

# Pre-Hospital Documentation

## GOAL & OBJECTIVES

At the end of this session, the student will be able to use the Vermont EMS Incident Report Form to document a pre-hospital call in a systematic and complete fashion.

Specifically, the student will be able to:

1. describe the SOAP or CHART method of charting
2. list at two principles of writing narrative comments
3. describe the role of documentation when a patient refuses care or transport
4. describe how care administered to a patient in a multiple casualty incident is documented
5. given pieces of information (in random order) about a call, properly document the assessment and treatment of the patient
6. describe the procedure to use when adding or correcting information on the run report form after the copies have been separated
7. (for Advanced EMTs only) list the pieces of information which should be recorded on the run report form when the EMT administers advanced life support in the field.

## Approaches to Organizing Narrative Comments

### The SOAP System

**Subjective**  
**Objective**  
**Assessment**  
**Plan**

### The CHART System

**Chief complaint**  
**History**  
**Assessment**  
**Rx (treatment)**  
**Transport**

### *Subjective/History*

- ▶ Chief Complaint (CC)
- ▶ History of Present Illness (HPI)
  - Onset
  - Provokes
  - Quality/Quantity
  - Region/Radiates
  - Severity
  - Time
  - Undo
  - + associated symptoms
- ▶ Past Medical History (PMH)
  - Medications
  - Allergies
  - Illnesses
  - Doctor
  - Surgery

or

**Allergies**  
**Medications**  
**Pertinent past history**  
**Last oral intake**  
**Events leading to illness or injury**

## *Objective/Assessment*

### Trauma

- ▶ pt appearance, position and surroundings
- ▶ head, eyes, ears, nose, throat
- ▶ neck
- ▶ chest
- ▶ abdomen and pelvis
- ▶ extremities

### Cardiorespiratory

- ▶ pt appearance, position and surroundings
- ▶ neck – jugular veins
- ▶ chest – lung sounds
- ▶ extremities – pedal edema
- ▶ other – oxygen saturation, EKG as appropriate

### Altered Mental Status

- ▶ pt appearance, position and surroundings
- ▶ mental status
  - AVPU
  - orientation
  - memory
  - loss of consciousness
- ▶ pupils
- ▶ trauma exam, including movement of extremities
- ▶ other - blood glucose, oxygen saturation, EKG as appropriate

### Selected Principles of Writing Narrative Comments

- Try to be chronological (within the SOAP or CHART format), including care prior to arrival of the ambulance.
- Include pertinent negatives.
- Describe, don't conclude, e.g., "pt. involved in accident" is much less informative than "pt. driver of car that hit truck head on at high speed"
- Record important observations about the scene, e.g., presence or absence of a gun, pill bottles, suicide note, etc.
- Avoid radio codes on the form - the meanings of codes change from time to time and not all of the hospital staff is familiar with our codes.
- Use abbreviations only if they are standard ones.
- Include changes in patient's condition after treatment or while en route.
- Identify the source of information when it is not the patient, especially when the information is of a sensitive nature.
- Check spelling and grammar; there are many references available to check medication names.