

Effective MAIS Reporting and Documentation

by: Carol L. Mitlacher, NREMT-P
JoAnn M. Yost, BS NREMT-P

United Steam Fire Engine Company Number 3

I. Effective MAIS Reporting and Documentation Instructor Guide

Session 1

Lesson 1:1

Title of Topic: MAIS Form Completion

Time: .75 hours

Teaching/Learning Level: Cognitive

Learning/Teaching Aids:

- Lesson 1:1 Transparencies
- Lesson 1:1 Handout
- Overhead
- Screen
- White Board
- Transparency Markers
- Dry Erase Markers

Behaviors to Foster: Active participation and discussion to enable the students to effectively complete MAIS forms.

Task: Completing Reports

Given: Information related to MAIS Form Components

Standard: MAIS User's Manual Guidelines

Prerequisite Knowledge: Basic writing skills
Successful completion of EMT-B Module III Exam

Prerequisite Skills: Enhancement of MAIS Form Completion Skills

Resources/References: MAIS User's Guide Manual

Attention: (Call to Order)

T-MRD-1-1-1

Motivation: (State Need to Know)

Student Performance Objective (SPO): Given the information related to MAIS form components, the student will be able to complete an entire MAIS form according to the MAIS User's Manual guidelines.

T-MRD-1-1-2

Enabling Objectives (EO):

T-MRD-1-1-3

EO 1-1-1 Review general rules for completing MAIS forms.

EO 1-1-2 List and discuss the different components of a MAIS form.

EO 1-1-3 Describe how to complete the three refusal forms.

EO 1-1-4 Identify upcoming changes to the MAIS form.

Overview/Main Points:

MAIS Form Completion

- General Rules
- Components of MAIS Form
- Refusal Forms
- Upcoming Changes to MAIS Forms

Opener: Call to Order; start with a motivator (need to know) related to objectives and the lesson; state objectives and main points.

Teaching Points

Notes

I. General Rules (1-1-1)

- A. Black Ink Only
- B. No Stray Marks On Forms
- C. Keep Your Writing in the Designated Areas
- D. Move Carbon Paper for Refusals

II. Components of MAIS Form (1-1-2)

- A. Station, Response, Patient, and Provider Information
 - 1. Station Run Number
 - 2. Jurisdiction Incident Number
 - 3. Suppl

H-MRD-1-1-1

4. Box Number
 5. District
 6. Receiving Facility
 7. Other Units on Scene
 8. Response Location
 9. Zip Code
 10. Inc Type
 11. Occup
 12. Action
 13. Disp
 14. Patient Name
 15. Parent/Guardian
 16. Patient Address
 17. Home Phone
 18. Provider ID Number
 19. Provider ID Name
- B. Date/MAIS Form Information
1. Date
 2. Serial Number
- C. Response Times
1. 911 Call
 2. Ambulance Call
 3. Depart Station
 4. Arrive Location
 5. Depart Location
 6. Arrive Hospital
 7. Return To Service
- D. Response Identification, No Care Rendered, Priority
1. County/City Code
 2. Unit Code
 3. Highest Staffed
 4. Dispatch
 5. First Due

6. No Care Rendered
7. Priority
- E. Patient Demographics
 1. Patient Age
 2. Patient Race
 3. Patient Gender
- F. Vital Signs
 1. First Vital Signs
 2. Glucometer
 3. Loss of Consciousness-Prior to Arrival
 4. Lungs
 5. Glasgow Coma Scale
 6. Safety Equipment Used
 7. Trauma ID
 8. Mechanism(s) of Injury
 9. Documentation of Care Rendered
 - a. SaO₂
 - b. ET Size
 - c. O₂ Liters Per Minute
 - d. Total cc's
 - e. Glucose Number
 - f. Gauge Site
 - g. Mileage
 - h. On Line Physician
 - i. Hospital Signature
 - j. Provider Signature
 - k. EMS Reviewer Signature
 - l. Written Vital Signs
- G. Physical Findings
 1. Signs and Symptoms
 2. Injury Type
 3. Conditions
 4. ECG

