MODULE III

ASSESSMENT

LEARNING OBJECTIVES

Upon completion of this course, you will be able to:

1. Assess scene safety.
    - Recognize hazards/potential hazards.
    - Describe common hazards found at the scene of a trauma and a medical patient.
    - Determine if the scene is safe to enter.
2. Assess the need for additional resources at the scene.
    - Explain the reason for identifying the need for additional help or assistance.
3. Assess mechanism of injury.
4. Assess the nature of any illness.
    - Discuss common mechanisms of injury/nature of illness.
5. Perform an initial patient assessment and provide care based on initial assessment findings.
    - Summarize the reasons for forming a general impression of the patient.
    - Discuss methods of assessing altered mental status.
    - Discuss methods of assessing the airway in the adult, child and infant patient.
    - Describe methods used for assessing if a patient is breathing.
    - Differentiate between a patient with adequate and inadequate breathing.
    - Distinguish between methods of assessing breathing in the adult, child and infant patient.
    - Describe the methods used to obtain a pulse.
    - Describe normal and abnormal findings when assessing skin color, temperature and condition.
    - Explain the reason for prioritizing a patient for care and transport.
6. Obtain a SAMPLE history (**s**igns and symptoms of the present illness/injury, **a**llergy, **m**edications, **p**ast medical history, **l**ast oral intake, **e**vents leading to present illness/injury).
    - Identify the components of a SAMPLE history.
7. Perform a rapid trauma assessment and provide care based on assessment findings.
    - State the reasons for performing a rapid trauma assessment.

- Recite examples and explain why patients should receive a rapid trauma assessment.

8. Perform a history and physical examination focusing on the specific injury and provide care based on assessment findings.
    - Discuss the reason for performing a focused history and physical examination.
9. Perform a history and physical examination focusing on a specific medical condition and provide care based on assessment findings.
    - Differentiate between the history and physical examination that are performed for responsive patients with no known prior history and responsive patients with a known history.
    - Differentiate between the assessment that is performed for a patient who is unresponsive or has an altered mental status and other medical patients requiring assessment.
10. Perform a detailed physical examination and provide care based on assessment findings.
    - State the areas of the body that are evaluated during the detailed physical examination.
    - Explain what additional care should be provided while performing the detailed physical examination.
11. Perform ongoing assessments and provide care based on assessment findings.
    - Discuss the reasons for repeating the initial assessment as part of the ongoing assessment.
    - Describe the components of the ongoing assessment.
12. Complete a prehospital care report.
    - Apply the components of the essential patient information in a written report.
13. Communicate with the patient, bystanders, other healthcare providers and patient family members while providing patient care.
    - Discuss the communication skills that should be used to interact with the patient.
    - Discuss the communication skills that should be used to interact with the family, bystanders, individuals from other agencies while providing patient care, and hospital personnel, and the difference between skills used to interact with the patient and those used to interact with others.
14. Provide a report to medical direction of assessment findings and emergency care given.
    - Explain the importance of effective communication of patient information.

The EMT-Basic will encounter patients who require emergency medical care. It is important to identify those patients who require rapid assessment, critical intervention, and immediate transport. The components of the assessment will assist the EMT-Basic in making patient intervention decisions.

SCENARIO

You are called to the scene of an unresponsive patient. You arrive at a well-tended suburban residence and are met at the door by an anxious middle-aged woman. She tells you that she came home a few minutes ago and found her husband in bed, unresponsive. He had just finished breakfast when she left two hours ago and he was fine then.

SCENE SIZE-UP

Scene size-up is an assessment of the scene and surroundings that may yield clues to the nature of the patient's illness or injury. Ideally, it begins when you get the call. What can the dispatcher tell you about the call? Keep dispatch information in mind but don't get tunnel vision once you arrive on scene. One detail that the caller didn't relate can change the whole nature of the incident! To what area of town are you going? Is it an area known for gangs or violence? Is it a nursing home or senior living complex? Is it a busy downtown intersection or a stretch of rural highway that is a frequent site of severe crashes? Do you need extra resources started or placed on standby?

