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**UNIT TERMINAL OBJECTIVE**

3-6 At the completion of this unit, the EMT-Intermediate student will be able to effectively document the essential elements of patient assessment, care and transport.

**COGNITIVE OBJECTIVES**

At the completion of this unit, the EMT-Intermediate student will be able to:

3-6.1 Identify the general principles regarding the importance of EMS documentation and ways in which documents are used. (C-1)
3-6.2 Identify and use medical terminology correctly. (C-1)
3-6.3 Recite appropriate and accurate medical abbreviations and acronyms. (C-1)
3-6.4 Record all pertinent administrative information. (C-1)
3-6.5 Explain the role of documentation in agency reimbursement. (C-1)
3-6.6 Analyze the documentation for accuracy and completeness, including spelling. (C-3)
3-6.7 Identify and eliminate extraneous or nonprofessional information. (C-1)
3-6.8 Describe the differences between subjective and objective elements of documentation. (C-1)
3-6.9 Evaluate a finished document for errors and omissions. (C-3)
3-6.10 Evaluate a finished document for proper use and spelling of abbreviations and acronyms. (C-3)
3-6.11 Evaluate the confidential nature of an EMS report. (C-3)
3-6.12 Describe the potential consequences of illegible, incomplete, or inaccurate documentation. (C-1)
3-6.13 Describe the special considerations concerning patient refusal of transport. (C-3)
3-6.14 Record pertinent information using a consistent narrative format. (C-3)
3-6.15 Explain how to properly record direct patient or bystander comments. (C-1)
3-6.16 Describe the special considerations concerning mass casualty incident documentation. (C-1)
3-6.17 Apply the principles of documentation to computer charting, as access to this technology becomes available. (C-2)
3-6.18 Identify and record the pertinent, reportable clinical data of each patient interaction. (C-1)
3-6.19 Note and record “pertinent negative” clinical findings. (C-1)
3-6.20 Correct errors and omissions using proper procedures as defined under local protocol. (C-1)
3-6.21 Revise documents, when necessary, using locally-approved procedures. (C-1)
3-6.22 Assume responsibility for self-assessment of all documentation. (C-3)
3-6.23 Demonstrate proper completion of an EMS event record used locally. (C-3)

**AFFECTIVE OBJECTIVES**

At the completion of this unit, the EMT-Intermediate student will be able to:

3-6.24 Advocate among peers the relevance and importance of properly completed documentation. (A-3)
3-6.25 Resolve the common negative attitudes toward the task of documentation. (A-3)

**PSYCHOMOTOR OBJECTIVES**

None identified for this unit.

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**DECLARATIVE**

I. Introduction
- A. Importance of documentation
- B. Written record of incident
  - 1. May be the only source of information for persons subsequently interested in the event
  - 2. Provides a source for identifying pertinent reportable clinical data from each patient interaction
  - 3. Legal record of incident
    - a. May be used in court proceedings
    - b. May be the EMT-Intermediate's sole source of reference to a case
  - 4. Professionalism
    - a. As a link to subsequent care, documentation may be the only means for EMT-Intermediates to represent themselves as professionals to certain other health professionals
- C. Other uses of documentation
  - 1. Medical audit
    - a. Run review conferences
    - b. Other educational forums
  - 2. Quality improvement
    - a. Tally the individual's performance of patient care procedures and to review individual performance
    - b. Identify systems issues regarding quality improvement
  - 3. Billing and administration
    - a. Acquire the necessary billing and administrative data
  - 4. Data collection
    - a. Research purposes

II. General considerations
- A. Be familiar with common medical terms, their meaning and correct spelling
- B. Be familiar with commonly-accepted medical abbreviations and their correct spelling
- C. Be familiar with common industry acronyms
- D. Incident times
  - 1. Understand the legal purposes of accurate recording of the following incident times
    - a. Time of call
    - b. Time of dispatch
    - c. Time of arrival at the scene
    - d. Time(s) of medication administration and certain medical procedures as defined by local protocol
    - e. Time of departure from the scene
    - f. Time of arrival at the medical facility (when transporting a patient)
    - g. Time back in service
- E. Accurately note in the document narrative (and elsewhere, when applicable) medical direction's advice and orders, and the results of implementing that advice and those orders
- F. "Pertinent findings"
  - 1. Findings that are relevant to the clinical situation
- G. "Pertinent negatives"
  - 1. Findings that warrant no medical care or intervention, but which, by seeking them, show evidence of the thoroughness of the EMT-Intermediate's examination and history of the event

