Royal College of Physicians

Setting higher standards

National Ambulance Documentation Standard

Final headings

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Ambulance headings and subheadings

Incident details	
Subheadings	**Clinical description**
Source of call	Where the call originated from e.g. 999, NHS 111, police, GP, hospital etc.
Caller details	The name and phone number of the person making the call and the relationship of the caller to the patient if known. Also whether the caller is with the patient.
Ambulance service	The ambulance service provider. This could be NHS, voluntary or private provider.
Incident number	The number that identifies the incident and is generated by the dispatcher in response to a call.
Incident date	The date of the incident.
Incident time	The time the incident occurred.
Time call received	The time that the call is connected to the ambulance control centre switchboard.
Incident details	Information about the incident recorded by the dispatcher.
Incident location	The location of the incident.
Normal place of residence?	Is this the patient's normal place of residence - yes/no?
Triage urgency code	The triage assessment by the dispatcher that determines the degree of urgency.
Dispatch time	The time the incident was allocated to the ambulance crew or individual responder.
Time mobile	The time the crew or individual responder is mobile following allocation of the incident.
Post-dispatch instructions	Additional information recorded and communicated by the dispatcher following allocation of the incident. This could include access instructions, such as key code.
Arrival time at incident	The time the crew or individual responder arrived at the scene of the incident.
Time at patient side	The moment of arrival at the patient's side.
Time left incident location	Time the crew or individual responder left the incident location.
Person accompanying patient	Person who has family, carer or other relationship who accompanies the patient.
Emergency driving exemption applies	Record of using blue lights travelling from the incident to handover destination.
Pre-alerts to receiving unit	Record of whether information has been transmitted to the expected handover destination prior to arrival (Y/N).

Patient demographics	
Subheadings	**Clinical description**
Patient name	The full name of the patient. Also patient preferred name: the name by which a patient wishes to be addressed.
Date of birth	The date of birth of the patient.
Patient sex	Sex at birth. Determines how the individual will be treated clinically.
Gender	As the patient wishes to portray themselves.
Ethnicity	The ethnicity of a person as specified by the person.
Religion	The religious affiliation as specified by the patient.
NHS number	The unique identifier for a patient within the NHS in England and Wales.
Other identifier	Country specific or local identifier, eg, Community Health Index (CHI) in Scotland.
Patient address	Patient's usual place of residence.
Patient telephone number	Telephone contact details of the person. To include, eg, mobile, work and home number if available.
Relevant contacts	Eg next of kin, main informal carer, emergency contact. Name, relationship and contact details.
Communication preferences	Preferred contact method, eg, sign language, letter, phone, etc. Also preferred written communication format, eg, large print, braille.
Educational establishment	If the patient is a child, name and address of where the child attends e.g play group, nursery, school.
Special requirements	
Subheadings	**Clinical description**
Special requirements	Eg level of language (literacy); preferred language (interpreter required); bariatric ambulance required; support for any disability or impairment; any other special requirements.
Existing care plan and care management information	Record that there is a care plan or similar information held by the patient or held on other health or social care registers eg Coordinate My Care, Hampshire Health Record, Special Patient Notes etc.
Participation in research	
Subheadings	**Clinical description**
Participation in research	This is to flag participation in a clinical trial. This may include whether participation in a trial has been offered, refused or accepted, the name of the trial, drug/intervention tested, enrolment date, duration of treatment and follow up, and contact number for adverse events or queries.

