Report Writing

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Event Sequence

- If Squad One responds enter EnRoute and Arrived times
- Enter all assessment "tests" and interventions (4-lead, 12-lead, BGL, lactate, temperature, EtCO2, advanced airway, O2, IV attempts, medications, etc)
- If possible, log intervention times in the monitor event log using the event button on the LifePack
- **Vital Signs:** Document initial and destination vital signs under the initial assessment and destination assessment sections –you DO NOT have to place these in the event sequence. If any **medications** administered or **invasive interventions** performed (cardioversion, pacing, advanced airway/RSI) enter before and after intervention vital signs in the event sequence. The ONLY other time vital signs must be listed in the event sequence is if it's pertinent to the patient's condition. Example: the patient complains of dizziness and is hypotensive. For billing purposes, if the pulse oximeter is used, list either a set of vital signs w/ SpO2 or pulse oximeter event in the sequence.
- Enter at least one Assessment or Initial Assessment event. You may enter multiple assessment events to document things such as lung sound auscultation, stroke assessment, repeat neurologic assessment, pain assessment, etc.
- Enter Report Called. **IF APPROPRIATE SELECT ALERT ACTIVATED**

  Example: STEMI, Trauma, Stroke

Key Points

- Be descriptive in one part of your report and refer to the area where you provide details

For example, 12-lead EKG must be listed in the event sequence and narrative, but you only have to provide your interpretation in one of those places

For physical exam you may be descriptive in the systemic information portion of the report or the narrative. Refer to whichever portion of the report you choose.

There will be overlap between assessment and treatment. For example, while BGL is considered an assessment, repeat BGLs may be directly related to the treatment you provide the patient. For situations with overlap place repeat/ongoing assessment findings either under assessment or treatment. Use your best judgement, create a cohesive report that you understand and could explain to others.

Narrative: 6 Headings

- Dispatch
- General Impression
- Assessment
- Treatment
- Transport
- Transfer of Care

Dispatch

- Medic Number
- Response address and type
- Nature of call (dispatch information)
- Emergency or Non-emergency
- Explanation for any response time >10 min.
- Any other responders to the scene: squad one, fire department, law enforcement

M520 dispatched to the residential address listed above (you may refer above instead of re-typing the address) for an elderly male w/ weakness and possible UTI. M520 responded in emergency mode and arrived w/o incident. Forestbend FD responded and arrived after EMS.

General Impression

- What did you find when you arrived on scene? Is the scene safe, are there any barriers to patient care?
- List any treatments, interventions, etc. performed by first responders prior to your arrival
- Describe the patient: age, gender, where you found them (position and place)
- State the patient's chief complaint
- Provide history of present illness
- Pain may be documented under General Impression or under Assessment.
- This portion of the report should be written in story/paragraph format

Arrived on scene to find (AOSTF) an 84 yo male, alert, sitting on a toilet. The pt. wife reported the pt. began running a fever on 2/6 and had become progressively weak. The wife stated the pt. had a 101.4 oF the previous afternoon and she gave him OTC Acetaminophen; she stated the pt. had not been running a fever that morning. The wife stated she had made an appointment w/ the pt. doctor for that afternoon but the pt. had become too weak to walk w/o significant assistance –the pt. is normally ambulatory w/ a walker. The wife reported the pt. has a history of chronic UTIs w/ previous sepsis and was currently prescribed a daily low-dose antibiotic.

Assessment

- **List protocol(s) followed during assessment**
- **Must use actual name of protocol!!!**
- **List differentials considered**
- **Do NOT refer to this as a "diagnosis!" Legally, we cannot diagnose a patient. This heading may be written as "differentials", "differentials assessed", or "differentials considered"**
- **Know your protocols! If you list a protocol as being followed for assessment you need to document an assessment finding for every item that protocol requires or an explanation for why that part of the protocol was skipped**
- Assessment includes initial and ongoing assessment findings. Changes directly related to a treatment performed should be documented under treatment.

Protocol(s) Followed: general medical illness, diabetic complication (sepsis considered, however as no findings consistent w/ sepsis found during assessment complete sepsis protocol no completed)

Differentials Considered: infection, sepsis, hypoglycemia, bradycardia

Assessment Continued

- List all assessments performed in line item format –you may refer to other portions of the report instead of re-typing every value. However, any abnormal findings should be described
- Assessment information may be listed by body system, in order of assessment, or any other **organized** system that works for you! You just must include:
  - Mental Status
  - Assessment of chief complaint (GI, stroke, chest pain, etc.)
  - Lung sounds
  - 4-lead EKG w/ interpretation
  - 12-lead EKG w/ interpretation
  - Pain –if not addressed in General Impression
  - Vital signs (Explain if time from pt. contact to V/S is >5min)
  - EtCO2 readings (if appropriate)
  - Lactate level (if appropriate)
  - Blood glucose level
  - Last oral intake
  - Temperature (if assessed)
  - PMHx, medications, and allergies
  - Physical exam (may refer to systemic information if no abnormal findings observed)

Assessment Continued

Alert and oriented to person, place, and event. The pt. presented w/ some difficulty recalling the date and his social security number. The pt. wife reported he was sometimes forgetful.

