

A Guide to Documentation

by
J. Nile Barnes, NREMT/P

Alf you didn't document it, you didn't do it! This often quoted axiom owes its origin to the litigious attitude of the American public. It is therefore incumbent on the health care practitioner to carefully record all pertinent findings (including the non-finding or Apertinent negative), if he wishes to avoid lengthy legal actions.

It is important to remember that the record made at the time of an incident is considered the most reliable record that an individual will produce. As time progresses, short-term memory losses will make recollection of the sequence of events increasingly difficult, leaving room for gaps and mistakes in later renditions. Clear and legible records often stimulate the long-term memory and can serve to help recreate the event in the mind of the provider. Clearly this recreation will be more accurate if the written record stimulating the mind is accurate.

With thoughts of courts and attorneys and fines and malpractice flying about, it is hard to imagine anyone feeling immune to litigation, however, an even better reason for documenting well exists; **the patient**. The EMS patient encounter form is a medical document as well as a legal document. It becomes part of the patient's permanent medical record. Physician, nursing, and clerical staff may each refer to the information on the pre-hospital report, particularly about a patient whose mental status changes.

SOAP is an acronym for **S**ubjective, **O**bjective, **A**ssessment and **P**lan. Much of this system is self explanatory. The beauty of this system is the fact that it is a systematic approach to symptoms, signs, findings and care plan, and therefore easy to place information.

The subjective section is often the longest, as it contains the information told to the EMT. It is sometimes referred to as the history of the present illness or injury (HPI). It contains the patient's symptoms and other information, preferably in patient's own words, but condensed by the skillful interviewer to contain only those statements that are relevant. Also part of the subjective is a listing of the patient's past medical history (PMH), medications, and allergies. These are generally listed separately, in order to clearly delineate the past medical history from the history of the present illness/injury. With patient's involved in collisions, vehicle damage must also be noted; although this information is usually objective in nature, it is listed with the subjective information because the objective section is reserved for patient information. It is also important to list the source of the information.

The objective section contains the observations by the examiner. This section is sometimes called the physical examination (PE). Nothing recorded in the objective section should come from any source other than the examiner's five senses (try not to taste anything). To be absolutely true to this technique, vital signs should be included in this area, but a timed flow chart provides a handy and manageable place for the vital signs. It is important that the adjectives used in describing a patient are not subject to different interpretations by different readers (avoid words like normal, good, poor).

In the assessment section the EMT reports his clinical impression of the patient (and often a triage category). Care should be taken to avoid making a diagnosis, because the diagnosis is usually considered the physician's realm. An example of an assessment vs. a diagnosis might be: chest pain & dyspnea vs. myocardial infarction. A standardized triage system separates non-life threatening from life threatening assessments at a glance for the reader. A common system is the MEDIC system: **M**inimal, **E**xpectant, **D**elayed, **I**mmEDIATE, **C**ontaminated.

In the plan section of the report, the actual plan of patient care is listed, even (or especially) if the step is already completed. Pay particular concern to the order of the steps, they should reflect the order treatment was given. A reminder that this area is reserved for treatment plans and therefore items such as primary survey, secondary survey, and vital signs should not be listed here.

An additional section can be added to document changes in patient condition or responses to treatment. This is sometimes called the Enroute section, since the changes to patient care typically occur enroute to the hospital.

No matter what style report is used, the report should be concise, readable and without spelling or grammatical errors. The entire document should give the reader a clear picture of the events surrounding the illness or injury, the physical examination findings, a summary assessment of the two and sequence of treatment steps with any responses to treatment.

PAST MEDICAL HISTORY: chronic or acute; cardiovascular disease (eg. angina, hypertension), pulmonary disease; metabolic disorders (eg. diabetes), gastrointestinal disorders, infectious diseases, neurological disorders (eg. seizures), psychological disorders, gynecological disorders, last menstrual period (normal?, on time?), pregnancy (gravity, parity, abortions, EDC), surgeries requiring general or regional anesthesia, usual childhood diseases, immunization status (tetanus and childhood diseases), last oral intake; physician or hospital choice.