GP practice	
Subheadings	**Clinical description**
GP name	Where the patient or patient's representative offers the name of a GP as their usual GP.
GP practice details	Name, address, email, telephone number, fax of the patient's registered GP practice.
GP practice identifier	National code which identifies the practice.
Health and care professional details	
Subheadings	**Clinical description**
Responsible health or care professional	The name, designation and/or personal identification number (if used) of the person with responsibility for the patient within this contact. Where multiple professionals have responsibility, provide details of the duration and extent of responsibility held. State whether identified professional was present, in communication, on call etc.
Health or care professional(s) present	The name, designation and/or personal identification number (if used) of all other health or care professionals present.
Other agencies present	
Subheadings	**Clinical description**
Other agencies present	Identifier, name and/or designation of individuals from attending agencies e.g. police, community first responder, fire, coast guard, midwife, chemical hazards team, voluntary services etc.
Relevant clinical risk factors	
Subheadings	**Clinical description**
Relevant clinical risk factors	Factors that have been shown to be associated with the development of a medical condition being considered as a diagnosis/ differential diagnosis. E.g. pregnancy, being overweight, smoker, no use of sun screen, enzyme deficiency, poor sight (can impact on falls), etc.
Environmental risk factors	Factors in the patients environment with immediate risk for the patient's health and wellbeing e.g. loose carpets, steep stairs, damp etc.
Clinical risk assessment	Specific risk assessments required/undertaken, including thromboembolic risk assessment, spinal risk assessment etc.

Risk mitigation	Advice given or action taken to reduce the clinical risk, including action and date and time actioned.
Patient at high risk	This patient is at high risk of clinical deterioration if a specific existing condition is not recognized as being present. E.g. Addison's disease, hard to control diabetes.
Presenting complaints or issues	
Subheadings	**Clinical description**
Presenting complaints or issues	The list and description of the health problems and issues experienced by the patient resulting in their attendance. These may include disease state, medical condition, response and reactions to therapies. Eg blackout, dizziness, chest pain, follow up from admission, falls, a specific procedure, investigation or treatment.
History	
Subheadings	**Clinical description**
History of each presenting complaint or issue	Information directly related to the development and characteristics of each presenting complaint, (eg, including travel history). Time of onset should be recorded when appropriate e.g. stroke, cardiac arrest. Record whether the information is given by the patient or their carer.
Information brought by patient	Eg Patient Passport, diary data, pre-completed questionnaire, hand held maternity record, etc.
Relevant past medical, surgical and mental health history	The record of the patient's significant medical, surgical and mental health history, (will include dental and obstetric history). Including relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc.
Management to date	Referrals, management, investigations and treatment that have already been undertaken, including patient managing their symptoms. Including: *Procedures conducted – procedures carried out (and the date) and procedure report.
Medications and medical devices	
Subheadings	**Clinical description**
Person authorising medication	The name and identification details of the person writing the prescription or authorising the medication
Source of medication	Whether the medication is the patient's own or part of the ambulance stock.
Medication name	May be generic name or brand name (as appropriate).

Medication form	Eg capsule, drops, tablet, lotion etc.
Route	Medication administration description (oral, IM, IV, etc): may include method of administration, (eg, by infusion, via nebuliser, via NG tube) and/or site of use, (eg, 'to wound', 'to left eye', etc).
Dose	This is a record of the total amount of the active ingredient(s) to be given at each administration. It should include, eg, units of measurement, number of tablets, volume/concentration of liquid, number of drops, etc.
Medication frequency	Frequency of taking or administration of the therapeutic agent or medication.
Additional instructions	Allows for: * requirements for adherence support, eg, compliance aids, prompts and packaging requirements * additional information about specific medicines, eg where specific brand required * patient requirements, eg, unable to swallow tablets.
Do not discontinue warning	To be used on a case-by-case basis if it is vital not to discontinue a medicine in a specific patient scenario.
Reason for medication	Reason for medication being prescribed, where known.
Medication recommendations	Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication.
Medication status	Whether or not a medication is being administered, eg, started, stopped, suspended, reinstated. Record date for each change in status.
Medication change	Where a change is made to the medication, ie one drug stopped and another started or, eg, dose, frequency or route is changed.
Reason for medication change	Reason for change in medication, eg, sub-therapeutic dose, patient intolerant.
Medicine administered	Record of administration to the patient, including self-administration.
Reason for non-administration	Reason why drug not administered, (eg, patient refused, patient unavailable, drug not available).
Relevant previous medications	Record of relevant previous medications.
Medical devices	The record of dietary supplements, dressings and equipment that the patient is currently taking or using.
Medicine batch number	Record of the batch number of the medication.
Medicine expiry date	Record of the expiry date of the medication.
Medicine effect	Record of the patient response to a given medication e.g. pain score following analgesia.

