

We are working toward implementing a unified structured narrative format across the two existing EMS agencies. After thorough consideration, we have narrowed down the options to two final formats and would like to gather your feedback. To streamline navigation, this document is organized into sections for easy reference using the navigation pane.

Summary

LCHART and DRAATT are structured methods for EMS narrative charting, each with distinct strengths. LCHART emphasizes clinical detail and comprehensive patient-centered documentation, ideal for complex cases. DRAATT focuses on clear chronological flow, making it well-suited for routine or time-sensitive scenarios. This document highlights their unique advantages, practical applications, and key considerations for effective use.

Overview

LCHART and **DRAATT** are two structured frameworks for EMS narrative charting. Both methods aim to enhance the clarity, thoroughness, and professionalism of documentation while addressing legal and operational requirements. This comparison evaluates the strengths, weaknesses, and best use cases for each method based on key metrics such as clarity, adaptability, teachability, and legal compliance.

Key Components

Component	LCHART	DRAATT
Acronym Breakdown	Location, Chief Complaint, History, Assessment, Rx (Treatment), Transport	Dispatch, Response, Assessment, Actions, Transport, Transfer
Focus	Patient-centered; emphasizes clinical findings and interventions	Chronological flow; focuses on event progression and actions taken
Main Strength	High clarity and usability in clinical settings	Strong chronological organization, ideal for operational contexts

Best Fit	Clinically complex cases requiring detailed assessment and treatment documentation	Straightforward cases with a clear timeline of events
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Here's a detailed break down of each with a comparison at the end.

CHART Training Manual: A Comprehensive Guide to Mastering EMS Narrative Charting

Introduction to LCHART

The **LCHART method** is a structured approach to EMS narrative documentation, designed to ensure clarity, compliance, and accuracy in pre-hospital care records. The acronym **LCHART** stands for:

- **L**ocation
- **C**hief Complaint
- **H**istory
- **A**ssessment
- **R**x (Treatment)
- **T**ransport

This training manual provides a detailed walkthrough of the LCHART method, step-by-step guidance for each component, examples, and best practices to ensure thorough and effective charting.

Why LCHART?

1. **Clarity and Structure:**
 - Simplifies complex narratives by organizing information logically.
 - Reduces ambiguity, improving the readability and utility of reports.
2. **Legal Protection:**
 - Ensures compliance with documentation standards and legal requirements.
 - Provides a clear timeline of events for audits, reviews, or court cases.
3. **Operational Efficiency:**
 - Speeds up the documentation process with a structured framework.
 - Minimizes errors and omissions through a standardized approach.
4. **Professionalism:**
 - Enhances the quality of documentation, reflecting positively on EMS providers.

Breaking Down the LCHART Components

1. Location

Definition: Document where the incident occurred and where the patient was found.

- **Why It's Important:**
 - Establishes the context of the call.
 - Essential for legal and operational tracking.
- **What to Include:**
 - Exact address or descriptive location (e.g., "125 Main St, living room" or "Highway 101, northbound lane, mile marker 15").
 - Scene details: indoors/outdoors, lighting conditions, hazards.
- **Example:**
 - "Dispatched to 450 Elm St, patient found in the bedroom on the second floor."

2. Chief Complaint

Definition: The primary reason for the EMS call, as stated by the patient or bystanders.

- **Why It's Important:**
 - Guides the assessment and treatment plan.
 - Central focus of the narrative.
- **What to Include:**
 - Patient's own words, if possible (use quotes for verbatim).
 - Observations when the patient is unable to communicate.
 - Bystander accounts if the patient is unconscious.
- **Example:**
 - "Patient states, 'I feel like I can't breathe.'"
 - "Bystander reports the patient collapsed suddenly while jogging."

3. History

Definition: A detailed account of events leading to the current situation and relevant medical history.

- **Why It's Important:**
 - Provides context for the patient's condition.
 - Helps identify potential underlying causes.
- **What to Include:**
 - Onset: When symptoms started and what the patient was doing.
 - Pertinent medical history: Chronic conditions, medications, allergies.
 - Events leading to EMS arrival: Witness accounts, mechanisms of injury.
- **Example:**

- "Patient states they began feeling chest pain 30 minutes ago while gardening. History of hypertension and high cholesterol. No known allergies."