The pt. denied any pain or discomfort. The pt. reported he felt weak and “shaky”

The pt. reported he urinated immediately prior to EMS arrival, the pt. denied any burning or pain w/ urination, the pt. denied any difficulty urinating or changes in urinary urge or frequency.

Upon palpation abdomen found to be soft and non-distended. Pt. denied abdominal or flank pain w/ palpation.

Skin dry, pale, warm to the touch –no apparent hyper or hypothermia, normal skin turgor

See systemic information for additional physical assessment

Lung sounds clear and equal in all lung fields, equal chest rise, respirations regular and non-labored. Lung sounds reassessed during fluid administration and remained unchanged.

Vital signs obtained –see event sequence and monitor sequence

4-lead EKG showed rhythm indicative of atrial fibrillation w/ RBBB. Continuous cardiac monitoring performed during transport w/no changes observed. HR range observed: 40-57 beats/min

12-lead EKG showed atrial fibrillation w/ criteria met for RBBB. Time to 12-lead EKG delayed as pt. was moved from the bathroom via stairchair prior to acquisition

Blood glucose level 27 mg/dL. Level improved to 50 mg/dL w/ oral glucose.

Pt. reported his last oral intake was the previous night.

Lactate level 0.8 mmol/dL. Venous sample

Temperature 97.6 oF oral

PMHx, medications, and allergies –see pt. information. The wife reported the pt. was compliant w/ all his medications. The wife reported the pt. required Rhythmol every 8 hr. and received his last dose at 1030 that morning.

Treatment

- List the protocol(s) followed for treatment. This list may be different than the protocol list under assessment. For example, your assessment protocol may be General Trauma and your treatment protocols may be General Trauma and General Pain Management. Any treatments listed under the protocol that you do not perform should be document with a brief explanation
- Include O2, bandaging/splinting, spinal immobilization, IVs, medications
- Document result of every intervention

- Examples:

O2 at 4 L/min administered via nasal cannula. SpO2 improved from 93% RA to 97%

R arm immobilized w/ SAM splint and Kerlix; secured w/ triangular bandage sling. PMS remained unchanged to the R hand

Spinal immobilization performed w/ c-collar and long backboard. PMSx4 remained unchanged after immobilization and after movement to M520

50 mcg Fentanyl administered IVP. Pain level improved from 9 of 10 to 6 of 10

Treatment Continued

Protocol(s) followed: diabetic complication

18g IV attempted R AC w/o success

20g IV established R hand w/ saline lock and 10gtt set, rate bolus. The pt. received 200 mL normal saline IV drip. Lung sounds and pt. condition remained unchanged.

24 gm oral glucose administered PO. BGL improved from 27 mg/dL to 50 mg/dL

24 gm oral glucose administered PO. BGL found to be 49 mg/dL

As pt. BGL was improving w/ oral glucose and mental status remained unchanged no D50 or Glucagon was administered

As pt. presented w/ chronic atrial fibrillation and was currently taking a beta-blocker no attempts to increase pt. HR were made

Transport

- If on scene time is >20 min justify the extended time
- Describe how the patient was moved to the ambulance
- Emergency or non-emergency transport
- Document report called to the receiving facility
- Document if patient condition changed

On scene time delayed as the pt. was moved from the bathroom to the stretcher via stair chair w/ the assistance of the FD. The pt. was moved to the stretcher and secured w/ straps and side-rails upright and locked. Stretcher locked into place in M520. The pt. was transported non-emergent safely and w/o incident. A report was called to the receiving facility during transport. The pt. blood sugar improved, condition remained otherwise unchanged.

Transfer of Care

- List where you left the patient: hospital, room
- Document providing a patient report and obtaining appropriate signatures
- List any belongings left with the patient
- End the report

The pt. was transferred to care at CLRMC ER room #10. A verbal report was given to the receiving nurse. Signatures were obtained from the pt. and receiving nurse. The pt. was left w/ his home medication list. M520 returned to service.

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CPR Reports: Event Sequence

- Enter every rhythm check in the event sequence. If possible document the time of every rhythm check by printing a strip or logging a monitor event
- Enter every defibrillation performed. This time will automatically be listed under the monitor event log
- Enter every drug administered. If possible document the time by logging a monitor event
- Enter every airway intervention performed: initiation of BVM ventilations, suction, intubation, advanced airway, capnography. If possible document the times by logging a monitor event. The LifePack will provide a record of the time ETCO2 was established and periodic readings.
- Enter all other interventions (IO/IV, BGL, etc) If possible document the time by logging a monitor event

CPR Reports: Narrative

- Dispatch: make sure to document any first responders, law enforcement, squad one, second ambulance
- General Impression: in addition to typical scene size up document if/when CPR was started by bystanders or first responders. Document if the pt. was moved prior to EMS arrival.
- Assessment: Document any assessments performed (BGL, trauma assessment, etc)
- Treatment: Refer to your event sequence!
  - See event sequence for all rhythm checks
  - Pt. defibrillated a total of 4 times –see monitor events and sequence chart
  - Total of 5 mg Epinephrine administered –see sequence chart for times

Spend more time describing advanced airway, IV/IO placement, post arrest treatment (if applicable)

Refer to Handout 2 for code report example