Adam's Narrative Outline

Paragraph 1:

- Unit number
- How were you dispatched? (Emergent/non emergent; code 1/2/3)
- Where were you were dispatched to? (A business, intersection, residence, etc.)
- Patient demographics (age/race/gender)
- Dispatch complaint?
- Transport decision information (Why did you transport to that specific destination?)
  - Establish medical necessity, if applicable.
- Transport mode and level of care during transport (emergent/non-emergent; ALS/BLS; code 1/2/3)
- Destination room number (example: ED room 25, room 4321, ED Triage, Hall Bed, etc.)

Paragraph 2:

- What is your patient's past medical history?
- List the following:
  - Current medications
  - Recent illnesses
  - If they're compliant/non-compliant with the medications they're supposed to take
  - If they have new medications or stopped taking current ones for some reason
  - If they've had recent falls, recent injuries, etc.
    - Be sure to ask if they're on blood thinners, especially if they had a potential traumatic event.

Paragraph 3:

- Elaborate on their current complaint
  - Why did they call 911?
  - What was going on?
  - What changed?
  - What happened?
  - If they've had this complaint for several hours/days/weeks, what provoked them to call 911 *now* as opposed to several hours/days/weeks *earlier*?
  - Establish medical necessity
    - Why are they going by stretcher *today*?
    - Gather information from other healthcare personnel and document what they say about why they're going by stretcher. If necessary, name and quote the personnel.

Paragraph 4:

- What happened on scene?
- Where did you find them?
    - Were they on a couch, chair, table, floor?
    - Ditch?
    - Inside of a car? What kind of car?
    - Suspended from a pull-up exercise bar?
    - On the toilet? Naked in a bathtub? Did the bathtub have water in it?
  - What was their mental status?
    - What was their level of consciousness?
    - Was their decision-making capacity present?
      - Did they have the mental capacity to understand the consequences of their decisions?
  - Initial physical assessment

    - What did they look like?
        - Were they pale, warm, cool, sweaty, dry, hot, feverish, clammy, cold?
    - Did they have any obvious injuries or obvious physical abnormalities?
        - Did they have any bones sticking out anywhere?
        - Any massive bruising?
        - Puncture marks?
        - Track marks?
        - Contractured extremities?
        - Extremity amputations?
        - Neurological deficits?
    - What were their surroundings like?
        - Were they in a house? Was the house disheveled? Messy? Dirty? Moldy? Did it have old food laying around? Dilapidated?
        - Was drug paraphernalia laying around? Were there pill bottles scattered around? Open containers of alcohol?
        - Were they outside? On the grass? Under a tree? In the mud? Underneath bushes? On the sidewalk? On gravel? In the middle of the road?
- What was their position when you found them?
    - Supine
    - Sitting
    - Prone
    - Fetal position
    - Upside down
    - Topsy turvy
    - Face down, booty up
    - On their side? Which side?
- What did you do for/to them on scene?

- If they had a wound, fracture, or dislocation, what did you do for it?
  - Did you check pulse, motor, and sensory functions first? Spinal assessment?
    - What did you observe with that?
  - Splint it? Wrap it with something? Tourniquet?
    - How? With what? Did they have pulse, motor, and sensory functions after?
    - If you were unable to manage it in a typical manner, how did you do it? Why?
      - Was it due to the extent of the injury? Due to patient location? Patient refusal?
- Did you medicate them before any of this?
  - How? Did you start a line? How did they respond to it?
- Did you use spinal precautions?
  - Board and collar? Towel rolls? How were they secured? How were they moved to the board? How many people helped move them?
    - Document pulse, motor, and sensory functions

- How were they moved to the stretcher or into the ambulance?
  - Did they walk to the stretcher? Stand and pivot?
  - Did they have help walking? How much help?
  - Sheet pull? Carried? Extremity lift?
  - Did they walk all the way to the truck? Did they want help walking? How far did they walk?
    - Did they walk to the truck and then sit on the stretcher outside? Did they hop in through the side door?
    - Did they have a steady gait while walking?
    - Did they have any new or worsening complaints while walking?
  - How were they secured to the cot?
    - Number of straps?
    - Were the side rails up?

