Charlottesville Albemarle Rescue Squad | Clinical Review and Training

Outline

1. What is the CHART Format/why are you reading this?

The goal of this document is to familiarize you with the CHART format of documentation. It is not the only way to write a narrative, but it is thorough and provides a good framework for providers who are still learning. In this document are the elements of a narrative as you would present them. At the end we have also included a different format that is a bit better for describing calls that are dynamically changing. Don't forget that a Patient care report (PCR) is a tool for you to remember the events of a call long after it has occurred. Inadequate or unclear documentation is unhelpful to the patient, the hospital staff, and potentially your future self. By the end of this document you should have the tools to write a professional and complete PCR.

If you have any questions on this topic please contact your crew captain, preceptor, or the CRAT committee at training@rescue1.org.

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2. History

- **CC**: Chief Complaint/Mechanism of Injury
- **PMH**: Past medical history. "What do you take medications for?"/"What do you see a doctor for?" This is recorded in its own section, but especially relevant parts of their history can be reiterated in the narrative (*i.e. 3 past Myocardial Infarctions in a patient with CP*)
- **HPI** (Initial interview and/or pt. transfer from first responders):
    - *SAMPLE/OPQRST*. What happened during the incident and how long did it last? What happened to/what was the pt's physical and mental condition afterwards and how was that different from pt's baseline?
    - Has this ever happened to the pt. before? Did they receive a medical diagnosis then? Treatment? Does this feel exactly the same as last time or different?
    - What treatments did the pt/bystanders attempt and what were the effects? What treatments/procedures were performed by first responders and what were the effects?
    - If no bystanders and pt. unresponsive, describe area found and any info provided by dispatch. Who called 911 and why?

3. Assessment

- **Primary A_x**
    - What was the initial condition of the patient?
    - *Example*: "EMS arrived on scene to find" pt where, in what position, level of responsiveness, any ABC issues, any apparent distress, "in care of" first responders/family/bystanders
- **Note:** Consider these when performing and documenting your primary assessment. Stating that the patient is awake and talking covers the ABCs, you only need to be more specific if they're altered or unresponsive:
    - **AIRWAY**: Patent/compromised. Position of head/neck. Snoring respirations. Secretions.
    - **BREATHING**: Are they? Work of breathing (Do they look like they're struggling.)
    - **CIRCULATION**: Does pt. have a pulse?
    - **DISABILITY***: Mental status? Gross neurological deficits?
    - **EXPOSURE***: Especially with trauma you need to look for injuries that might be covered by clothing or in the patient's own crevasses. THis should be part of a primary assessment

*These last two are very important for trauma patients, but can be applied to medical patients as well. Some clinical findings won't be visible with their shirt on.

- **Secondary A_x:**
    - This is a head to toe assessment that goes into depth with individual systems. You may not be able to assess all of these systems on every call. It is important to NOT DOCUMENT THINGS YOU DID NOT ASSESS.
        - We would rather have you write that you did not assess pupils than for you to document that they were *PERRL*.

NEUROLOGICAL

Warning Indicators/Pertinent Negatives - Should be assessed and documented for all patients	If indicated, assess and document these factors for severity and potential origin
Behaving and conversing appropriately Neurological complaints (examples:) ● Headache ● Dizziness ● Weakness ● Lethargy ● Syncope/near-syncope ● Falls ● Vision changes Pupil Assessment ● Size ❑ Constricted ❑ Dilated ● Bilateral equality ● Responsiveness	Description of speech and behavior ❑ Stuttering ❑ Slow to respond ❑ Repetitive statements ❑ Confusion ❑ Inattentiveness ❑ Disorganized thinking ● How is this different from baseline? Recent increased falls or loss of balance Cincinnati Stroke Assessment ● Facial droop ● Pronator drift ○ One-sided arm drift ○ One-sided arm weakness ○ One-sided inability to hold palm face up ● Slurred speech Traumatic injury Alcohol or drug use Glucose check

PULMONARY**

- ****IMPORTANT!:** Pulmonary issues can often cause chest pain and cardiovascular issues can often cause difficulty breathing. *In the presence of warning indicators for either system, consider a more in depth assessment of both systems*.
- When describing breath sounds, more general descriptions ie "fluid noises" or simply "adventitious" is fine if you're not sure. Want practice? http://www.easyauscultation.com/lung-sounds

Warning Indicators/Pertinent Negatives - Should be assessed and documented for all patients	If indicated, assess and document these factors for severity and potential origin
Pt. complaining of dyspnea Visibly increased work of breathing Low O2 saturation Adventitious (bad) breath sounds	Tachypneic/bradypneic Accessory muscle use (belly breathing) Duration of speech ❑ Full sentences ❑ Short phrases ❑ Individual gasping words Location and description of breath sounds ❑ rhonchi (snoring) ❑ rales (rub your hair together) ❑ wheezing (hee-haw) ❑ stridor (whistle) ❑ diminished ❑ absent (hopefully only one side) Temperature