A good scene size-up will quickly identify elements that could make the scene unsafe. If you assess that the scene is not safe, don't go in. If you get there and the scene becomes unsafe, get out. "Hero" looks good on a tombstone but in reality heroes are part of the problem, not part of the solution. Shootings, assaults, cuttings, and other reports of violence make a scene unsafe until proven otherwise. Situations involving psychotic patients may be unsafe. Further, situations where there is not enough information available to ensure that the scene is safe must be approached with extreme caution. Law enforcement should respond first to these scenes.

The presence, or suspected presence, of toxic substances is another opportunity for rescuers to become victims! Do not enter these scenes unless you have the necessary protective equipment and the training to use it properly. If possible, park well out of the way and have patients brought to you once they have been properly decontaminated.

Approach crash scenes with care. These scenes can involve spills and leaks that may be slippery or, worse, may be toxic. Be alert for fire or downed power lines. Count the number of vehicles involved in the incident and get a quick look at the nature of the damage. Look for your patients. Are they trapped in the vehicle or walking around? How many are there? Order extra resources early.

Crime scenes should be approached only when cleared by law enforcement. While patient care is your first priority, don't do anything that will destroy evidence unnecessarily. Only necessary personnel and equipment should enter. Watch where you step. If you move or step on something, whether accidentally or on purpose, show law enforcement exactly what you did as soon as you can. Don't worry—they realize that these things happen and are grateful when you report them promptly.

There are things that can cause concern on any scene. Consider your access and exit routes, not just for your safety if the scene later becomes unsafe, but for practical purposes as well. Are the front steps to the house steep and unstable? If there is no back way out, you may need additional manpower. Will slopes, ice, or other surfaces be an issue? Will the patient need to be protected from extreme weather conditions? Is the patient showing signs of abuse, neglect, or inability to care for self? Do you see pill bottles, drug paraphernalia, or empty alcoholic beverage containers. Can an object near the patient be used as a weapon?

Who else is at the scene? Are they potential patients? Will they be able to manage if you remove your patient from the scene? This is a frequent issue when the primary caregiver of a bedridden or dementia patient gets sick. The same concern exists if there are small children at scene.

Determine whether the problem is medical or traumatic. Use caution—and be open to changing your mind! A car wreck may have been preceded by a stroke or heart attack. Signs of trauma may be subtle if the patient is unconscious. Information about a medical patient's **nature of illness (NOI)** may be determined from the patient, bystanders, family, or clues at the scene. How many patients do you have? Are there others in the house with similar symptoms? An entire family that comes down with "the flu" all at the same time should have you thinking carbon monoxide poisoning.

With a trauma patient, you should have started assessing **mechanism of injury (MOI)** prior to patient contact. Determine the number of patients and call for additional resources before beginning any patient care. Determine how the patient was injured. Was it a fall, a car wreck, a machinery accident, or other MOI?

What can the scene tell you about the injuries to expect? Where is the damage on the car and how severe is it? How far did the patient fall and what did they land on? Do not neglect these observations as they provide valuable information for the receiving facility in later treatment. The trauma surgeon cannot see the bent steering wheel or broken windshield but they will know what to look for if you give an accurate report. If spinal injury is likely, take precautions early.

SCENARIO	Your patient is a middle-aged male who has the appearance of general good health but is unresponsive to any stimulus. His wife gives a history of borderline diabetes and a blood clot in his leg 6 months ago. His only medications are glyburide and warfarin. You partner has noticed a blood spot on the floor and walks back to the bathroom. He notices that the bath mat is rumpled and there is a spot of blood on the wall.