4. Assessment

Definition: Documentation of findings from the patient assessment.

- **Why It's Important:**
 - Forms the basis for treatment decisions.
 - Ensures continuity of care by providing a detailed clinical picture.
- **What to Include:**
 - Primary survey: Airway, breathing, circulation.
 - Secondary survey: Focused exam based on the chief complaint.
 - Vital signs: Initial and subsequent readings.
 - Diagnostic findings: ECG, blood glucose, SpO2, etc.
- **Example:**
 - "Initial assessment: Patient alert and oriented x3, breathing labored, BP 160/90, HR 112, SpO2 89% on room air. Chest pain reported as 8/10, radiating to left arm. ECG shows ST-elevation."

5. Rx (Treatment)

Definition: Record of all treatments administered during the EMS encounter.

- **Why It's Important:**
 - Documents clinical interventions and their outcomes.
 - Serves as proof of care provided.
- **What to Include:**
 - Medications: Name, dose, route, time of administration, patient response.
 - Procedures: IV insertion, oxygen therapy, splinting, etc.
 - Changes in patient condition post-treatment.
- **Example:**
 - "Administered 324mg ASA PO, 0.4mg Nitro SL x2 with improvement in chest pain to 4/10. Oxygen 15L NRB applied, SpO2 improved to 96%."

6. Transport

Definition: Details of the transport phase, including patient's condition and destination.

- **Why It's Important:**
 - Ensures a complete record of the EMS encounter.
 - Provides receiving facilities with critical handover information.
- **What to Include:**
 - Mode of transport: Emergent, non-emergent.
 - Destination: Name and type of receiving facility.
 - Patient's condition en route.

- Handoff report: Information shared with receiving staff.
 - **Example:**
 - "Transported non-emergently to General Hospital ED. Patient remained stable en route. Report given to RN Smith at 14:35."
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Common Pitfalls and How to Avoid Them

1. **Omitting Key Details:**
 - Always include pertinent negatives (e.g., "No history of diabetes or heart disease").
 2. **Using Ambiguous Language:**
 - Be specific (e.g., "Patient's pain improved from 8/10 to 4/10 after treatment" instead of "Patient felt better").
 3. **Inconsistent Terminology:**
 - Use standard medical abbreviations and avoid slang.
 4. **Incomplete Vital Signs:**
 - Ensure all vital signs are recorded at appropriate intervals.
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Best Practices for Using LCHART

1. **Plan Before Writing:**
 - Quickly jot down key points during the call to ensure nothing is missed.
 2. **Follow the Acronym Strictly:**
 - Document each section in order to maintain consistency and completeness.
 3. **Review and Revise:**
 - Double-check your narrative for clarity and completeness before submission.
 4. **Practice Regularly:**
 - Use mock scenarios to build proficiency with the LCHART method.
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Conclusion

Mastering the LCHART method is essential for creating clear, comprehensive, and legally defensible EMS narratives. By following the steps outlined in this manual, EMS providers can ensure their documentation reflects the high standards of care delivered in the field. Consistent use of LCHART not only improves operational efficiency but also enhances patient care and professional reputation.

DRAATT Training Manual: A Comprehensive Guide to EMS Narrative Documentation

Introduction to DRAATT

The **DRAATT method** is a structured EMS documentation framework designed to ensure thoroughness and clarity in pre-hospital narratives. The acronym **DRAATT** stands for:

- Dispatch
- Response
- Assessment
- Actions
- Transport
- Transfer

This training manual provides detailed guidance on each component of the DRAATT method, practical examples, and best practices for efficient and compliant documentation.

Why DRAATT?

