Riverview Health Audit and Review

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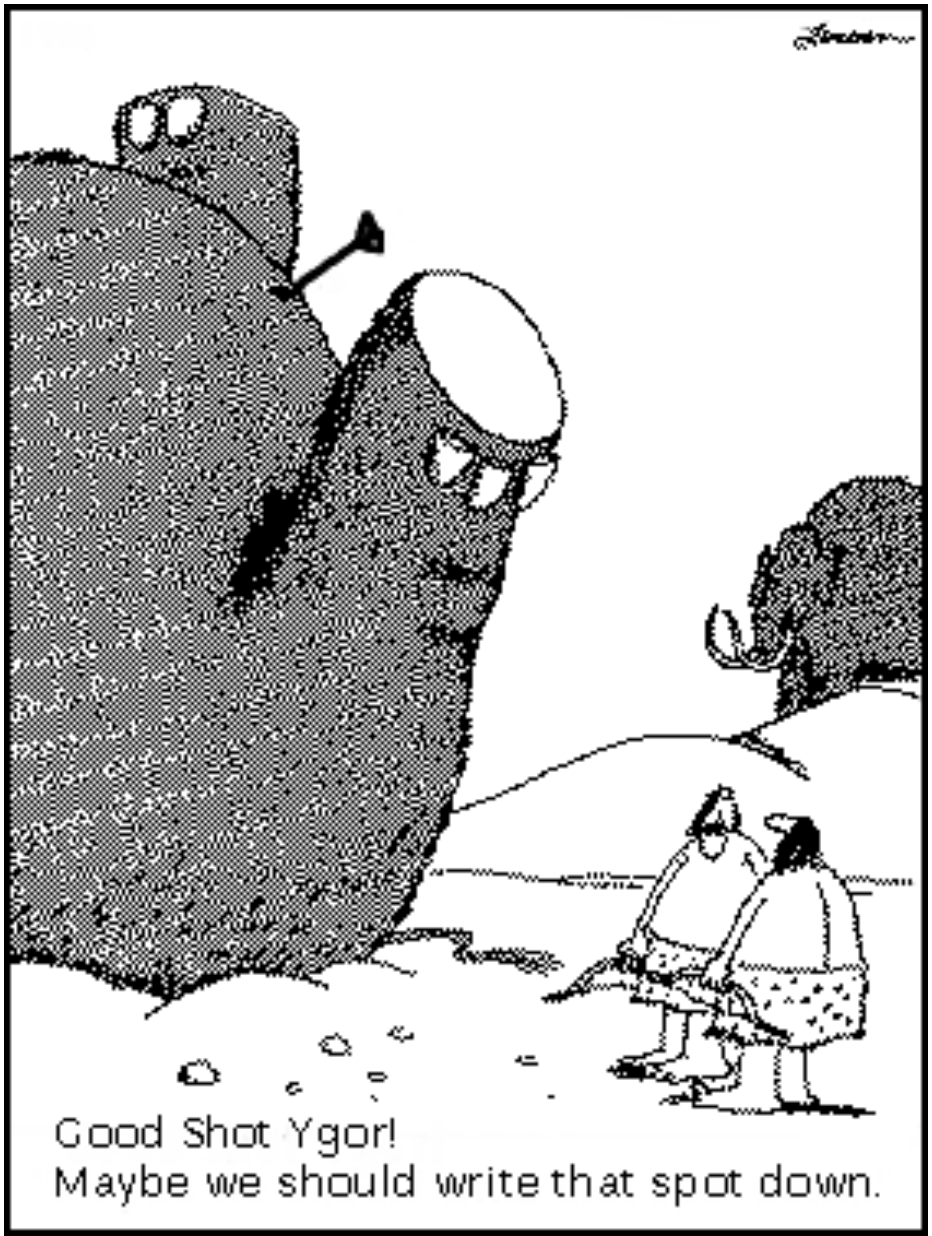
Documentation



Why Should I Care?

