Title: Documentation Standard	Reference #: AMB 1048
Section: Departmental	Date Effective/Revised: 6/1/2025
Department (s): Ambulance	Approved By: EMS Director

Policy

To provide consistent standards in documentation for all patient encounters and refusals. Using this format will help to provide protection for the provider and service in legal liability issues, improve our QI process and help to improve the reimbursement for services rendered.

The intent of writing a narrative documentation is to tell a story that can be thoroughly understood by those who are not present at the scene. Narrative documentation should provide an unbiased, factual, clear and concise yet thorough explanation of what occurred.

Procedure

All narrative documentation should be in the following format. Using the ESO auto-generate narrative format is acceptable, but may need additional information.

DISPATCH

- Dispatch information, responding agencies/units
- Specific dispatch instructions
- Response mode (emergent vs. non-emergent)
- Any exception to call such as weather, road travel, unexpected delay in accessing patient.
- Scene summary (scene description, patient location and position)

COMPLAINT

- Age, gender, race patient identifies with
- Notation for unknown identity or approximate age
- Chief complaint as indicated by the patient or observed by the paramedic
- Document sources of information: family member, friend, bystander, MD
- Primary reason the patient is seeking medical care (provider judgment)

HISTORY

- Events leading to incident, last known well date and time
- Mechanism of injury if applicable
- History of present illness (OPQRST & SAMPLE)
- Past medical history

ASSESSMENT

- Assessments, primary and secondary
- Important physical exam findings
- Associated symptoms
- Pertinent negatives and positives
- Vitals sign interpretation, diagnostic findings (12-lead)
- Primary suspected problem, differential problem list

TREATMENT

- Interventions in chronological order, including any prior to EMS arrival

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    - may be general or referenced, if detailed in events/procedures list
- Patient response to interventions
- Adjustments to treatments (repeat, modify, or discontinue)

TRANSPORT & TRANSFER OF CARE

- Patient movement to ambulance
- Changes in patient condition
- Transfer of care at destination
- Details of any refusal of transport conversation with patient/family

Remember the importance of painting a picture. The first thing that a medical director, QA reviewer, insurance payor, billing coder, or lawyer will read is your narrative because it sets the pace. Your narrative indicates your thoroughness, it implies your competence, and it links your findings with your actions.

Run Type (Used for State Data Reporting)

- Emergency Response Primary Response Area
    - 911, Direct Calls, Walk-in, flagging down, care center to ER
- Hospital to Hospital Transfer
- Hospital to Non-Hospital Transfer
    - hospital to care center, hospital to home
- Emergency Response Intercept
    - ALS Tier
- Emergency Response Mutual Aid
    - Out of county calls
- Mortuary Services
    - Body transports
- Other Routine Medical Transport
- Public Assistance/Other Not Listed
- Standby
- Support Services
    - Fire rehab

Response Mode: Emergent vs. Non-emergent Transport

All transports from one medical facility to another (e.g. CMH to UIHC) will be classified as emergent transports unless it is scheduled for a different time in the future. This designation of emergent vs. non-emergent is made independently from the use of lights and/or sirens. Here are some scenarios to clarify:

- If the requesting hospital would like to schedule a transport for 2 hours from now, that is non-emergent classification.
- If CMH requests a routine transfer to the UIHC right now, that is an emergent classification.

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- If we receive a call for transport now, but we let the caller know that we will need to schedule it for a later time, it is still considered emergent as they had requested it for right now.
- All take-backs to nursing homes, etc. will be classified as non-emergent.

Checklist before submitting a patient care report (PCR)

- Are your descriptions detailed enough?
- Are the abbreviations you used appropriate and professional?
- Is your PCR free of grammar and spelling errors?
- Is the chief complaint correct?
- Is your impression specific enough?
- Is medical decision making clearly stated and supported?
- Are all other details in order?
- Are the patient demographics correct and current?
    - Is the patient's phone number entered?
    - If there is a next of kin contact, is that information entered?
- Is the Run Type and Response Mode correct?