1. **Clarity and Organization:**
 - Provides a logical sequence of events from dispatch to patient transfer.
 - Reduces confusion, ensuring that reports are easy to read and understand.
 2. **Comprehensive Coverage:**
 - Captures every aspect of the EMS encounter, leaving minimal room for omissions.
 3. **Operational and Legal Safeguards:**
 - Ensures compliance with regulatory requirements and documentation standards.
 - Provides a clear record for audits, reviews, and legal proceedings.
 4. **Professionalism:**
 - Establishes consistency and professionalism in EMS narratives.
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Breaking Down the DRAATT Components

1. Dispatch

Definition: Details about the initial call and information received during dispatch.

- **Why It's Important:**
 - Establishes the starting point of the EMS encounter.
 - Sets the stage for understanding the context of the call.

- **What to Include:**
 - Nature of the call (e.g., "Unresponsive adult male").
 - Time of dispatch and responding unit(s).
 - Pertinent information from dispatch (e.g., caller's description, location hazards).
- **Example:**
 - "Dispatched at 13:45 for a 52-year-old male, unresponsive. Caller reported patient collapsed at home."

2. Response

Definition: Documentation of the EMS unit's journey to the scene and any relevant details upon arrival.

- **Why It's Important:**
 - Provides a timeline of events leading up to patient contact.
 - Highlights environmental factors and initial observations.
- **What to Include:**
 - Time en route, arrival time, and scene description.
 - Environmental factors (e.g., weather, traffic).
 - Initial impressions upon arrival.
- **Example:**
 - "Unit responded non-emergently, arriving on scene at 13:55. Patient found lying supine on the living room floor. No apparent hazards."

3. Assessment

Definition: Findings from the primary and secondary assessments of the patient.

- **Why It's Important:**
 - Forms the basis for clinical decision-making and treatment plans.
 - Ensures a detailed record of the patient's condition.
- **What to Include:**
 - Primary survey: Airway, breathing, circulation (ABC).
 - Secondary survey: Detailed physical exam and focused assessments.
 - Vital signs and diagnostic findings (e.g., SpO2, ECG).
- **Example:**
 - "Primary survey: Airway patent, breathing labored, pulse weak. BP 88/60, HR 120, SpO2 88% on room air. Secondary assessment revealed cyanosis, diminished breath sounds bilaterally."

4. Actions

Definition: All treatments and interventions performed during the call.

- **Why It's Important:**
 - Provides a record of care delivered and its impact on the patient.

- **What to Include:**
 - Medications administered (name, dose, route, time).
 - Procedures performed (e.g., CPR, intubation, splinting).
 - Patient's response to interventions.
- **Example:**
 - "Administered 500mL NS IV bolus, BP improved to 102/70. Oxygen therapy initiated at 15L NRB, SpO2 increased to 95%."

5. Transport

Definition: Details of the patient's condition and care during transport.

- **Why It's Important:**
 - Ensures continuity of care between EMS and the receiving facility.
- **What to Include:**
 - Mode of transport (e.g., emergent, non-emergent).
 - Patient condition en route.
 - Interventions performed during transport.
- **Example:**
 - "Transported emergently to Regional Medical Center. Patient remained stable en route with SpO2 maintained at 95% on 15L NRB."

6. Transfer

Definition: The handover of care to the receiving facility.

- **Why It's Important:**
 - Completes the documentation of the EMS encounter.
 - Provides receiving staff with critical patient information.
- **What to Include:**
 - Time of transfer.
 - Report given to receiving personnel (name and role).
 - Patient's condition upon transfer.
- **Example:**
 - "Transferred care to ED RN Johnson at 14:20. Patient stable, SpO2 95% on 15L NRB. Verbal and written report provided."

Common Pitfalls and How to Avoid Them

1. **Inconsistent Timeline:**
 - Ensure times match across all sections (e.g., dispatch, arrival, transfer).
2. **Incomplete Details:**
 - Always include pertinent negatives (e.g., "No signs of head trauma").
3. **Ambiguous Descriptions:**

- Be specific and avoid vague terms (e.g., "moderate pain" without a scale).
 - 4. **Missed Vital Signs:**
 - Document all vital signs at appropriate intervals.
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Best Practices for Using DRAATT

1. **Chronological Accuracy:**
 - Follow the sequence of events strictly to maintain logical flow.
 2. **Comprehensive Notes:**
 - Ensure each section contains sufficient detail for continuity of care.
 3. **Review for Errors:**
 - Double-check for missing times, vital signs, or interventions.
 4. **Practice with Scenarios:**
 - Use mock calls to refine documentation skills.
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Conclusion

The DRAATT method is a powerful tool for EMS narrative documentation, emphasizing clarity, thoroughness, and professionalism. By mastering the steps outlined in this manual, EMS providers can ensure their reports meet the highest standards of care and compliance. Regular practice and adherence to DRAATT principles will lead to more efficient and effective documentation.