1. This is how we prove what we do
2. If it ain't on the paper/computer…it never happened
3. It's a medico legal world out there
   - *Medic certification*
   - *Physicians license*
4. It is very useful when they arrive in the Emergency Department

Goals for Today

1. Case by Case presentation of common EMS Runs
2. Focus on key areas of what is needed for documentation purposes
3. Explain why we ask for certain things on the run report
4. Feel free to ask questions

Minimum on the Chart

- 2 sets of vitals if transporting
  - *Including O2 sats*
- **Run times** including time on scene and time of departure
  - *Gives us an idea of what you had to deal with*
- Any intervention *including* any problems you had with an intervention

What Does Not Have to Be There

1. A long history into every detail of their illness
2. A definitive Diagnosis
   - » *Sometimes it is still very unclear*

Case #1

1. Called for a single vehicle MVA
2. Patient is ambulatory at the scene
3. Appears intoxicated and limping

What Do We Need?

1. Mechanism-Brief statement of what the scene looked like, how many people,
   - » *Mechanism can determine injury*
2. LOC?
   - » *World of difference*
3. Documented physical exam with pertinent positives with emphasis on C-SPINE
   - » *This is what trauma is all about*

Trauma Continued

1. Be sure to mention any interventions
   - » *Including C-collar, Backboard*
   - » *Include any splinting or bandaging, with neurovascular exam after application*
2. If C-spine is cleared prehospital there must be documentation of how that was done
   - » *C-spine rules per protocol*
   - » *If any question go into specifics on this one*

Case #2

1. Called For 67 y/o female with known CAD presenting with CP
2. Upon your arrival she has taken 2 of her own NTG and is still having pain.

Cardiac Documentation
What do You Want to Have?

- History
  - *Onset*
  - *What they were doing when this occurred?*
  - *What they have done before your arrival?*
  - *What makes it better/worse?*
  - *Is this their Angina, or a new type of pain?*