INITIAL ASSESSMENT

The initial assessment begins with the general impression of the patient and is made very quickly. Look at the patients, their environment, their appearance, their activity level, and ask yourself, Is this patient sick or not? With practice, this becomes something you do without thinking but it guides your next steps. A patient who is sitting up and responds to your greeting has a patent airway, is breathing, and has a pulse. If the patient does not

seem to respond to you, assess for altered mental status. Maintain spinal precautions if indicated and gently shake the shoulder and speak to the patient.

AVPU Scale

Assess mental status using the AVPU scale:

A Alert: the patient has eyes open and talks to you.
V Verbal: the patient opens eyes to respond to voice, may or may not talk to you.
P Pain: the patient opens eyes or moves to painful stimulation.
U Unconscious to any stimulus.

ABCs: Airway, Breathing, Circulation

Once you have assessed mental status, move on to the ABCs. Assess the airway and open it if needed. If trauma is suspected, control the cervical spine and use a jaw thrust. If you can't open a trauma patient's airway with a jaw thrust, you may have to use the head tilt–chin lift method. With a medical patient, use the head tilt–chin lift. Does the patient show signs of an obstructed or partly obstructed airway?

Listen for noisy breathing. You may hear **gurgling** or **snoring**. Such patients often need an airway adjunct such as an oral or nasal airway. **Stridor** is a harsh sound from the upper airway that indicates a partial obstruction. **Crowing** is a high-pitched upper airway sound heard in children with a partial airway obstruction due to swelling. If you need to clear the airway, first try repositioning. Use suction as needed and place an adjunct if tolerated by the patient. If the airway is clear, can patients maintain it on their own? If not, insert an airway adjunct.

Check for adequate breathing. Adequate breathing is unlabored, with a rate and depth that will provide enough oxygen to the body. A patient who is breathing too fast or to slow may not be breathing adequately. Adults usually breathe 12 to 20 times a minute. Rates less than 10 or greater than 30 may not give adequate minute volume. Shallow respirations may not give adequate air exchange, even if the rate is fast.

Note any irregular respiratory pattern. Cycles of decreasing rate and depth followed by a period of apnea indicate serious distress. Lung sounds may be noisy or diminished. Absent breath sounds are a serious finding. The chest may not expand completely or may expand unevenly. This is often a problem with chest trauma. The work of breathing may be greatly increased. Agonal respirations are slow, gasping, ineffective breaths taken just before the patient becomes apneic.

If breathing is adequate and the patient is responsive, deliver oxygen if indicated. If the patient is responsive but not breathing adequately, give high-flow oxygen and be prepared to assist ventilation. If patients are unresponsive and breathing adequately, make sure they can keep their airway open and use an adjunct if they cannot. Give high-flow oxygen. If the patient is unresponsive and not breathing adequately, place an adjunct and provide ventilation with a bag valve mask (BVM) device using high-flow oxygen.

Assess the patient's circulation. A patient who is responsive and/or breathing adequately has a pulse. If the patient is unresponsive and not breathing adequately, feel for a pulse, using the carotid for an adult and the brachial for an infant. Check for at least 5 seconds but no more than 10 seconds. If you cannot feel a pulse clearly, begin chest compressions on a medical patient. If you have a trauma patient without a pulse, follow your local protocol. Some systems consider cardiac arrest due to trauma incompatible with life and do not attempt resuscitation. If any doubt exists, begin compressions. If patients have a pulse, are they perfusing well? Can you feel a radial pulse as well as a carotid pulse? Look for major bleeding and control it.

Assess the patient's skin. Note the color. If your patient has dark skin, examine the lips, palms, and nail beds. Look for normal pink color. Pale skin may indicate poor perfusion. **Cyanosis** (blue-gray skin) indicates a lack of oxygenated blood. Flushed red skin may be seen in hyperthermia and is a very late sign in carbon monoxide poisoning. Yellow or jaundiced skin is seen in liver failure. Is the skin warm or cool, taking the environment into consideration? Is the skin dry, moist, or wet? Check capillary refill. It should be less than 2 seconds in adults and children.