MEDICATIONS: current and recent OTC and Rx (including ASA, APAP, NSAIDs and BCPs). Include dose, route, schedule and compliance.

ALLERGIES: medication allergies and idiosyncratic reactions. Include other significant environmental allergens with the PMH.

SUBJECTIVE: age M/F; source (pt, family, bystander, witness, first responder) reports: (un)restrained, (un)helmeted driver/passenger in MVA/MCA; involved in alleged (sexual, physical, armed) assault; victim of a fall (xx feet); time of onset/injury, sudden or gradual onset; c/o pain (radiating, non-radiating, localized, diffuse, worsening with:; improving with:), difficulty breathing, loss of consciousness, nausea, vomiting, diarrhea, constipation, urinary frequency, visual disturbances, hallucinations, auditory disturbances or other complaints. Pt admits EtOH/illicit drug use/abuse. Pt denies any of the above. **VEHICLE DAMAGE:** type of vehicle, xx inches indentation on location(s), windshield intact (or starred or spidered), steering wheel/column intact (or damaged), encroachment on the driver/passenger compartment, axle displaced forward/rearward, damage to fixed objectives or other vehicles.

OBJECTIVE: found ambulatory, standing, supine, prone, sitting, reclined, R/L laterally recumbent. Mental status: awake, alert, oriented (to person, place, time), disoriented, asleep (easy or difficult to arouse), lethargic, stuporous, somnolent, confused, responds to (loud) verbal stimuli, responds to painful stimuli (appropriately, withdraws, posturing: flexion/extension) unresponsive, unconscious. General: airway patent or obstructed; apneic; respirations: (un)labored, shallow, deep; strong, bounding, weak, thready carotid (femoral, radial) pulse; pulseless; obvious hemorrhage; speech clear, garbled, slurred; malodorous, odor of alcoholic beverages or chemicals. Skin/Mucosa: warm/cool, dry/moist, pink/reddened/pale/cyanotic/jaundiced/mottled/dependent lividity. HEENT: intact, wounds, tenderness, deformities, crepitus, other injuries; PERRL(A), EOMI, dysconjugate gaze, nystagmus; blood/CSF/fluid draining from ears/nose/mouth; missing/loose teeth; tongue extends midline/left/right; facial droop; retropharynx reddened or dulled. Neck: intact, wounds, tenderness, deformities, crepitus, other injuries; JVD present/absent; larynx midline/deviated (L/R); carotid bruits present/absent. Thorax: intact, wounds, tenderness, deformities, crepitus, subcutaneous emphysema, other injuries; breath sounds: (un)equal clear/diminished/rales/rhonchi/wheezes (inspiratory/expiratory), dull/hyperresonant to percussion, symmetrical/paradoxical motion. Abdomen: intact, wounds, tenderness (localized or diffuse), deformities, crepitus, other injuries; soft/guarded/rigid; masses (pulsatile?); bowel sounds present/absent. Pelvis: intact, wounds, tenderness, deformities, crepitus, (un)stable, other injuries. Genito Urinary: intact, wounds, tenderness, deformities; juvenile or adult genitalia; discharge (including blood); incontinent of urine/stool; crowning/breech/limb presentation. Extremities: intact, wounds, tenderness, deformities, crepitus, obvious fractures/dislocations, (false) motions, other injuries; distal movement; distal sensation; capillary refill (x seconds); reflexes; grip strength & equality; pedal push/pull strength & equality dependent edema. Back: intact, wounds, tenderness, deformities, crepitus, other injuries; motions; posture (kyphosis, lordosis).

ASSESSMENT: Triage category, summary assessment.

PLAN: rescue maneuvers, resuscitative measures (including airway maneuvers, airway adjuncts, respiratory assistance, oxygen therapy, chest compressions), calm, reassure, arouse, cervical immobilization (including stiff neck collar, short spinal device, long board, head immobilization blocks, straps), dressings, bandages, splints, icepacks & other treatments; transport destination and code.

ENROUTE: specific changes or response to treatments; no apparent changes; continued treatments & psychological support.

Wounds: edema, ecchymosis, contusions, hematomas, abrasions, lacerations, penetrations, punctures, avulsions, eviscerations, amputations.

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