Event Health Services Patient Record Completion Guidelines

August 2014

Version Control

Date	Changes
January 2012	Original Version.
August 2014	Updated Version. Revised language, additional content and revised terminology.

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Contents

Introduction

The Patient Record is the standard form used by St John Ambulance Australia members for the majority of documentation of individual patient assessment, treatment and advice information.

These guidelines should be read in conjunction with a number of other important guidelines, including:

- *Event Health Services Clinical Governance Guidelines*
- *Event Health Services Clinical Accreditation Guidelines*
- *Event Health Services Credentialing Guidelines for Health Professionals*
- *Event Health Services Guidelines for Managing Patient Records*
- *Event Health Services Medication Guidelines*

All guidelines are available via Member Connect at http://members.stjohn.org.au.

Documentation is an important and integral part of the management for any patient. These guidelines have been prepared to explain how to comprehensively complete a Patient Record. These guidelines should be distributed widely, and should be used during the training of all members providing accredited and/or credentialed clinical care.

In addition to the Patient Record being an essential component of good clinical care, it is an important part of our clinical governance.

Many clinical governance activities rely on a high standard of documentation, for example:

- Recognising best practice
- Auditing clinical practice
- Informing clinical policy directions
- Informing practice innovation and change
- Identifying and taking action to actively prevent adverse patient outcomes
- Research

The Patient Record is also used to support the effective handover of a patient, usually to a Health Professional or ambulance service. Our clinical capability is often measured by the quality of the patient documentation we hand over; which means it has to be specific, accurate, legible and relevant.

Abbreviations can be misleading or misunderstood and they should not to be used when completing the Patient Record.

It is important to remember that the Patient Record can be accessed for a variety of medico-legal purposes including investigations by statutory authorities such as the Police, Safe Work Australia / WorkSafe / WorkCover or the Coroner. Legal proceedings typically occur months or years after an incident and long after you have forgotten about the patient or the case.

Patient Record

Confidential
© version 4/2014
Top copy: S/T Office
Pink copy: Patient

Patient Record
ST JOHN AMBULANCE AUSTRALIA

St John

Information collected on this record is only used in accordance with the St John Ambulance Australia Privacy Statement on the back of this record.

Date	Event / duty		Time in	Time out
Patient's family name	Given names		Sex	D.O.B. (00/00/00)
Patient's address		Postcode	Phone No.	

Allergies	**Medications**

History (What happened? How, where and when?)

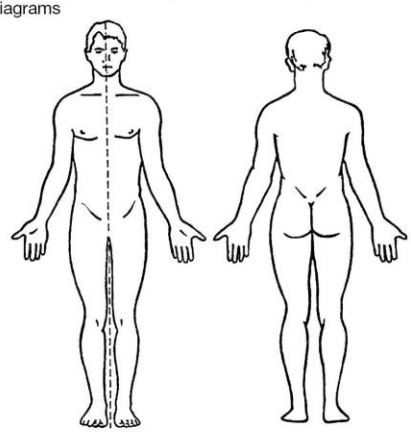
Past medical history

☐ Not known ☐ Asthma ☐ Diabetic ☐ Hypertension ☐ Medi Alert—what? .....
☐ Nil ☐ Cardiac ☐ Epilepsy ☐ Loss of consciousness ☐ other? .....

Time	Breathing	Pulse	Conscious level AVPU / GCS	Pain score	Blood pressure	Other observations (e.g. temperature)

Mark injuries on the diagrams using this legend:

A abrasion
Bl bleeding
Bu burns
C contusion
D deformity
F fracture
L laceration
P pain
S swelling
T tenderness



Overall assessment

Treatment (include any medications given: **time**, **dose** and **affect**)

☐ **Refused treatment**	Witness name	Witness signature	Phone no.

Discharged How? ☐ Ambulance ☐ Hospital ☐ Home ☐ GP ☐ Returned to event

Primary / Treating Member (print)	Signature	Member no.	Division
Secondary / Supervising Member (print)	Signature	Member no.	Division

General

All patients that are assessed, treated or provided with clinical advice must have this encounter thoroughly documented on a Patient Record. The member treating the patient must complete the Patient Record.