With the information you have gathered so far, decide whether you have a priority patient. Transport priority patients immediately and request advanced life support (ALS) backup if available. Any problem found in your initial assessment indicates a priority patient. This includes poor general impression, unresponsive or altered mental status, airway compromise, inadequate or difficult breathing, and inadequate perfusion or shock, which includes cardiac arrest, severe uncontrollable bleeding, and chest pain that is severe or accompanied by low blood pressure. With these patients, focused exam can be done en route. If the patient is not a priority, you can proceed with a focused history and physical exam at the scene.

SCENARIO

You apply oxygen and begin your assessment. The patient's airway is open and he is breathing easily at 18 times a minute. He has a strong radial pulse of 60 and a blood pressure of 180/96. His oxygen saturation is 96% on room air. His wife is very familiar with the use of his blood glucose monitor and checks his blood sugar for you. It is 130, which she says is typical for him at this time of day.

FOCUSED HISTORY AND PHYSICAL EXAMINATION

The focused history and physical examination will give you more information about the patient's condition and guide your treatment decisions. Ideally, the history is obtained from the patient. If the patient cannot answer your questions, some information may be obtained from family or bystanders. Use the mnemonic SAMPLE to assist you in getting a complete history. Ask about:

SAMPLE

Signs and Symptoms of the present illness or injury
Allergies
Medications being taken
Past medical history that may be pertinent to this incident
Last oral intake
Events leading up to the illness or injury

For a trauma patient, most serious injuries will be found during the initial assessment. Any immediate threats to life should be treated as soon as they are found. Anyone who has sustained a major MOI should have a rapid trauma exam to ensure that no serious injuries have been overlooked. Someone who steps in a hole and breaks their ankle will not usually need a full trauma assessment. For a minor mechanism of injury, the exam can be limited to the area injured.

It is important to develop a systematic approach to any assessment. This helps to ensure a complete, organized, and efficient exam. Be sure to maintain spinal stabilization if indicated. If the patient is responsive, ask them what hurts or doesn't feel right. Assess each major area for signs of injury. The mnemonic, DCAP-BTLS may be helpful:

DCAP-BTLS

- Look and feel for any **D**eformities.
- Note **C**ontusions, **A**brasions or **B**ruises, and **P**enetrating injuries. (These may indicate internal injuries.) Look very carefully. A tiny penetrating wound is easy to miss but can signal severe internal damage.
- Note any **B**urns, **T**enderness, **L**acerations, or **S**welling.

With most adults, begin by examining the head. In addition to the above signs of injury, look for blood or clear fluid coming from the ears or nose. When you assess the neck, look for the large veins on either side of the neck. The jugular veins should not be distended if the patient is supine. Apply a cervical collar if needed. Assess the chest, watching it rise as the patient breathes. Look for unequal chest rise or **paradoxical motion** (one segment of the chest rises as the other falls and falls as the rest of the chest rises).

Listen to breath sounds in the midclavicular and midaxillary lines bilaterally. Note absent, unequal, or noisy breath sounds. As you assess the abdomen, palpate in all four quadrants and note whether it is firm or soft. Note any distention or palpable masses. Gently compress the pelvis to note any motion or tenderness. Assess all extremities and check for distal pulses, movement, and sensation. While maintaining spinal stabilization, log roll the patient and assess the back. Assess baseline vital signs. Obtain a SAMPLE history if it has not already been obtained.

Medical patients should have a rapid assessment as well. If the patient is responsive, assess the **history of present illness (HPI)** and obtain a SAMPLE history. Ask about signs and symptoms. Injuries are not usually an issue, so the focus on DCAP-BTLS changes to OPQRST. When gathering information about their symptoms, ask about:

OPQRST

- **O**nset of the symptom—what they were doing when it started.
- **P**rovocation, or what seems to make it worse.
- If the symptom is pain, ask about the **Q**uality—is it sharp, dull, burning, or crushing?
- Does the pain **R**adiate anywhere?
- How **S**evere is it? Have them rate their pain on a scale of 1 to 10 with 10 being the worst the pain can be and 0 being no pain. Record their rating as part of your assessment.
- Ask what **T**ime the symptom began.