CARDIOVASCULAR**

Warning Indicators/Pertinent Negatives - Should be assessed and documented for all patients	If indicated, assess and document these factors for severity and potential origin
Pt. complaining of Acute Coronary Syndrome (ACS) ie. chest pain/numbness/tingling ● Potentially back/extremities/neck/upper abd., especially in female, diabetic, or geriatric populations Pulse assessment ● Presence of peripheral pulses ● Strength ● Bilateral equality Perfusion assessment ● Skin temperature ● Skin color ● Skin moisture ● Blood pressure	Chest pain assessment ● Known traumatic injury ● Reproducibility (NOT a rule out) Swelling in extremities Jugular Vein Distention

GASTROINTESTINAL/GENITOURINARY

Warning Indicators/Pertinent Negatives - Should be assessed and documented for all patients	If indicated, assess and document these factors for severity and potential origin
Pt. complaining of abdominal/groin pain Nausea/Vomiting ● Blood Urination and defecation ● diarrhea/constipation ● pain ● blood ● decreased output Appetite changes	Visualize abdomen Palpate abdomen in 4 quadrants

MUSCULOSKELETAL

Warning Indicators/Pertinent Negatives - Should be assessed and documented for all patients	If indicated, assess and document these factors for severity and potential origin
Traumatic mechanism Pain Ease and comfort of movement ● How does pt. normally get around?	Rapid trauma exam (see below) Focused trauma exam of injury ● Visualize ● Palpate Focused exam of non-traumatic pain ● Visualize ● Palpate ● Range of movement Difference in movement from baseline

RAPID TRAUMA EXAM (Assess and document each segment for deformity, bleeding, pain, stability).

- **Primary Survey**
  - **Airway**
  - **Breathing**
  - **Circulation**
  - **Disability**
  - **Exposure**
- **HEAD/NECK** (Before C-collar!)
  - **HEENT** (Head, ears, eyes, nose, throat)
- **BACK** (Before backboarding!)
- **CHEST**
- **ABD**
- **PELVIS**
- **EXTREMITIES** (especially PMS. *VERY IMPORTANT for new immobilization protocol*)

PSYCHOSOCIAL *(May not be necessary to document, but keep an eye out for warning signs): Appearance of living conditions. Pt. cleanliness. Interactions between pt. and caretakers/family. Suicidal ideations (thoughts? plan? history?), homicidal ideations. Pt. demeanor/affect. Increased stressors. Drug/alcohol use. Does pt. feel safe and comfortable at home?*

MVA Narrative

Accident: Public or private road, cause of accident, how many vehicles involved, points of impact, what speed, hazards (fire, fluids down, smoke, electrical wires) how many patients and their levels of acuity

Vehicle: Type of vehicle, where was the vehicle found, position, degree of damage (still drivable?), location of damage, intrusion into passenger space, airbag deployment, starring of windshield, damage to steering wheel

Patient: Location in vehicle, seatbelt, helmet, leathers, other safety equipment, points of impact, LOC, how was pt. extricated (ejection?), head/neck/back involvement, pregnancy, impairments (ETOH, cell phones, arguments)

Pregnancy A_x

- Gravida (pregnancies), Para (live births), Abortus (non-births)
- **Pregnancy H_x**: how many weeks, complications, regular checkups, prenatal vitamins, complications past pregnancies
- **Current Issues**: abd. pain, spotting, bleeding (volume, time frame, clots?), hypertension, pedal edema, blood sugar, HA, dizziness
- **Labor**: start time, water broken, minutes between contractions, crowning, 1 minute APGAR, 5 minute APGAR

Pediatric A_x

- Primary Ax (Pediatric Assessment Triangle):
    - **APPEARANCE/ACTIVITY**: Wriggling and active/too busy struggling to breathe to interact/limp.
    - **BREATHING**: Crying. Too busy struggling to breathe to cry.
    - **CIRCULATION**: Skin condition.
- Secondary Ax:
    - **Baby specific**: Pre-term. Up-to-date vaccines. Medical hx. Given any meds for complaint already (Tylenol). Known growth/mental deficiencies (via genetic testing).
    - **NEURO**: Behavior vs. baseline. Looking around curiously, meeting eyes. Crying when bothered. Shy.
    - **RESP**: Accessory muscle use (Remove clothes. Look at torso). Audible noises. Breath sounds.
    - **C/V**: Tachycardia. Skin condition.
    - **GI/GU**: Diaper output vs. baseline. Appetite changes.
    - **M/S**: No apparent traumatic injury. Moving all limbs appropriately.

