Objectives:

• At the conclusion of this lecture the student shall be able to:
  
  • Describe why to document,
  
  • Describe when to document,
  
  • Describe what to document,
  
  • Describe and implement DCHARTE method of documentation.
What is a PCR?

• Patient care report is a record of an interaction with a person that requires our services.

• It is a legal document.

• It is a record of medical procedures, assessments, changes, and conversations.
Why do we document?

• Record Care,

• Record Events,

• Provide a medical record.
When do we document?

• Any interaction with a person while functioning in a professional capacity.
What do we document?

• EVERYTHING:
  • All details,
  • All events,
  • All care,
• EVERYTHING
What is DCHARTE?

- DCHARTE is a method of documentation. The mnemonic stands for:
  - Dispatch
  - Chief Complaint
  - History of present illness
  - Assessment
  - Rx = Treatment
  - Transport
  - Exceptions
Dispatch

• What is the dispatch information:
  • Dispatched priority 1 with SJFD and SJPD to 123 Smith Street for a unresponsive male.
Chief Complaint

• What is the Chief Complaint?

• Patient is unresponsive and unable to provide chief complaint. Bystander states that patient was complaining of chest pain just prior to collapsing.
History

• What is the current history and pertinent past medical history.

• The patient was walking down the street, stopped a bystander and asked for help. He stated that he was having chest pain and could not breath. He told the bystander that he has had 5 heart attacks in the past.
Assessment

• What was your assessment.

• Make sure you document the complete assessment that you did.

• Patient is alert and oriented to person, place, time, and event; all appropriately. His neuro exam is unremarkable. Skin is warm, pink and dry. HEENT: Normocephalic, atraumatic, Pupils PEARRLA, airway clear of obstruction. Neck: Atraumatic, += carotids, no JVD, trachea is midline. CHEST: Symmetric and atraumatic, good chest excursion. LUNGS: CTAB. HEART: S1S2 no r/m/g noted. ABDOMEN: soft non-tender. PELVIS: Stable. LowExt: No noted peripheral edema, atraumatic, += CSMs. UpExt: Atraumatic, += CSMs. POST: Exam deferred due to spine board.
Rx = Treatment

- Oxygen, Monitor, 12-lead, V/S, PIV, ASA, NTG, Morphine.
• What happens during transport? How did you get there?

• Patient moved to stretcher using draw sheet method and secured with all straps. Blankets placed for warmth. Patient moved to ambulance and secured along with crew and equipment. Continues on oxygen. Patient continues to complain of pain. NTG continued per medical control (Baker MD 1232PM). Serial 12-leads done. V/S as documented. Morphine for pain (10 mg total). Transport is otherwise uneventful. Report to ED at 10 minutes out via Med One radio. Patient received in room 1 with verbal bedside report to D. Bach RN.
Exception

• What exceptions were present on call?

• Patient complains of cervical collar pain. States “take it off or I will kick you in the teeth.” After explaining to the patient the risks involved with removing the cervical collar the patient states “I don’t give a sh*t, take it off.”
Do’s and Don’ts:

• Do not erase, white out or stick note,
• Do use one line through an error write the word ‘error’ and initial,
• Use 24 hour clock “military time”,
• Only use recognized abbreviations that are approved,
• Record only objective facts,
• Late entries should be done in form of addendum,
• Don’t forget to document adverse reactions,
• BE SPECIFIC in your note,
• WNL means we never looked! Who is actually ‘normal?’
To:       AE EMS Personnel From: Chief of Operations
Subject:  Proper Narrative Descriptions

It has come to our attention from several emergency rooms that many EMS narratives have
taken a decidedly creative direction lately.
Effective immediately, all nurses are to refrain from using slang and abbreviations to describe
patients, such as the following.

1. Cardiac patients should not be referred to as suffering from MUII (missed up heart),
   PHS (pasty hot skin), PCL (purr-ear licking) or HIBGA (hid it before; got it again).

2. Senior patients are NOT "Charlie Curtain." Nor are nurses to use CCFP (Coco Cereal for Cocoa Puffs)
   to describe their mental state.

3. Trauma patients are NOT CATS (cut all to skin), FDGB (fall down, go boom), TBC (total body coren)
   or "hamburger helper." Similarly, descriptions of a car crash do not have to include phrases like "negrove
   vehicle in vehicle interface" or "terminal deconvo syndrome."

4. HAZMAT teams are highly trained professionals, not "globo worms."

5. Persons with altered mental states as a result of drug use are not considered
   "pharmacologically gifted."

6. Gunshot wounds in the head are not "trans-orbital implants."

7. The homeless are not "urban waitresses," nor is andriehic medical referral referred to as a "PVC Challenge."

8. And finally, do not refer to recently deceased persons as being "gave up,
   ART (assuming room temperature), CC (Counsel Christians), CTD (dying the dead),
   BRT (dead right there) or NLPR (no longer playing recept).

I know you will all join me in respecting the cultural diversity of our patients to include
their medical orientations in creating proper narratives and log entries.

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Summary

• Why do we document?
• When do we document?
• What do we document?
• What is DCHARTE?