Use the same systematic approach to assess the major areas of the body as you did in the rapid trauma assessment. If the patient is conscious and gives you a specific complaint, limit your exam to that area. If the patient is unresponsive or their symptoms are vague, your assessment must be more complete. Assess baseline vital signs and determine treatment priorities based on your findings.

SCENARIO

You identify this man as a priority patient, then request additional backup if needed, and begin a rapid exam. As you examine his head, you feel what seems to be an ice bag under his head. You carefully log roll the patient and discover a bloody towel wrapped around an ice bag and a 1 inch laceration to the back of his head. The bleeding seems to have stopped.

Examination of the neck and back reveals no deformities. There is no deformity to his chest, and his lungs are clear and equal to auscultation. His abdomen is soft and his pelvis is stable. He has blood smears on his hands but no wounds or deformity to his extremities. You take spinal precautions, placing a cervical collar, long backboard and head restraint.

You review the information you have obtained so far with his wife to ensure that you have it correct. You obtain the additional information that the patient has no allergy to any medication. You reassure the wife and make sure she knows which facility you are transporting to, knows how to get there, and has appropriate transportation. The patient is then moved to the unit for immediate transport.

DETAILED PHYSICAL EXAM

A detailed physical exam may be performed on some trauma patients. It is used to gather even more information about the patient's condition. The detailed exam is generally not indicated for a minor injury; it may not be done for a critical patient either. If the patient has critical injuries, multiple injuries, and a complex ongoing exam with multiple concerns, the detailed exam will not be performed. It will not be performed on short transports where time does not allow. If your patient is fairly stable despite a major mechanism of injury and you have a long transport time, you may perform a detailed exam during transport.

Follow the systematic approach described earlier, but now you will need more time so you can be more thorough. This is especially true with the head. Using the DECAP-BTLS approach, inspect and palpate the scalp. Palpate the facial bones and look at the face for asymmetry or swelling. Check the ears for drainage. Assess the eyes for discoloration, foreign bodies, or blood. Check the pupil size and reactivity to light. Assess the nose for drainage or bleeding. Assess the mouth for loose or missing teeth, swollen or lacerated tongue, or foreign bodies.

Assess the neck again looking for distention of the jugular veins. Assess the chest for paradoxical motion. Also feel for bony crepitus. This is the grating sensation felt when broken bone ends move against each other. Subcutaneous crepitus is a similar crackling or popping sensation of tiny air bubbles felt just beneath the skin in the chest or neck as a result of air leaking from a punctured lung and getting into the soft tissue. This is a serious finding.

Reassess breath sounds. Reassess the abdomen—is it firm or soft? Are any masses or pulsations palpable? Check the pelvis for motion or crepitus. Assess all extremities for injury as well as distal pulses, movement, and sensation. Check the back if you can do so safely.

SCENARIO

En route, you perform a detailed exam. The fresh bandage you placed on the head wound has no visible blood seeping through. There is no instability or crepitus around the wound. There is no wound, swelling, or deformity to the rest of the scalp. The facial bones are stable. The left pupil is midrange in size and briskly reactive but the right pupil is dilated and reacts sluggishly. There is no blood or fluid from the nose or ears.

There are no foreign bodies, wounds, or blood in the mouth. The neck has no wound or deformity and the trachea is midline. There is no bruising to the chest, the ribs are stable, and there is no crepitus when you compress them. The lungs are clear and equal in all four quadrants. The abdomen is soft, and there is no bruising and no palpable masses. The pelvis is stable. The arms and legs show no wounds, bruising, or instability.