Allergies and adverse reaction	
Subheadings	**Clinical description**
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this patient.
Description of the reaction	A description of the manifestation of the allergic or adverse reaction experienced by the patient. This may include: * manifestation, eg, skin rash * type of reaction (allergic, adverse, intolerance) * severity of the reaction * certainty * evidence (eg, results of investigations).
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.
Date first experienced	When the reaction was first experienced. May be a date or partial date, (eg, year) or text, eg, during childhood.
Safety alerts	
Subheadings	**Clinical description**
Risks to self	Risks the patient poses to themselves, eg, suicide, overdose, self-harm, self-neglect.
Risks to others	Risks to care professional or third party.
Legal information	
Subheadings	**Clinical description**
Consent	Whether consent has been obtained and the situation the consent relates to e.g. treatment, referral, information sharing, transfer etc. May include where record of consent is located or record of consent.
Record of refusal	The record of the objections made by the patient and the reasons for their objections. Also include the information given when patient refuses consent, including signature and designation of staff and patient signature.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) patient has been undertaken, if so who carried it out, when and the outcome of the assessment. Also record best interests decision if patient lacks capacity.
Mental Health Act status	Record where a patient diagnosed with a mental disorder is formally detained under the Mental Health Act, including the section number.
Advance decision to refuse treatment (ADRT)	A record of an advance decision made by the patient to refuse a specific type of treatment at some time in the future. This may be verbal, but it must be in writing, signed and witnessed if it is the refusal of life-sustaining treatment. Also record if there has been a change in the decision.

Advance statement	Requests or preferences that have been stated by a patient conveying their wishes, beliefs and values regarding future care. This includes: *whether there is a written document *location of the document
Lasting power of attorney or similar	Record of individual involved in healthcare decision on behalf of the patient if the patient lacks capacity. This includes: *whether there is a person with lasting power of attorney for health and welfare , independent mental capacity advocate (IMCA), court appointed deputy. *name and contact details for person. Confirm that lasting or enduring power of attorney is not restricted to financial matters.
Consent relating to child	Consideration of age and competency, applying Gillick competency or Fraser guidelines. Record of person with parental responsibility or appointed guardian where child lacks competency. Record if there is disagreement between patient and parent.
Do not attempt cardio-pulmonary resuscitation (DNACPR)	Whether a decision has been made, the decision, the date of decision, date for review and location of documentation.
Safeguarding issues	Any legal matters relating to safeguarding of a vulnerable child or adult, eg, child protection plan, child in need, protection of vulnerable adult.
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.
Social context	
Subheadings	**Clinical description**
Household composition	Eg: lives alone, lives with family, lives with partner, etc. This may be free text.
Important patient relationships	Others present at the incident, or not present but with important relationships e.g. dependants such as very young child. Record the name and the relationship with the patient where relevant.
Lives alone	Yes/no/don't know (Y/N/DK)
Lifestyle	The record of lifestyle choices made by the patient which are pertinent to his or her health and well-being, eg, the record of the patient's physical activity level, pets, hobbies, sexual habits.
Smoking	Latest or current smoking observation.
Alcohol intake	Latest or current alcohol consumption observation.
Recreational substance use	Record of current or previous recreational substance use.
Occupational history	The current and/or previous relevant occupation(s) of the patient/individual. This may include educational history.