For all patients with a low risk clinical presentation, please refer to page 12.

In circumstances where another member completes the Patient Record on your behalf (e.g. whilst managing a complex patient) it is highly recommended that you review and amend (as appropriate) prior to completion and signing.

Ensure all Patient Records are completed as close as possible to the clinical encounter (preferably during the delivery of care), that writing is legible and that they are completed in black or blue pen. The Patient Record may be the only evidence of your encounter with a patient and may be required months or years after the event. The Patient Record is also an excellent way of promoting to other organisations the standard of health care and professionalism provided by St John.

Errors must have a single line drawn through them and be initialled. If there is insufficient space on the Patient Record, use a second Patient Record and label both Patient Records numerically (e.g. page 1 of 2, page 2 of 2, etc.).

If the patient does not speak English or you are unable to understand their speech, ‘non-English speaking’ or ‘speech not understood’ is to be documented on the Patient Record.

Event and Patient Information

Date	Event / duty		Time in	Time out
Patient's family name	Given names		Sex	D.O.B. (00/00/00)
Patient's address		Postcode	Phone No.	

Event Information

Date — Document the date of the event (DD/MM/YYYY)

Event / duty — Document the name of the event / duty / emergency (e.g. Herbville Community Festival, Grand Prix or Staging Post One – Kingston Heights Fire).

Time in — Document the time the patient arrived at the first aid post or you attended the patient. This will enable the total patient contact time to be calculated. 24 hour time should be used.

Time out — Document the time when the patient leaves the care of St John or when you leave the patient. This may be when the patient is discharged, leaves the post, or is handed over to the ambulance service. This will enable the total patient contact time to be calculated. 24 hour time should be used.

Patient Information

Patient's family name — Document the last of the patient.

Given names — Document the first and middle name (where applicable) of the patient.

Sex — Document the gender of the patient (male or female).

D.O.B. — Document the date of birth of the patient (DD/MM/YYYY). Where possible the full date of birth is preferred to the age of the patient to assist with identification of patients with similar or identical names (e.g. '22/04/1942' in preference to '68 years').

Patient's address — Document the address of the patient. Where possible this should be a complete residential/postal address, not simply a suburb to assist with contacting the patient or returning personal property if required.

Postcode — Document the postcode for the address of the patient.

Phone No. — Document the telephone contact number of the patient. This will allow the patient to be contacted promptly by St John if required (e.g. clinical follow-up, risk management).

If any patient is unknown (e.g. name where the patient is unconscious) you can write UNKNOWN however attempts should be made to add this information retrospectively wherever possible.

Allergies and Medications

Allergies	Medications

Allergies Ask the patient if they have any allergies before administering any medication. Document any allergies the patient may have. When a patient has no allergies, write 'nil known'.

Medications Document all current medications the patient is taking, has taken recently and is prescribed. This will assist in determining the patients past medical history and whether or not other medications may be administered by St John members.

History

History (What happened? How, where and when?)

Document the patient's history as described by the patient using 'What happened? How, where and when?' as a guide.

Document sufficient information that will assist a Health Professional or ambulance service to understand what has happened, how it happened, when it happened and where it happened. Always re-read this section after you have completed it to ensure that someone else reading it would know exactly what / how / when and where the injury or illness occurred.

The 'where' refers to the location where the injury / illness / incident occurred and could be at the patient's home, on the way to an event or at the event. For injuries occurring at events the location (e.g. a particular ride or place) may assist with identifying patterns of injury or illness. The 'when' gives an indication of how long the patient has had the injury or illness.

A good description of what / how / where and when will assist greatly in recalling the injury / illness / incident months or years after the event.

Past Medical History

Past medical history

☐ Not known	☐ Asthma	☐ Diabetic	☐ Hypertension	☐ Medi Alert—what? .....
☐ Nil	☐ Cardiac	☐ Epilepsy	☐ Loss of consciousness	☐ other? .....