ONGOING ASSESSMENT

A good assessment is not an action but a continuous process that lasts for the length of the patient encounter. Once the focused exam and detailed exams are completed, go back and repeat your initial exam. If the patient is responsive and stable, you are doing this as you converse with the patient. The responses demonstrate an airway and a pulse, and the pattern of response gives an indication of mental status and ease of breathing.

For the unstable or unresponsive patient, go back and repeat the steps of the initial assessment at least every 5 minutes. Reassess every time you deliver or change an intervention. Repeat and record vital signs. Repeat a focused exam if indicated. Swelling may cause a correctly applied splint to become too tight en route. Make sure that your oxygen delivery and artificial ventilations are adequate. Don't arrive at the hospital ventilating from an empty oxygen cylinder!

Check dressings to make sure bleeding is controlled. Use the ongoing assessment to reestablish priorities. Once major bleeding is controlled, it may be time for a splint somewhere else.

SCENARIO

You reassess the patient. He remains unresponsive, with a patent airway and unlabored respirations. His blood pressure is 160/90, his pulse is 68, and his respirations are 18 bpm with an oxygen saturation of 100% on high-flow oxygen.

VERBAL COMMUNICATION

Verbal communication takes place at several points during patient care. Privacy laws dealing with **protected healthcare information (PHI)** are still fairly new and some are rather subjective. They apply to verbal communications as well as to written reports. Information that is protected by the **Health Insurance Portability and Accountability Act (HIPAA)** includes anything about the patient's medical history and treatment. It also covers any information that can be used to identify a patient, including name, address, phone number, birth date, social security number, medical record number, and even their picture! (HIPAA, 45CFR164.501). This information may be shared with those who will be providing medical care to the patient, whether it is a hospital or other healthcare facility or another emergency unit (HIPAA, 45CFR164.502). It should not be accessible to anyone not involved in the patient's care.

Communication at the scene has the potential to be most problematic. Without the permission of the patient or their personal representative, you cannot give out any information about their condition. Many patients want close family members to take part in their care and will gladly share any medical information with them, but you must never assume anything. If the patient is unconscious, the situation becomes less clear. Your agency should have policies in place.

Use good judgment. Keep your replies as general as possible. Unrelated bystanders and curious neighbors should receive information from the patient or their representative only. If they ask you questions, a friendly "Someone's not feeling well" acknowledges their concern but gives them nothing specific. You may give law enforcement officers information about the identity of, or injuries to, suspects in a crime or victims of a crime if legitimately needed for their activities (HIPAA, 45CFR164.512).

Radio communications should take place prior to arrival at the receiving facility whenever possible. This should be done over a reasonably secure line and in a manner that does not identify the patient. Radio reports should be short, usually less than 30 seconds. The receiving facility needs to know enough about the patient to decide what room to use and if any special resources (eg, ventilator, trauma surgeon) need to be obtained. Identify yourself and give your patient's age and sex with a brief description of their problem. A current set of vital signs and a summary of your treatment and the patient's response will usually be all that is needed.

Once at the hospital, introduce the patient by name and give a more detailed report to the nurse or other staff members who will assume care of the patient. This is the time to give

detailed medical history, list of medications and allergies, and any information about the scene that will be useful in the patient's care. Be careful about where this communication takes place. Crowded desk areas and curtained cubicles may allow PHI to be overheard by those not authorized to hear it.

INTERPERSONAL COMMUNICATION

Verbal and nonverbal communication also takes place with the responsive patient. Use their name. Most of society seems to have gone to a first-name basis, but remember that many older patients come from a time when use of their first name by a stranger was a mark of disrespect. Start with Mr. Doe or Ms. Smith. They will tell you if they want their first name used. In some areas of the country, using a title with a first name, such as Miss Mary or Mr. John, is considered a respectful form of address.