- 5. Circulation
- H. Cardiac Arrest Related
 - 1. Cardiac Arrest Witnessed
 - 2. CPR Started By
 - 3. AED Started By
 - 4. Return of Spontaneous Circulation at ED
- I. Airway, Procedures, Other Care Rendered
 - 1. Airway/Ventilation
 - 2. Procedures
 - 3. Other Care Rendered
- J. Medications
- K. Hospital Codes
- L. Transportation/Communication/Special Purpose
 - 1. Transported By
 - 2. Reason Hospital Chosen
 - 3. Radio
 - 4. Special Purpose
 - 5. Variable
 - 6. Provider Exposure
- III. Refusal Forms (1-1-3)
 - A. Refusal for IV Therapy
 - B. Refusal of Services and Transportation
 - C. Refusal of Services Not Transportation
- IV. Upcoming Changes to MAIS Form (1-1-4)
 - A. Web Based Data Entry System (Pilot)
 - B. Current MAIS Document Changes
 - 1. Procedure Addition – Combitube Dot Added
 - 2. Condition Change - Exposure to Environmental

Summary:

Session 1

Lesson 1:1 MAIS Form Completion

Student Performance Objective (SPO):

Given information related to MAIS form components, the student will be able to complete an entire MAIS form according to the MAIS User's Manual guidelines.

Review/Main Points:

II. MAIS Form Completion

T-MRD-1-1-4

- General Rules
- Components of MAIS Form
- Refusal Forms
- Upcoming Changes to MAIS Form

Evaluation:

Oral Review: Under each review point, recall and list three features from the discussion. Make a note of these points or highlight points in your notes as you may use them for exam review.

Other Evaluation: Use course quizzes, if any, or create and use lesson quizzes and other learning reinforcements. Quizzes are diagnostic and may be given as in-class group assignments to generate discussion or as home assignments and used as review prior to starting the next session.

III. Effective MAIS Reporting and Documentation

Instructor Guide

Session 1

Lesson 1:2

Title of Topic: Written Narrative Completion

Time: .75 hours

Teaching/Learning Level: Cognitive

Learning/Teaching Aids:

- Lesson 1:2 Transparencies
- Lesson 1:2 Handout
- Overhead
- Screen
- White Board
- Transparency Markers
- Dry Erase Markers

Behaviors to Foster: Active participation and discussion to enable the students to effectively formulate written narratives and utilize abbreviations.

Task: Completing Reports

Given: Information and Knowledge about Narrative Formats and Abbreviations

Standard: Medically Accepted Abbreviations and Narrative Formats

Prerequisite Knowledge: Basic writing skills
Successful completion of EMT-B Module III Exam

Prerequisite Skills: Enhancement of Narrative Report Writing Skills

Resources/References: Report Writing Formats (as needed)

Attention: (Call to Order)

T-MRD-1-1-1

Motivation: (State Need to Know)

Student Performance Objective (SPO): Given the information and knowledge about narrative formats and abbreviations, the student will be able to formulate effective written narratives utilizing medically accepted abbreviations in accordance with medically accepted narrative formats.

T-MRD-1-2-2

Enabling Objectives (EO):

T-MRD-1-2-3

EO 1-2-1 Discuss effective narratives and some important items to include when documenting.

EO 1-2-2 List and discuss the components of the CHART format.

EO 1-2-3 List and discuss the components of the SOAP(IER) format.

EO 1-2-4 List and discuss the components of the Chronological format.

EO 1-2-5 Discuss effective documentation of patient refusals.

EO 1-2-6 Review common medical abbreviations and symbols.

Overview/Main Points:

IV. Written Narrative Completion

- Effective Narrative
- CHART format
- SOAP(IER) format
- Chronological format
- Refusal Documentation
- Abbreviations, Acronyms and Symbols

Opener: Call to order; start with a motivator (need to know) related to objectives and the lesson; state objectives and main points.

