E.M.S. and DOCUMENTATION
LESSON OUTLINE:

I. INTRODUCTION/IMPORTANCE

II. MEDICAL-LEGAL SIGNIFICANCE

III. ESSENTIALS OF DOCUMENTATION

IV. RECORD FORMAT
   S.O.A.P./C.H.A.R.T.E.

V. SUMMARY
I. INTRODUCTION

A. Importance/Goals

The Goal of Pre-hospital EMS Incident Reports should be to provide as perfect and complete a record as possible thereby increasing your credibility and professional standing within the medical community. These Reports serve to communicate potentially vital information concerning the patient history, physical exam, treatment, as well as, any response or lack thereof to treatment that very well could impact the patient's diagnosis, welfare and further treatment.
II. MEDICAL-LEGAL SIGNIFICANCE

- The Pre-hospital EMS Medical Incident Record is recognized as a legal record of great weight. So much is the significance given this record the courts have recognized the Past Recollection Recorded Doctrine. This doctrine simply states that the medical record can be entered into evidence and will stand as your entire testimony on the matter should you have no recollection of said incident. This doctrine essentially removes effective cross examination of the witness.
B. Malpractice Protection

- The Pre-hospital EMS Incident record can be the EMTs best ally, or worst enemy concerning malpractice litigation.
C. Lawsuit Prevention

- *Patient refuses care/transport* and *patient left at the scene* incidents account for 50 to 90% of pre-hospital EMS lawsuits. Other incidents that pose a greater risk of litigation are when patients are intoxicated by drugs and/or alcohol and when patients and family members are angry or unhappy about care provided or the incident disposition.
D. Confidentiality

- The Pre-hospital EMS Incident Record is a medicolegal (pertaining to medicine and law) document and therefore is confidential.
III. ESSENTIALS OF DOCUMENTATION

Each Pre-hospital EMS Medical Incident Report should contain at least the following basic elements:

- The reporting agency name.
- Designation and incident number.
- Incident date.
- Dispatch times.
- Incident location address.
- Patient's full name address number, phone, age and date of birth.
- Patient's private physician.
- Vital sign.
- Flow chart.
- SOAP/CHART narrative.
- Statement of reason if cancelled.
- Personnel names, skill levels.
- Signature and title of the EMT completing the report.
The record must be a truthful accurate chronological/description of the incident and examination. Don't embellish the record under any circumstance, for inaccurate information very well could have deleterious effects to the patient.
Objectivity

- Be especially careful to avoid value laden terminology when describing the patient such as *hop head*, *drunk*, *alcoholic*, *druggie*, etc… for these terms could be construed as slander/libel. Avoid placing blame for any potential litigious circumstances.
Concise

- Be as succinct as possible including only pertinent information. Avoid duplicating data.
Comprehensive

- Include as much pertinent information as necessary to **paint as clear a picture as possible** for the medical staff. Again the more comprehensive your report is the better it will serve your recollection years later should the need arise.
Understandable

- It’s not necessary to use a lot of “technical jargon” to write a valuable creditable report. Use only terminology that you comprehend and officially accepted medical abbreviations.
Spelling and Grammar

- It’s important that other medical professionals are able to clearly read and understand your report for the benefit of the patient. A carelessly written report with many spelling and/or grammatical errors not only discredits you in the eyes of other medical professional, but it also may indicate to a jury/judge that your care was careless as well.
Timeliness

- Make every effort to complete your report as soon after the incident as possible. This will allow for the best recollection of the circumstances.

- CLEMC SOG requires reporting be completed PRIOR to the END of your scheduled shift.
Organization

- Use the currently accepted organizational SOAP/CHARTE format for your narrative section. This is the format that other medical professionals use, so they are very familiar with this format.
Unaltered

- Never fraudulently or otherwise alter the record in an attempt to protect yourself against litigation because there are very sophisticated methods at detecting these alterations.
Don't leave blank spaces that call for a response, such as allergies, because this can infer that you didn't bother asking discrediting you. Instead note unknown or unattainable.
IV. REPORT FORMAT (SOAP)

Subjective
Objective
Assessment
Plan
Subjective

- Perceived or experienced by an individual himself or reported to you by bystanders, friends, or family members. Basically the who, what, when, where, how and why. It should include the patient's chief complaint and associated symptoms along with any pertinent positive and negative symptoms. Include all pertinent past medical history as well as current medications and any drug allergies.
Objective

- Pertaining to conditions of the body perceived by another. What you can see, hear, smell, and feel. The objective section should include a scene description, mechanism of injury, patient exam findings (pertinent positive and negative signs), initial vital signs and level of consciousness. A good format is to record your exam details in a head to toe list.
Assessment

- This is what you actually think is wrong with the patient. It is based solely on the subjective and objective information that you gathered. Your assessment should logically provide a basis for your plan.
Plan

- This is what you have done for the patient. It should include all the actions you have taken and all treatment you have rendered no matter how trivial that treatment may seem.
V. REPORT FORMAT (C.H.A.R.T.E.)

Chief Complaint

History

Assessment

R- Treatment

Transport

Exceptions
Chief Complaint

What the patient tells you, or items that cannot be measured. Can be quoted, Can be paraphrased.

Document the medical necessity.
History

Included are past medical Hx, allergies, and current medications.

Include relevant Hx. Of events leading up to the present illness of injury.
Assessment

Include a scene survey. Perform a complete neuro and cephalocaudal (head to toe) exam.

a. Neuro
b. Neck
c. Chest
d. Abdomen
e. Pelvis
f. Extremities
g. Skin
R. Treatment

- State what you did for the patient, and the results of your actions.
Transport

- Emergency or Non-emergency
- Did anything occur while enroute to the hospital?
- Delays, stops, etc...
- Did the patient condition change?
Exceptions

- Any information pertinent to patient care.
V. SUMMARY

- Pre-Hospital EMS Incident Reports are valuable medicolegal documents that when properly completed, benefit the health care team, the pre-hospital provider, and most important the patient!