Position yourself where the patient can see you easily if possible. Use a calm, quiet, but confident voice. If others are raising their voice, lower yours! It helps calm the situation. Speak clearly and use language that patients can understand. Pace your questions so they have enough time to respond. If the patient is hard of hearing, don't shout because it will distort your voice. Position yourself so they can see your lips and speak distinctly.

Be honest with the patient, and don't be afraid to say "I don't know." Don't say it won't hurt if it will. Be aware of you body language and use good eye contact. No one style will work for every patient. Be aware of the patient's responses and body language and adjust your technique as needed.

PRE-HOSPITAL CARE REPORT

Filling out the paperwork may not have the excitement or the glory of running the call but it is one of the most important aspects of your care and it should be taken seriously. Complete, legible documentation will do more to keep you out of trouble, on many levels, than anything else you do. The forms you use may be dictated by the state and will certainly be dictated by your service. They have many functions. The first is to provide continuity of care. Prehospital care does not exist in a vacuum. What we do becomes a part of the patient's overall medical care and may affect care given to them hours or even days later. Your form becomes a part of the patient's permanent medical record. Your form may also be used for educational purposes or as part of a case study. It may also be used for research or for quality improvement.

Your form is also a legal document. Even if your care is perfect, it may be called into question. It's a common dictum that if it wasn't documented, it was never done. Complete legible documentation will hold up well in court; better yet, it may never become part of a court case. You may be called to testify in court as to the patient's condition or injuries if the patient became sick or injured because of a crime. In many cases this happens several years after the call so you cannot rely on memory to fill in any missing gaps in your record. It is imperative that the document be both complete and accurate.

Falsification of information can cause you to lose your job and your license. It may adversely affect ongoing care of the patient. Errors occur. When they do, document what did or did not happen and what steps were taken to correct it. Never attempt to cover up errors. If vital signs were not taken, document the reason, don't make them up. If you forgot to administer oxygen, don't document that you did. No one is perfect.

Most people are familiar with a written form with lines to fill in, some check boxes, and a place for a narrative and to record vital sign and treatments. Many services are going to computerized forms using laptop or handheld devices. While the layout and organization of the form may vary from one service to another, most have similar features.

The run data will include the date, times, service, unit number, and crew identification. Patient data will be demographic and include their name, address, birth date, race, and sex. The billing section will include information about insurance and guarantors, if indicated. There should be a place for the nature and priority of the call as well as the location of the call. Additional information such as the chief complaint, treatment prior to arrival, signs and symptoms, exam findings, history, vital signs, care administered, and changes in condition may have a separate section or check boxes.

Everything else should be included in the narrative. There are many good formats for the narrative. Your service may dictate which one you use. Otherwise, find one that works well for you that you can use consistently to give a complete, organized picture of what happened on the call. The narrative should be impartial. Describe what was said or what you found, don't draw conclusions. If you were getting different stories from different people, report both sides and identify who said what. Include observations about the scene, damage to vehicles, pill bottles, or weapons.

Include pertinent negatives—significant things that you did **not** find (eg, patient complains of chest pain but denies pain to the arm or jaw). If you use abbreviations, make sure they are standard and do not use radio codes. Your form should be easy to read. If you have poor handwriting, print slowly. If you cannot spell a word, look it up or use a different word. Be sure to record times on vital signs and treatments. If at all possible, complete your form prior to departing from the receiving facility and leave a copy. Follow local protocols for distribution of other copies.

SCENARIO

You give a brief radio report to the receiving facility and continue to monitor the patient. Upon arrival you give a detailed report to the nurses accepting care and have one of them sign your run form. You then sit down in a quiet place and document all findings and treatments in a careful, complete, and organized fashion. You give a copy to the nurse who took your report. You later find out the patient had bleeding that was causing pressure on his brain and resulting in his altered mental status and dilated pupil. You suspected that the patient was at increased risk of this with even minor head trauma because of the warfarin medication he was taking.