Social circumstances	The record of a patient's social background, network and personal circumstances, eg, housing and religious, ethnic and spiritual needs, social concerns and whether the patient has dependants or is a carer. May include reference to safeguarding issues that are recorded elsewhere in the record.
Services and care	The description of services and care providing support for patient's health and social well-being.
Family history	
Subheadings	**Clinical description**
Family history	The record of relevant illness in family relations deemed to be significant to the care or health of the patient, including mental illness and suicide, genetic information etc.
Review of systems	
Subheadings	**Clinical description**
Review of systems	The clinical review of systems. The record of clinical information gathered in responses to questions to the patient about general symptoms from various physiological systems, including food intake (increasing/decreasing), weight change, swallowing difficulties, mood/anxiety, etc.
Patient and carer concerns	
Subheadings	**Clinical description**
Patient's and carer's concerns, expectations and wishes	Description of the concerns, wishes or goals of the patient, patient representative or carer. This could be the carer giving information if the patient is not competent or the parent of a young child.
Examination findings	
Subheadings	**Clinical description**
General appearance	The record of a clinician's 'first impression' assessment including general clinical examination finding, eg, clubbing, anaemia, jaundice, obese/malnourished/cachectic, height, weight, etc.
Vital signs	The record of essential physiological measurements, eg, heart rate, blood pressure, temperature, pulse, respiratory rate, level of consciousness. Use of Early Warning Score (which may be computed) chart where appropriate.
Mobility	Patient's mobility e.g. requirement for walking aid, wheel chair, etc.
Mental state	Formal mental state examination or general description Eg depression, anxiety, confusion, delirium.

Cardiovascular system	The record of findings from the cardiovascular system examination.
Respiratory system	The record of findings from the respiratory system examination.
Abdomen	The record of findings from the abdominal examination.
Musculoskeletal system	The record of findings from the musculoskeletal system examination.
Skin	The record of findings from examination of the skin.
Nervous system	The record of findings from the nervous system examination.
Genitourinary	The record of findings from the genitourinary examination.
Head and neck examination	The record of findings from the head and neck examination.
Oral examination	The record of findings from oral examination.
Assessment scales	
Subheadings	**Clinical description**
Assessment scales	Assessment scales used, eg, Glasgow Coma scale, AVPU (alert, voice, pain, unresponsive) scale, Wong Baker Pain scale, etc.
Problems and issues	
Subheadings	**Clinical description**
Problems and issues	Summary of problems that require investigation or treatment. This would include significant examination findings which are likely to have relevance, yet are not a diagnosis. In mental health and psychiatry, this may be the place for formulation.
Diagnosis	
Subheadings	**Clinical description**
Clinical impression	The clinical impression the clinician has made based on available evidence.
Differential diagnosis	The determination of which one of several conditions may be producing the symptoms.
Diagnosis	Confirmed diagnosis; active diagnosis being treated. Include the stage of the disease where relevant.
Procedures	
Subheadings	**Clinical description**
Procedure	The therapeutic procedure performed. This could include site and must include laterality where applicable.

Complications related to procedure	Details of any complications during the procedure or associated with the procedure.
Specific anaesthesia issues	Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction, etc.
Treatments and interventions	
Subheadings	**Clinical description**
Treatments and interventions	Record here any specific treatments and interventions that should be identified. All medications should be recorded under the medications heading.
Clinical summary	
Subheadings	**Clinical description**
Clinical summary	Narrative summary of the episode. Where possible, very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under 'plan'. In mental health and psychiatry, this may be the place for formulation.
Investigations and results	
Subheadings	**Clinical description**
Investigations requested	This includes a name or description of the investigation requested and the date requested.
Investigations results	The result of the investigation (this includes the result value, with unit of observation and reference interval where applicable and date), and plans for acting upon investigation results.