Ask the patient about their past medical history and tick the appropriate box(es). Check if the patient is wearing a medical alert such as a bracelet / wristband (could be metal or silicon) or necklace and if so tick 'Medi Alert' and document the information provided.

Past medical history is as stated by the patient. Tick 'Not known' if this cannot be ascertained. Tick 'Nil' if the patient does not report any past medical history. If the patient has a condition that is not listed, tick 'other' and document the patient's medical history.

Observations

Time	Breathing	Pulse	Conscious level AVPU / GCS	Pain score	Blood pressure	Other observations (e.g. temperature)

Two sets of observations are encouraged for all patients, especially for patients in St John care for greater than 15 minutes.

Abnormal vital signs have been shown to be predictive of adverse outcomes including admission to intensive care, cardiac arrest and death. Assessment and recording of vital signs is necessary to ensure that deterioration of a seemingly well patient is identified.

The frequency of recording observations will depend on the severity of the patients injury or illness, or as directed by a health professional. Observations should be undertaken every 15 minutes whilst a patient remains in St John care. However more frequent observations may be required for patients with acute or serious injuries and/or conditions.

For all patients with a low risk clinical presentation, please refer to page 12.

Time — Document the time that observations are taken. This will allow for trends in vital signs to be observed. 24 hour time should be used.

Breathing — Count the patient's respiratory rate and document the rate in breaths per minute.

Pulse — Count the patient's pulse rate and document it in beats per minute.

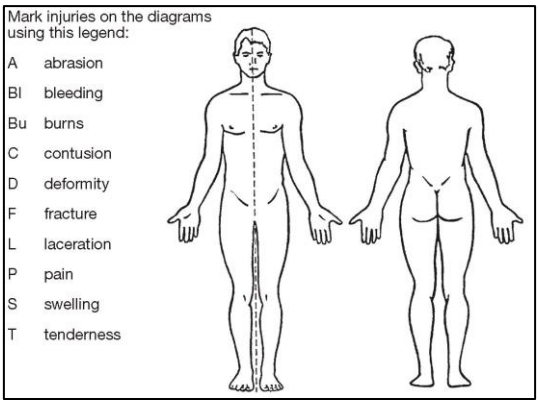
Conscious level — Determine the patient's level of consciousness and document using the AVPU scale or Glasgow Coma Scale (GCS).

Pain score — For patients experiencing pain (especially if being given analgesia (i.e. paracetamol or Methoxyflurane)) document a pain score out of 10. A pain score should be recorded both before and after the administration of analgesia.

Blood pressure — If accredited, obtain the patient's blood pressure and document the reading as systolic blood pressure / diastolic blood pressure.

Other observations — Other observations (other than breathing, pulse, conscious level, pain score and blood pressure) should be recorded in this section. Other observations may include: temperature, blood glucose level, distal pulses and oxygen saturation levels as appropriate. All patients with suspected dislocations, fractures or soft tissue injuries must have distal pulses recorded and documented as other observations. Temperature should be assessed where a patient is suspected of consuming substances associated with 'dance party' type events.

Injury and Illness Identification



Mark the affected area appropriately on the body and head charts using the injury legend.

Indicate symptoms (pain), signs (bleeding, deformity, swelling and tenderness) or injuries (abrasion, burn, contusion, fracture, laceration) by drawing an arrow or shading / marking the relevant area and label with the corresponding abbreviation (more than one can be used). If the item you wish to describe is not on the list, free text can be used to assist in describing the injury or illness.

For all patients with a low risk clinical presentation, please refer to page 12.

Overall Assessment

Overall assessment

Document your overall assessment of the patient (provisional diagnosis or impression of the clinical situation). An exact diagnosis is not required – this is a brief description of your assessment of the patient and what you are treating them for.