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2. Record all “pertinent negative” findings

H. Pertinent oral statements made by patients and other on-scene people

3. Record statements made which may have an impact on subsequent patient care or resolution of the situation, including reports of
   a. Mechanism of injury
   b. Patient’s behavior
   c. First aid interventions attempted prior to the arrival of EMS personnel
   d. Safety-related information, including disposition of weapons
   e. Information of interest to crime scene investigators
   f. Disposition of valuable personal property (e.g., watches, wallets)
4. Use of quotations
   a. The EMT-Intermediate should put into quotation marks any statements by patients or others which relate to possible criminal activity or admissions of suicidal intention

I. Record support services used (e.g., helicopter, coroner, rescue/ extrication)

J. Record use of mutual aid services

III. Elements of a properly written EMS document

A. Accurate
   1. Document accuracy depends on all information provided, both narrative and checkbox, being
      a. Precise
      b. Comprehensive
   2. All checkbox sections of a document must show that the EMT-Intermediate attended to them, even if a given section was unused on a call
   3. Medical terms, abbreviations, and acronyms are properly used and correctly spelled

B. Legible
   1. Legibility means that handwriting, especially in the narrative portion of the document, can be read by others without difficulty
   2. Checkbox marking should be clear and consistent from the top page of the document to all underlying pages

C. Timely
   1. Documentation should be completed ideally before the EMT-Intermediate handles tasks subsequent to the patient interaction

D. Unaltered
   1. While writing the document, should the EMT-Intermediate make an error, a single line should be drawn through the error, initialed, and dated
   2. Should alterations to a document be required after the document has been submitted, see “document revision/ correction” (below)

E. Free of non-professional/ extraneous information
   1. Jargon
   2. Slang
   3. Bias
   4. Libel/ slander
   5. Irrelevant opinion/ impression

IV. Systems of narrative writing

A. Head to toe approach
   1. The narrative uses a comprehensive, consistent physical approach from head to toe

B. Body systems approach

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1. The narrative uses a comprehensive review of the primary body systems

C. Call incident approach
D. Patient management approach
E. Other formats
F. Know how to differentiate subjective from objective elements of documentation

V. Special considerations of documentation
A. Documentation of patient's refusal of care and/ or transport
1. When a patient refuses medical care, the EMT-Intermediate must show in the report the process undergone to reach that conclusion, including
a. The EMT-Intermediate's advice to the patient
b. The advice rendered by medical direction by telephone or radio
c. Signatures of witness(es) to the event, according to local protocol
d. Complete narrative, including quotations or statements by others
B. Document decisions/ events where care and transportation were not needed
1. If canceled en route, note canceling authority and the time
2. If canceled at scene, note canceling authority and special circumstances (e.g., "On scene officer reported no injuries and asked us to leave the scene - no patient contacts made")
C. Documentation in mass casualty situations
1. In unusual circumstances, comprehensive documentation has to wait until after mass casualties are triaged and transported
2. The EMT-Intermediate should know and follow local procedures for documentation of mass casualty situations

VI. Document revision/ correction
A. Procedure
1. Write revisions to documents on separate report forms
2. Note the purpose of the revision, and why the information did not appear on the original document
3. Note the date and time
4. Revisions should be made by the original author of a document
5. When the need for revision is realized, it should be done as soon as possible
B. Acceptable method(s)
1. Corrections
a. Written narrative is appropriate, on a new report form which is then attached to the original
2. Deletions and additions
a. Should only be done on a new report form, not the original
3. Supplemental narratives
a. If more information comes to the EMT-Intermediate's attention, a supplemental narrative can be written on a separate report form and attached to the original

VII. Consequences of errors, omissions, and inappropriate documentation
A. Implications to medical care
1. An incomplete, inaccurate, or illegible report may cause subsequent care givers to provide inappropriate care to a patient
B. Legal implications
1. A lawyer considering the merits of an impending lawsuit can be dissuaded from a case when the documentation is done correctly

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2. The converse is true if documentation is anything less

C. Timeliness

VIII. Closing

A. The EMT-Intermediate shall assume responsibility for self-assessment of all documentation

B. Peer advocacy for good documentation

1. Documentation is a maligned task in EMS, but one of utmost importance for a variety of reasons
2. A professional EMS provider appreciates this and strives to set a good example to others regarding the completion of the documentation tasks

C. Respect the confidential nature of an EMS report

D. Principals of documentation are to remain valid regarding computer charting, as that technology becomes available

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