Plan and requested actions	
Subheadings	**Clinical description**
Actions	Including planned investigations, procedures, and treatment, for a patient's identified conditions and priorities: a) person responsible – name and designation/department/hospital/patient etc responsible for carrying out the proposed action, and where action should take place b) action – requested planned or completed c) when action requested for – requested date, time, or period – as relevant d) suggested strategies – suggested strategies for potential problems, eg, telephone contact for advice.
Escalation plan	Who needs to be contacted in the event of significant problems or patient deterioration.
Agreed with patient or legitimate patient representative (Y/N/NA)	Indicates whether the patient or legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments if any. Also if agreement cannot be obtained and reason for this.
Aims and limitations of treatment and special instructions	The current aim of treatment including limitations to treatment and communication issues.
Information given	
Subheadings	**Clinical description**
Information and advice given	This includes: - what information - to whom it was given. The oral or written information or advice given to the patient, carer, other authorised representative care professional or other third party. Also the preferred format for information. May include advice about actions related to medicines or other ongoing care activities on an 'information prescription'. State here if there are concerns about the extent to which the patient and/or carer understand the information provided about diagnosis, prognosis and treatment.
Disposition details	
Subheadings	**Clinical description**
Disposition type	The type of disposition including handover (eg to A&E, from community first responder to ambulance crew), referral (to other service), discharge (e.g. home or self discharge).

Handover	
Handover destination	Details of the hospital or other location where handover occurs. This may also include team or department.
Additional handover information	Eg list of items such as personal belongings and other information relevant to the handover.
Date of arrival at handover destination	The date the ambulance parks at the handover destination.
Time of arrival at handover destination	The time the ambulance parks at the handover destination (e.g. A&E, clinic, etc).
Time of notification of arrival	The time of the notification to the receiving team that the ambulance has arrived.
Time of handover	The time the patient was handed over to the receiving care professional.
Time of leaving handover destination	The time taken by ambulance crews to complete any reports and to prepare their vehicle for the next call and to call "clear" with the ambulance control room.
Person receiving handover	
Name	
Personal identification number	
Designation or role	
Grade	
Specialty	
Contact details	
Referral	
Referral to	Name, designation and organisation. If not an individual, this could be a service, eg, GP surgery, department, specialty, subspecialty, educational institution, mental health etc.
Reason for referral	A clear statement of the purpose of the person making the referral, eg, diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the patient, (eg, palliative care), provide referrer with advice/guidance. This may include referral because of carers' concerns.
Referral Date	The date the referral was made.
Referral Time	The time the referral was made.
Person to attend with patient	Identify others who will/may accompany the patient, eg, relative, carer, chaperone. Includes: * name * relationship (friend, relative, etc) * role (patient advocate, chaperone etc) * attendee's special requirements.
Attachments	Documents included as attachments which accompany the communication.

Referral criteria	Records whether specific criteria required for referral, to a particular service, have been met (may be nationally or locally determined).
Expectation of referral	A clear statement of the expectations of the person making the referral as to the management of the patient, eg, advice only, diagnosis, treatment, etc.
Discharge	
Discharge date	
Discharge time	
Discharge reason	Reason for discharge of patient e.g. completion of treatment, treatment advised, refusal of treatment, no treatment required, life extinct etc.
Discharge destination	The destination of the patient on discharge from hospital. National codes. Eg NHS-run care home.
Discharged into care of	Record of individual or organisation taking responsibility for patient upon discharge e.g. carer, relative, care home, supported living environment etc.
Discharge address	Address to which patient discharged. Only completed where this is not the usual place of residence.
Recognition of life extinct	
Evidence for decision	The evidence used in coming to the decision that the patient's life is extinct.
Date and time life extinct confirmed	The date and time at which the decision that life is extinct is made
Person making decision	Name, personal identification number, and or designation.
Person completing record	
Subheadings	**Clinical description**
Name	
Designation or role	
Grade	
Specialty	

Contact details	
Date completed	
Distribution list	
Subheadings	**Clinical description**
Distribution list	Other individuals to receive copies of this communication/referral letter.