifically did in your exam. Again without it documented and the findings you could not respond. If you did attempt to state the specific exams you did you would be challenged as to how you know you did them since they were not mentioned in your documentation. How do you respond to this? To say you always do certain things is inadequate and leaves room for questioning as to how you know you did it that time. Even worse is to say you remember doing it. You will suddenly find yourself barraged with questions to disprove you are able to remember that day. Questions such as "what was the patient wearing?", "what were you doing before the call?", "what was the call prior to this one?", "what did you eat for breakfast/lunch/dinner that day?" will all be asked to prove that you are not able to truly remember every specific detail about the call. This can go on and on in the legal realm, but the basics remain similar to this example.

Therefore the trick is to document thoroughly and completely, yet be brief at the same time. There are ways to accomplish this.

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First, all pertinent negatives must be described specifically, rather than generically as "unremarkable". A pertinent negative is anything that is absent that you would expect to find based on other portions of the history and physical exam. If the patient is complaining of severe dyspnea yet speaks in complete sentences and is not using accessory muscles in the respiratory effort it must be documented.

Second, it is not necessary to document *every negative finding* unless they relate directly to the patients complaint or to specific exclusions in your assessment. Do not try to list everything you did not observe, instead concentrate on a few major ones to indicate what you actually assessed.

For example, **"the extremities are unremarkable" vs. "the extremities show no obvious signs of trauma or injury, the skin is smooth and intact without discoloration, and there is full range of motion with sensory and circulatory function intact.** With minimal extra effort you have just dramatically increased the quality of your documentation and information it delivers. You have indicated there are no soft tissue injuries, no hemorrhage, no swelling or deformity, no bruising, echymosis, or hueing, no rashes or other skin lesions, there are no needle marks, the patient has full ROM to the extremities, CMS is intact, and there are no abnormal findings. With only a few more words than "unremarkable or negative", you have provided future clinicians with a wealth of information and yourself with legal defense if needed.

A final example is **"HEENT negative" vs. "HEENT: PERRLA, EOMI, consensual reflexes intact, negative nystagmus, there are no obvious signs of trauma to the head or face, and no drainage. There is no bony instability or deformity, or evidence of soft tissue trauma."** Again, only a few more words, but much more information conveyed in the second description.

In summary, the use of the words unremarkable, negative, etc. in documenting the physical exam can hide important medical information, and leave you defenseless in a legal situation. Be sure to qualify what you did in your exam and what you did and did not find. Many "unremarkable" findings can be expressed in simple statements such as those examples above.

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