

	MARSING AMBULANCE EMS DISTRICT POLICY & PROCEDURES	Effective Date: 9/17/2026
TITLE: Medical Policy: Medical Documentation		Revision Date:
APPROVAL:  Medical Director  EMS Chief		

PURPOSE:

The purpose of this policy is to provide clear guidance on what information should be included in a medical document (ePCR).

POLICY:

I. Chart Creation

- a. A chart must be created on any activation whereby the ambulance departed the base. It is not required to complete a chart for activations that were cancelled prior to departure.
- b. A full chart/documentation will be completed and ready for processing no later than 72 hours from the time of the call.

II. General Narrative Documentation Standards

Narratives will be completed using the SOAP format.

Information must be documented using proper punctuation, appropriate grammar, approved abbreviations, and correct spelling

SOAP Format:

S: Subjective – Information you were given. Dispatch information—what were you dispatched to? Age, gender, complaint. History of present illness. What the patient/family member/caregiver/QRU tells you is the current problem or reason for the call. OPQRST (Onset, Provokes, Quality, Radiation, Severity, Time since onset), last meal, last menses, pertinent negatives and pertinent positives that are pertinent to the chief complaint. *Past medical history is documented in the PMH, Allergies, and Medications tab.*

O: Objective —In this section of the narrative, include a statement about how and where you find the patient upon your arrival. Include pertinent information such as damage to vehicle. Assessment findings can be placed here in lieu of the assessment tab but assessment must be thorough including pertinent negatives. This should “paint a picture”.

A: Assessment – In this section identify the patient’s primary and secondary (if indicated) diagnostic conclusions.

P: Plan – This section should “tell a story”. What was done for the patient, including care provided prior to your arrival if another agency was first on scene. Include the patient’s response to treatments and changes in condition. Where the patient was transported to and to whom you released the patient to.

III. ALS Rendezvous

- a. Document unit rendezvous occurred with
- b. Name of Paramedic and time report was provided
- c. General overview of care provided by Paramedic during transport – specific times and details are not needed as Canyon County Paramedic is required to complete their own chart

IV. Signatures

- a. All patient transport or refusal of treatment/transport charts will be signed by the EMT authoring the chart
- b. Patient/guardian signature will be obtained either electronically or physically for ALL calls unless contraindicated (minor, altered level of consciousness, physically unable). This does not apply to agency assist calls
- c. If unable to obtain – document a reason in the SOAP note under the Plan section
- d. The second crewmember will sign all patient transport charts

V. Vitals

- a. Vital signs are to be obtained and documented a minimum of every 15 min and every 5 minutes for critical or unstable patients

VI. Procedures – to be documented in the procedures section

- a. AED – Include pad placement and shocks advised/delivered
- b. 12 Lead EKG – Include the computer-generated interpretation.
- c. Airway
 - i. Type – OPA, LMA, NPA
 - ii. Size
 - iii. Difficulties encountered
 - iv. Supraglottic Airway

Medical Documentation

1. Amount air to fill cuff
 2. Confirmation of placement
 3. End tidal waveform
 4. End tidal value
 5. Auscultation lung/epigastric sounds
 6. Chest rise and fall
 7. BVM compliance
 8. SpO2 before, and post placement
- d. Spinal Immobilization
- i. Collar, board, straps
 - ii. Neuro checks pre-post
- e. Splinting
- i. Limb
 - ii. Type of splint
 - iii. Circulatory, sensory, and motor checks pre-post
- f. Wound Care
- i. Detailed description of the wound to include
 1. Size
 2. Location
 3. Depth
 4. Presence or lack of active bleeding
 - ii. Type of dressing
 - iii. Any steps taken to clean

VII. Abdominal Pain

Required Documentation:

History:

- Chief complaint
- Type and location of pain
- Description of pain
- Quality of pain
- Pregnancy/ectopic r/o
- Recent abdominal trauma

Management:

- Pain management if provided
- Any treatments provided including positioning for comfort
- Any relief of or changes in pain

VIII. Cardiac (AMI, Angina, Chest pain)

Medical Documentation

Exam:

- JVD, Chest Trauma?
- Diaphoresis?
- Edema noted?
- Mid-sternal scares?
- Breath sounds
- Equal pulses?