- Stretcher position?
  - Fowlers? Semi-fowlers? Supine? Trendelenburg? On a backboard?

- **If they were secured to the airway seat:**
  - How did they get to the airway seat?
    - Did they walk with or without assistance?
    - What was their gait like? Did they walk steadily?
    - How were they secured to the airway seat?
    - Did they request to sit in the airway seat?
      - Did they refuse to get on the stretcher and would only consent to the airway seat?

Paragraph 5:

- What happened during transport?
  - Overview of their vitals:
    - Were they severely hypertensive? Hypotensive?
    - Tachycardic? Bradycardic?
      - Irregular? Irregularly irregular? Regular? Intermittently irregular?
      - Strong? Weak? Bounding?
    - What were their oxygen saturations? What was their ETCO2? What did capnography indicate their respiratory rate was?
  - **Reassess their mental status:**
    - Was their decision-making capacity still intact?
    - Were they confused, lethargic, anxious, angry, pleasant, intoxicated, belligerent?
    - Did they have any respiratory distress? Did they complain of breathing difficulty?
      - Did they talk in full and complete sentences? Short sentences? Did they talk with difficulty? Was their speech cadence abnormal?
- Second physical assessment

    - New physical findings? Other obvious abnormalities?

- What procedures did you do?
    - Cardiac monitor?
        - What was the rhythm?
            - What was the range of their heart rate?
        - Did it change?
        - Notable ectopy?
            - PVC, PAC, PJC, runs of SVT or VTACH?
        - 12-lead information
- Venous access?
    - Angio size? Location? Number of attempts? Any issues establishing it?
        - If you were unable to establish a line, why? Poor vasculature? Patient refusal?
    - IV bag information?
        - Type of fluid?
        - Wide open? TKO? How many milliliters did they receive before you turned care over?
        - Gravity? Pressure bag? IV Pump?
- Medications?
    - Drug name? Dose? Route? Improvement/worsening? Vitals before and after?
        - If you should've given a drug but didn't, why? Patient refusal? Allergies? Too close of proximity to the hospital? Did something more important happen to prevent you from giving it?
- More detailed list of complaints from patient:
    - Chest pain?
        - Is it radiating? Sharp? Dull? Pressure? Stabbing? Made worse on inspiration? Recent cough? Possibly due to trauma?

    - If it radiates, where does it start at? Where does it go to? Arms, back, shoulder, neck, jaw, etc.
  - Physically look at chest/ribs/abdomen.
  - What did the 12-leads look like?
- Nausea/vomiting?
  - Currently? How much? When did it start? What did the vomit look like?
- Lightheadedness? Dizziness?
  - All the time? Only when standing or walking?
  - History of vertigo?
- Abdominal discomfort?
  - Location on abdomen?
  - Sharp? Pressure? Referred pain? Which quadrant?
  - If it radiates, where does it start and go to?
- Back pain?
  - Where? What does it feel like? When did it start? Chronic back pain? Radiating anywhere? History of sciatica?
- Abnormal extremity sensations?
  - Pins and needles? Complete numbness?
  - Where? When did it start? Neurological deficits?
  - Does it look like it could be a stroke or a TIA?
  - Have they ever had a stroke or TIA?
- Diarrhea?
  - Last bowel movement? When did it start? Frequency?
- Breathing difficulty?
  - Accompanied with chest pain? If so, which started first?
  - Lung sounds? Can't get air in or can't gat air out?

    - Cigarette use?
    - Neb treatments at home? Oxygen or CPAP at home?
    - Oxygen saturation? Respiratory history? CPAP? Increased effort while talking?
  - Vision changes?
    - Double vision? Blindness? Blurry? Impairment? Glasses/contacts?
- Did anything change during transport pertaining to their condition?

Paragraph 6:

- What happened when you arrived at the destination?
  - How did they go into the facility/residence?
    - Ambulate? Stretcher? Wheelchair?
- How were they moved from the stretcher to the bed?
  - Stand and pivot? Sheet pull? Sheet carry? Backboard lift? Walk?
- Who did you give report to?
  - Facility staff? Family? RN? Physician?
- Did the patient have personal belongings and/or paperwork?
  - What were the belongings?
  - Where did you leave them?
  - Was the patient and family/facility staff aware?