EMS Charting Training Manual

Comparison and General Guidelines: When to Use LCHART vs. DRAATT

Comparison Table

Aspect	LCHART	DRAATT
Primary Focus	Patient-centered, emphasizing clinical findings and interventions.	Chronological flow of events and actions taken.
Best For	Complex cases with detailed assessments (e.g., chest pain, trauma, stroke).	Routine or time-sensitive cases with a clear event timeline.
Structure	Organized by sections focused on patient care.	Organized chronologically, following the timeline of events.
Detail Level	High clinical detail, in-depth documentation.	Moderate detail with a focus on sequence of actions.
Ease of Learning	Requires more training and practice to master.	Easier to learn and apply, especially for beginners.

General Guidelines for Use

1. **Use LCHART When:**
    - The case is clinically complex and requires thorough documentation of assessments and treatments.
    - You need to prioritize patient-centered details for legal, medical, or review purposes.
    - The case involves significant interventions, such as advanced airway management, medication administration, or high-risk conditions.
2. **Use DRAATT When:**
    - The case involves routine or less complex scenarios (e.g., basic life support, transport cases).
    - A clear chronological flow of events is required for simplicity and quick understanding.

- Training new EMTs who need an easy-to-follow framework for documentation.

Part 1: LCHART Training Guide

Purpose

LCHART is designed for clinically complex cases where detailed documentation is essential for patient care and legal compliance.

Components

1. Location

- **What to Document:**
  - Address or exact scene location.
  - Scene details: hazards, lighting, indoors/outdoors.
- **Example:**
  - "Dispatched to 450 Elm St, patient found in the bedroom on the second floor."

2. Chief Complaint

- **What to Document:**
  - Patient's primary issue, quoted verbatim if possible.
  - Observations if the patient is non-verbal or unconscious.
- **Example:**
  - "Patient states, 'I can't breathe.'"

3. History

- **What to Document:**
  - Events leading to the call.
  - Relevant medical history, chronic illnesses, medications, allergies.
  - **Include Pertinent Negatives:**
    - Example: "No prior chest pain or known cardiac conditions."

- **Example:**
    - "Patient felt chest pain 30 minutes ago while gardening. History of hypertension."

4. Assessment

- **What to Document:**
    - Findings from the primary and secondary surveys.
    - Vital signs and diagnostic results.
    - Include changes over time.
- **Example:**
    - "Patient alert, BP 160/90, SpO2 89%. Chest pain radiating to left arm."

5. Rx (Treatment)

- **What to Document:**
    - Medications administered with dose and response.
    - Procedures performed, like IV insertion or splinting.
- **Example:**
    - "Administered ASA 324mg PO. Oxygen 15L NRB improved SpO2 to 96%."

6. Transport

- **What to Document:**
    - Mode and priority of transport.
    - Patient's condition during transit.
    - Environmental factors, such as traffic delays.
- **Example:**
    - "Transported non-emergently to General Hospital. Stable en route."

Best Practices

- Use the acronym to structure notes consistently.
- Double-check entries for completeness.

- Avoid ambiguous language.
- Review the chart with a peer for critical cases.

Part 2: DRAATT Training Guide

Purpose

DRAATT is ideal for straightforward or time-sensitive cases where documenting a clear sequence of events is crucial.

Components

1. Dispatch

- **What to Document:**
    - Information received during dispatch.
    - Caller details, time of call.
- **Example:**
    - "Dispatched at 13:45 for a 52-year-old male, unresponsive."

2. Response

- **What to Document:**
    - Time en route, arrival time, and scene description.
    - Initial impressions and scene challenges.
- **Example:**
    - "Arrived on scene at 13:55. Patient found supine on living room floor."

3. Assessment

- **What to Document:**
    - Primary and secondary surveys.
    - Vital signs and diagnostic findings.
- **Example:**
    - "Airway patent, breathing labored, BP 88/60. Cyanosis noted."

4. Actions

- **What to Document:**
    - Treatments and interventions performed.
    - Patient response to each intervention.
- **Example:**
    - "Administered 500mL IV NS. BP improved to 102/70."

5. Transport

- **What to Document:**
    - Mode of transport and patient status during transit.
- **Example:**
    - "Transported emergently. SpO2 maintained at 95% with 15L NRB."

6. Transfer

- **What to Document:**
    - Handoff details and patient condition.
    - Include the names and roles of receiving personnel.
- **Example:**
    - "Care transferred to RN Johnson at 14:20. Verbal and written report provided."

Best Practices

- Document in chronological order.
- Ensure all time-sensitive details are accurate.
- Use specific terminology and approved abbreviations.
- Conduct mock call scenarios regularly to reinforce DRAATT's simplicity.

Final Notes

This training document reflects the collective expertise of EMS professionals, physicians, and legal experts. It provides a comprehensive guide to mastering LCHART and DRAATT,

ensuring that EMTs can produce accurate, professional, and legally defensible documentation. Regular practice and periodic updates will ensure continued excellence in EMS charting.