Required Documentation:

History:

- Chief complaint
- OPQRST
 - Onset – sudden/gradual, active/at rest
 - Provoked – anything makes it better/worse
 - Quality – sharp/dull/pain/pressure
 - Radiation
 - Severity – scale 0 - 10
 - Duration
- Treatment PTA
- Associated symptoms or complaints
- Pertinent PMH
- Pertinent medications

Management:

- O2 administration, flow rate, method of delivery
- 12 lead performed for potential cardiac and computer interpretation
- Medication administration
- Evaluations of treatments, assessments and interventions
- Any changes in pain quality, quantity, or radiation
- If STEMI – designation of STEMI alert

IX. Cardiac Arrest

Required Documentation:

History:

- Good history of events leading to arrest
- Dispatch info (who, what, and how responded)
- Down time
- PMH, current medications and Allergies
- Witnessed?
- Pre-arrival CPR? Last time scene or talked too

Management:

Medical Documentation

- CPR documented
- Application of LUCAS device
- Application of AED
- Appropriate H's and T's addressed for scope of practice
 - Hypoxia
 - Hypothermia
 - Toxins/Tablets – contact Poison Control if suspected OD
 - Trauma – blood loss control
- Evaluations of all treatments, assessments and interventions
- ALS rendezvous if appropriate
- Transfer of care, to whom

Other Documentation points:

- Temp if appropriate
- Ensure correct procedure notes for each procedure**
- Complete all fields in the CPR tab

X. Environmental Emergencies

Required Documentation:

History:

- Chief complaint
- A complete description of the current events
- Type of exposure
- Timeline of exposure

Management:

- Warming or cooling as appropriate
- Evaluations of treatments, assessments and interventions
- Follow up skin conditions and temperatures

XI. Diabetic Emergency's – General

Required Documentation:

History:

- Chief complaint
- History of current events
- Timeline leading up to today's events
- History of infection if any
- Last meal (type)
- Insulin dependent or not
- PMH, Current medications and Allergies
- Respiratory pattern

- Neuro exam

Management:

- Oral paste, IV glucose, or food given to maintain Glucose Levels
- Evaluations of treatments, assessments and interventions
- Glucose levels before and after Tx
- LOC changes before and after Tx
- ALS rendezvous if appropriate

XII. Diabetic Refusals

- All appropriate information from Diabetic – General

Other Documentation points:

- Vital Signs: At least one set, Temperature should be included
- Patient Neuro status alert and oriented OR back to baseline
- Presence of family/caretaker for ongoing monitoring
- Patient education to include
 - Need to continue oral intake to prevent additional episodes of hypoglycemia
 - See Refusal of Care/Transportation
- Base hospital contact if completed

XIII. Gynecology Emergences

Exam Section:

- Complete exam
- Abdominal exam (Guarding, distention rigidity)
- Description of discharge/bleeding

Required Documentation:

History:

- Chief complaint. Descriptions of current events
- Amount of bleeding/Discharge
- Description/location of pain
- Pertinent PMH and Medications
- Last sexual contact
- Type of contraceptive if any

Management

- Pain Management
- Evaluations of treatments
- Assessments and interventions
- Orthostatic vital signs if completed

XIV. Neurological/ Altered Mental Status/Stroke

Exam Section:

- Neuro exam noting any deficits
- Stroke Scale Assessment (if appropriate)

Required Documentation:

History:

- Chief complaint
- A complete description of events
- Timeline of onset – Last known well
- Type of changes and descriptions of LOC
- Pertinent PMH and medications

Management:

- O2 management
- Blood glucose checks
- Evaluations of treatments, assessments and interventions
- Stroke Scale reassessment or changes (If appropriate)
- Designation of Stroke Alert