Descriptions such as the following are acceptable:

- Suspected fracture [insert location]
- Sprained [insert location]
- Laceration/abrasion
- Head injury
- Suspected intoxication
- Headache
- Chest pain
- Nausea/vomiting
- Allergic reaction / Anaphylaxis

Treatment

Treatment (include any medications given: **time**, **dose** and **affect**)

Document accurately the treatment and information about any medications given (including time, does and affect.

Treatment

Any treatment provided to the patient must be recorded in this section. If no specific treatment is provided then 'assessment only' can be written. Treatment can be documented in point form provided that sufficient information is provided.

Documentation should include whether and who the patient was handed over to. For example, patient transferred to the care of the onsite Medical Assistance Team or patient handed over to Peter Jones (St John Registered Nurse) or patient transported to hospital. Also document the use of a stretcher, spine board or carry chair to assist with the initial movement and transport of a patient.

Any clinical advice or after care instructions given to the patient must also be documented in this section. **Put simply, if clinical advice is not documented then it was not given.** Members must only give clinical advice and must only provide advice consistent with their level of St John clinical accreditation. Head injury advice is available on the rear of the Patient Record pad.

Medication given

All medications given by accredited and/or credentialed members as a result of an appropriate assessment must be documented. This must include their affect and, as required, subsequent vital signs.

Time

The time that any medication is given or procedure undertaken must be documented.

Dose

The dose of any medication given must be documented. Where possible (and practical) generic names of medications should be used rather than trade names (e.g. paracetamol rather than Panadol).

Route

The route of administration for any medication given must be documented.

Refused Treatment

☐ Refused treatment	Witness name	Witness signature	Phone no.

If treatment is refused, tick the 'Refused treatment' box and document comprehensively the circumstances of the refusal and have this signed by a witness.

Patients who are competent (and able to understand the consequences of their choices i.e. receive, believe, retain and explain information given to them) are able to refuse assessment and/or treatment even if treatment is required. It is imperative that the circumstances of the refusal are thoroughly documented. Any risks explained to the patient must be documented.

Caution is needed with patients suffering from mental health problems who are threatening suicide or self-harm and for patients who are affected by drugs and/or alcohol. Assistance should be sought from a Health Professional if available or from ambulance or police as appropriate for these patients.

Discharge

Discharged How?	☐ Ambulance	☐ Hospital	☐ Home	☐ GP	☐ Returned to event

Document how the patient was discharged (e.g. ambulance, hospital, home or returned to event). Document who the patient was discharged with (e.g. self, friend, family, parent – including name where possible) and how the patient was discharged (walked, private vehicle, bus or train).

If a patient is referred to hospital by ambulance, document the ambulance vehicle number and the hospital the patient is being transported to.

Concluding Treatment

Primary / Treating Member (print)	Signature	Member no.	Division
Secondary / Supervising Member (print)	Signature	Member no.	Division

On completion of treatment, the treating member must print their name (in block capitals), sign in the space provided, include their clinical accreditation level (FA, FR, AR, Health Professional), their member number and their unit (Division, Region, State, National).

The 'Time out' (time patient left the care of St John) is to be documented at the top of the Patient Record. This is essential to determine the total care time.

Low Risk Clinical Presentations

Whilst a Patient Record is required for all who are assessed, treated or provided with advice, it is recognised that some patients and encounters are considered to be low risk clinical presentations and as such do not require assessment of vital signs.

Low risk clinical presentations are:

- Contusion to the periphery with minimal swelling and pain
- Insect bite - minimal swelling, no history of allergy and no sign of Anaphylaxis
- Mild sun burn
- Simple wound – abrasion (smaller than 7.5cm x 7.5cm)
- Simple wound – superficial, clean laceration not requiring suturing
- Simple wound – needing a single Band-Aid
- Simple wound – small friction blister
- Uncomplicated epistaxis (with bleeding controlled in < 5 minutes)

Patients who fall into the low risk clinical presentation category listed above still require a Patient Record to be completed, however, no vital sign assessment or recording of injuries on the patient diagram is required.

If unsure about the level of risk or severity with any patient presenting for treatment, a complete Patient Record should be generated.