Comparison of LCHART and DRAATT Narrative Charting Methods

Overview

LCHART and **DRAATT** are two structured frameworks for EMS narrative charting. Both methods aim to enhance the clarity, thoroughness, and professionalism of documentation while addressing legal and operational requirements. This comparison evaluates the strengths, weaknesses, and best use cases for each method based on key metrics such as clarity, adaptability, teachability, and legal compliance.

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Detailed Comparison

1. Clarity and Organization

- LCHART:** Excels in organizing clinical details with a logical flow focused on the patient’s condition and treatment. Ideal for medical reviews.
- DRAATT:** Provides a clear chronological narrative, making it easier to track events but can be less detailed about clinical findings.

2. Legal Compliance

- LCHART:** Strong in capturing all necessary medical and legal details, minimizing liability risks.
- DRAATT:** Meets legal requirements but relies on the completeness of chronological entries for defensibility.

3. Adaptability

- **LCHART:** Adaptable to a variety of clinical scenarios, particularly those requiring in-depth assessments.
- **DRAATT:** More rigid due to its chronological nature, best for routine cases.

4. Teachability

- **LCHART:** Slightly more challenging to teach due to its clinical focus but offers long-term benefits for advanced documentation skills.
- **DRAATT:** Easier to teach and learn, especially for new EMS providers, due to its straightforward structure.

5. Documentation Teaching Effectiveness

- **LCHART:** Provides a deeper understanding of patient care and clinical reasoning, making it a robust teaching tool for advanced EMS training.
- **DRAATT:** Focuses on process-driven documentation, which is easier to learn but less nuanced in clinical reasoning.

6. Risk Mitigation

- **LCHART:** Reduces omissions with its structured focus on clinical and transport details.
- **DRAATT:** Ensures no step in the event timeline is missed but may underemphasize specific clinical findings.

7. Usability in EMS Charts

- **LCHART:** Integrates seamlessly with EMS software, particularly those prioritizing clinical data.
 - **DRAATT:** Works well with EMS systems that emphasize time-stamped event logging.
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Strengths and Weaknesses

Metric	LCHART Strength	DRAATT Strength	Potential Weakness
Clarity	Detailed and logical structure	Simple chronological flow	DRAATT may lack clinical depth
Legal Compliance	Comprehensive clinical and legal coverage	Strong timeline focus	LCHART requires diligence for consistency
Teachability	Robust for advanced providers	Easier for beginners	LCHART takes longer to master
Adaptability	Suitable for diverse clinical cases	Best for straightforward scenarios	DRAATT may not fit complex cases
Risk Mitigation	Thorough clinical and operational details	Ensures event sequence is captured	May overlook nuanced clinical issues

When to Use Each Method

Use LCHART When:

- Cases involve complex clinical assessments (e.g., chest pain, trauma, stroke).
- Detailed documentation of treatments and patient responses is critical.
- Reports need to prioritize clinical accuracy for medical or legal reviews.

Use DRAATT When:

- Cases are routine or time-sensitive, such as non-critical transport or basic life support.
- A clear chronological sequence of events is required.
- Training new EMS providers on fundamental documentation skills.

Conclusion

Both LCHART and DRAATT offer unique strengths tailored to different EMS scenarios. While **LCHART** excels in clinical depth and detailed documentation, **DRAATT** is optimal for clear, event-driven narratives. EMS providers should select the method that aligns best with the complexity of the case, the operational environment, and documentation priorities. Mastery of both methods ensures adaptability and excellence in EMS narrative charting.