XV. Obstetrics

Exam Section:

- Abdominal assessment
- If full term; Crowning?
- Bleeding/discharge description

Required Documentation:

History:

- Chief complaint
- Description of events leading up to
- Description of history
- Gestation time
- Prenatal care
- Para/Gravitas
- Bleeding/Discharge
- Seizure activity
- High risk history

Management:

- O2 administration if used
- Description of delivery noting any discharge
- Bleeding or meconium presence
- Pain management
- Procedure used to clamp and cut the cord

Medical Documentation

- Evaluations of treatments
- Assessments and interventions
- APGAR score at 1 and 5 min after delivery

XVI. Obvious Death/ DOA

Definition: To include obvious deaths both trauma, medical and patient's that crews do not begin resuscitation efforts on.

Exam Section:

- Complete exam
 - Noting why obvious death/DOA
 - Describe details of lividity/Rigor or traumatic injuries

Required Documentation:

History:

- Time last seen alive
- PMH and Meds
- Any complaints or problems prior
- Description of the scene
- Description of how patient was found
- Who found patient, who called 911
- Detailed description of why you determined Obvious Death/DOA

Management:

- What PD agency was requested and responded
- What has been done for surviving family members or who found the patient.

XVII. Patient Refusals

Criteria for Patient Refusal:

- 18 years of age and older, or emancipated minor
- Alert and oriented to person/place/time/situation
- Coherent speech
- Judgment not clouded by drugs or alcohol – presence alone does not equal impaired judgement
- No evidence of Bizarre/psychotic speech or behavior
- No evidence of life or limb threatening injuries

Exam Section

- Complete assessment, detailed exam

Required Documentation:

History:

Medical Documentation

- Chief complaint
- History of events
- Reason for call
- Description of events leading to call
- Documentation of pts level of consciousness
- ETOH or other substance usage
- Establish ability to refuse treatment and/or transport
- Pertinent negatives

Management:

- Any Tx performed
- Ensure Tx is appropriate for history
- Evaluations of treatments assessments and interventions
- Why was the Pt. refusing care
- Was the pt advised to follow up with anyone?
- Was the Pt advised of the consequences of refusal and did they understand?
- Refusal signed
- Clear statement of risks of refusing treatment/transport and acceptance of risk.

XVIII. Respiratory

Exam section:

- Complete assessment
- Airway obstruction
- Level of distress
- Signs of respiratory distress (nasal flaring, retractions, ect)
- Edema
- Lung sounds
- Skin assessment
- 12 lead EKG

Required Documentation:

History:

- Chief complaint
- Detailed description of the current events
- What position was pt found in
- # words in a sentence
- Coughing anything up
- Level of consciousness

Medical Documentation

- Fever/Infection

Management:

- O2 application if indicated
- Description of before and after treatment
- Evaluations of treatments, assessments and interventions

XIX. Trauma

Exam Section:

- Head to toe exam
- Lung sounds
- Neuro exam
- Skin exam and
- Detailed description of injuries
- Level of distress

Required Documentation:

History:

- Chief complaint
- Description of MOI
- Where the pt was found in relation to the accident
- Restraint and airbag
- Level of consciousness/Loss of consciousness
- Associated medical problems and medications

Management:

- Spinal precautions taken
- O2 application
- Management of bleeding
- Pain management
- Splinting (details)
- Evaluations of treatments
- Assessments and interventions
- Designation of a Trauma Alert if indicated
- Transfer of care – ALS/Helicopter as indicated

XX. Focused Charting Points

a. Every chart should

- Paint a picture of what you saw – the environment, the injuries, etc.
Can someone reading the chart see the picture of what you saw?

Medical Documentation

- Tell a story – from the time you arrived on scene until you turned over care – is the chronological story of the call clear?
- Vitals – Every 15 minutes, every 5 if non-stable/critical
- Assessments – detailed and includes “Pertinent negatives”