4. Treatment

- What did you do during the call in order and why?
    - Medications administered (Including oxygen):
        - It can be helpful to reiterate dose and route as well as patient response
            - *Patient presented with audible bilateral wheezing and O2 saturations at 85%. Patient was placed on 15L NRB and then 2.5mg of Nebulized Albuterol and 0.5mg of Atrovent with 6L O2 were administered with improvement in patient's dyspnea by arrival in ED.*
    - Procedures
        - Backboarding, splinting, ice packs, defibrillation, etc. (should also document response to this)

5. Transport

- How did the pt. get to the truck, were there any changes in pt's condition during transport, any additional complaints, "transferred to" higher level provider "at" hospital "room" #. Belongings.

6. CHART Example:

CC: Difficulty Breathing/Anxiety

PMH: Anxiety. Depression. Asthma.

Hx:

At ~1730, pt was having an argument with his mother when he started experiencing a "tight sensation" in his chest that made it difficult for him to breathe. Pt. stated that he has had these episodes before and associates them with his anxiety. Pt's mother had him lie down on the couch and called 911.

E10 arrived to find pt. lying on couch in care of his mother. E10 reported pt. tachypneic and distressed. E10 placed the pt. on 15lpm O2 via NRB.

EMS arrived to find pt. still lying on the couch, awake and talking, in no apparent distress, respiratory rate within normal limits, but still complaining of shortness of breath. Pt. denies other medical complaints.

Ax:

Neuro: Pt. A&Ox4, conversing appropriately. Pt. complaining of headache, dizziness, and tingling in his hands. Pupils equal and reactive to light.

Pulm: Pt. states that he feels short of breath, no apparent increased work of breathing. Pt. speaking in full sentences without difficulty. Breath sounds clear to auscultation in bilateral lungs.

C/V: Bilateral radial pulses strong and equal. Pt's skin flushed, warm, slightly sweaty. Pt. denies chest pain, but is complaining of a "tight" feeling in his chest.

GI/GU: Pt. denies abdominal pain, nausea, vomiting. Pt. endorses normal urination and defecation output and normal appetite.

M/S: No apparent traumatic injury. Pt. ambulatory without difficulty.

Treatment: Pt. placed on 15lpm O2 via NRB by E10 which pt. stated did help his shortness of breath. O2 discontinued by EMS. Vitals taken.

Transport: Pt. ambulated to cot then placed in ambulance in Fowler's position. Pt. stated that his shortness of breath and anxiety were decreased by arrival at the hospital. Pt. care transferred to MD and RN at UVA rm 10 after verbal report given with his backpack.

7. Chronological Format

The CHART format is great for thorough documentation in an organized format, and it works well for patients who go through only binary or no changes during transport ie. “Pt. complaining of headache, pt. no longer complaining of headache”.

However, if the patient goes through multiple major status changes during transport, especially mental status changes, the CHART format may be too restrictive. To be accurate, the provider would have to document an assessment section for every stage of the patient’s care. For those cases, writing out a chronological narrative describing assessments, treatments, and changes as they happen may be more accurate so long as the provider is careful to include a thorough assessment including pertinent negatives.

Example:

EMS was dispatched for the unknown problem/man down. Pt. found lying supine on the sidewalk outside asleep but rousable to painful stimuli.

When roused, pt. A&Ox4 and able to answer questions appropriately, but slow to respond and lethargic. When left alone, pt. falls back asleep. PERL. Strong smell of ETOH about person. No apparent traumatic injury to head and neck. Bilateral radial pulses strong and equal. Pt. denied any medical complaints stating only that he was “very tired”.

EMS placed pt. on cot using the Reeves stretcher then loaded the pt. in the ambulance.

Checked pt’s vitals including a blood sugar which was 32mg/dL. Pt. given 15g oral glucose after it was determined that he could safely swallow.

Within 5 minutes of glucose administration, pt. became much more awake and responsive, conversing appropriately. Pt. stated that he is diabetic and that he “hasn’t had anything to eat or drink except for ETOH” for the “past couple days” and also took a “double dose of insulin this morning” because he wasn’t feeling well.

Cincinnati stroke assessment resulted in negative findings. Pt. denied chest pain or difficulty breathing, bilateral breath sounds clear to auscultation. Pt. still denied any other medical complaints.

En route to UVA hospital, pt. became unresponsive and could not be roused by painful or noxious stimuli. Noted that pt. still had strong bilateral radial pulses and was breathing adequately. Rechecked pt’s blood sugar: 63mg/dL. UVA informed about change in pt’s status and upgraded transport to emergent. Pt’s vital signs remained consistent.

Pt. care transferred to RN and MD at UVA room 10 with backpack and walking stick.