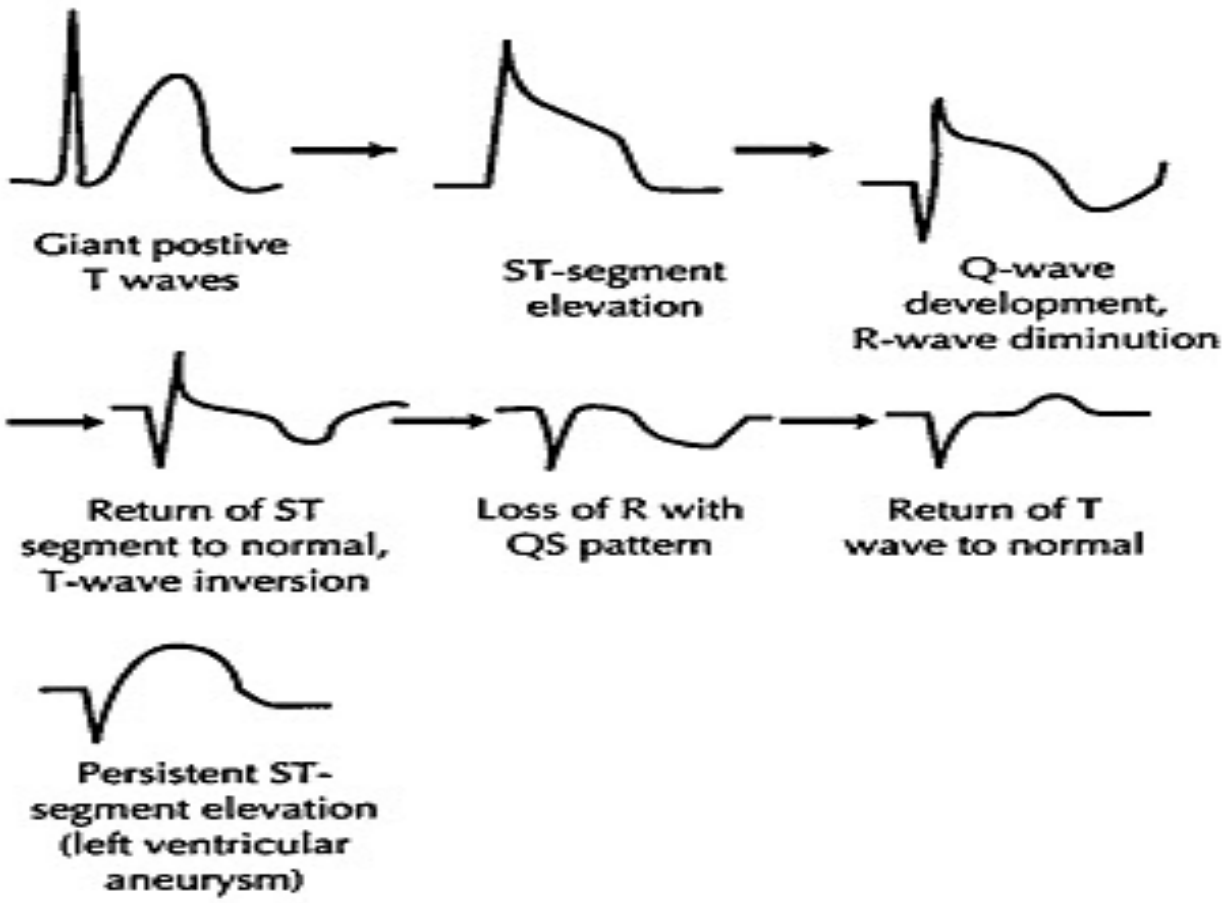
What Else

1. Physical Exam
   - *How do they look (uncomfortable, fine, dying)?*
   - *How is their breathing?*
   - *Any diaphoresis or other associated symptoms*
   - *What are their lung and CV exams*

Interventions/Course

1. Mention any relief with interventions
2. Brief mention of ECG findings
   - » *No need to repeat findings*
   - » *Okay to refer to vitals "as above"*
3. Do vitals or ECG tracings vary with your interventions?

Acute Coronary Syndrome



Case #3

- Called for Difficulty breathing
- Arrive to find 48 y/o male with history of COPD, CHF and CAD c/o progressively worsening shortness of breath

Shortness of Breath

1. Can be one of the most difficult things to figure out what exactly is going on.
2. Not everybody is wheezing all over the place
3. DDx:
   - *COPD/ Asthma exacerbation*
   - *CHF exacerbation*
   - *PE, ACS, Pneumonia, etc.*.
4. The documented story is a key piece of information

Shortness of Breath
The Basics

- Vitals with early SaO2 and capnography is key
  - *Good to see how they were before albuterol*
- Document what is on the monitor
  - *Are they having an MI masking as a COPD exacerbation?*
- Reassess and document what you see

Key Components of the Assessment and Physical

1. History
   - » *What started it?*
   - » *Is this similar to their COPD, MI, PE*

   You might get the best history
2. Physical Exam
   - » *Appearance*

   Paints a picture of the seriousness of the call
3. A lot of the key components are in the first few minutes of the encounter

Case 4

1. Called to your favorite local nursing home for altered mental status
2. Find a 98 y/o female who is "acting funny"
3. There is a temporary nurse there who doesn't know much

Altered Mental Status

1. Often times the documented EMS record is the best tool we have in the ED to figure out what is going on.
2. Sometimes your hands are just tied but get what you can

AMS the "Must Haves"

1. Baseline
   - » *What were they like before?*
   - » *How is this different*
2. Medications
   - » *Grab everything you can*
3. Accucheck
4. Baseline neurologic status
   - » *GCS, AVPU*

Some General Notes

1. No need to repeat things in your narrative that are on the sheet
2. Take a minute after the run to collect your thoughts and put together a good narrative
   - *Too hard to do it in the "heat of the moment"*
3. When "handing off" to another medic, still document what you saw and did
   - *Be sure to mention if they were there first*

Some General Notes

1. S.O.A.P notes are the standard:
2. S: Subjective: What the patient is describing. All of the identifiers of the symptoms (onset, location, quality, radiation, aggrav./relieving factors, etc.) Words like nausea, dizziness, headache, pain, chills
3. O: Objective: What your examination shows. (crepitance, tenderness, swelling/ discoloration, diaphoresis)

Some General Notes

1. A: Assessment – An impression of what is happening. Include ECG, Blood sugars, etc.
2. Plan – Interventions and reassessments after to document change in patient's conditions
3. Many software developments have truncated the normal appearance of notes. USE THE NARRATIVE.
4. Medical records can be subpoenaed and can be your key defense if malpractice is alleged.

Takin' it All Home

1. Documentation is necessary in all aspects of medicine
2. When writing your note ask "Could others who weren't there figure out exactly what was done"
3. Be aware of the "must haves" with your most common runs
4. The longest narrative isn't always the best one
5. Legibility counts !

Questions