Teaching Points

Notes

- I. Effective Narrative (1-2-1)
 - A. Tells a story
 - 1. Accurate
 - 2. Concise
 - 3. Legible
 - 4. Complete
 - B. Important Items to Include when Documenting
 - 1. Document Everything
 - 2. Use Additional Narratives
 - a. Priority 1 and 2
 - b. Refusals
 - 3. Apparatus and Crews on Call
 - 4. Events Leading to Incident
 - 5. Treatment of Patient
 - 6. Medic Information
 - a. Name
 - b. Rank
 - c. Medic Unit Number
 - d. MAIS Number of Medic Report
 - 7. Hospital Turnover Information

II. CHART format (1-2-2)

T-MRD-1-2-4

- A. C – Chief Complaint
- B. H – History
 - 1. Medical History
 - 2. Possibly Family History, If Needed
- C. A – Assessment
 - 1. Subjective - What was given?
 - 2. Objective - What information was found?
 - a. Visual
 - b. Audible
 - 1) Patient's Answers to Questions
 - 2) Auscultation
 - c. Olfactory

- d. Touch/Palpation
 - e. Vital Signs –Include Time
 - 3. Overall Patient Status – Include Patient Priority
- D. Rx – Treatment/Therapy per Protocol
 - 1. Treatment Given to Patient – Include Time
 - 2. Patient's Status
 - a. Vital Signs – Include Time
 - b. Changes in Patient Condition
- E. T – Transport and Transfer
 - 1. Transport
 - a. Transport Destination
 - b. Transport Time
 - 2. Transfer
 - a. Whom was care transferred to?
 - b. Time

III. SOAP(IER) Format (1-2-3)

T-MRD-1-2-5

- 1. S – Subjective
 - a. Chief Complaint
 - b. Symptoms
 - c. Self-Treatment
 - d. Pertinent Medical History
- 2. O - Objective
 - a. Provider Observations
 - 1) MVC – MOI
 - 2) Scene Observations
 - 3) Signs
 - b. Vital Signs
 - c. Findings from Assessments
- 3. A – Assessment or Analysis of Assessment
 - a. Provider Impression of Patient Condition
 - b. Diagnosis not Expected
- 4. P – Plan or Protocol

- a. Describe Every Aspect of Patient Treatment
 - b. Keep in Chronological Order
- 5. I – Implementation of Protocol
 - a. Can be Merged with (P)
 - b. Note Times of Implementation of Treatment
- 6. E – Evaluation of Treatment
 - a. Can be Merged with (P)
 - b. Changes in Patient Status due to Treatment
 - c. Reassessed Vital Signs
- 7. R – Report Finale
 - a. Can be Merged with (P)
 - b. Transport Information
 - c. Hospital Transfer Information

IV. Chronological Format (1-2-4)

T-MRD-1-2-6

- A. Dispatch
 - 1. Call Type
 - 2. Any Pertinent Information About the Response
- B. En Route to Scene
- C. On Scene
 - 1. Crew/Provider Observations
 - a. Scene Observations
 - b. Signs
 - c. Subjective Information
 - 1) Chief Complaint and Events Leading to Incident
 - 2) Symptoms
 - 3) Medical History
 - d. Assessments and Findings
 - 1) Vital Signs
 - 2) Injury/Illness
- D. Treatment
 - 1. Chronological Order
 - 2. Time of Treatment Component

- E. Transport
 - 1. Patient Transport to Ambulance
 - 2. Patient Transport Priority
 - 3. Transport Intended Destination
- F. En Route to Hospital
 - 1. Reassessments and Findings
 - 2. Vital Signs
 - 3. Additional Treatment Provided
 - 4. Any Consultation Information
- G. At the Hospital
 - 1. Destination of Patient (i.e. –Room Number)
 - 2. To Whom was Care Transferred
 - 3. To whom was the Report of Patient Care Given

V. Refusal Documentation (1-2-5)

- A. Legally Important
- B. Pertinent Information to Include
 - 1. Patient Identification Information
 - 2. Call Type
 - 3. Scene Description
 - 4. Subjective Information
 - 5. Objective Information
 - a. Assess Patient
 - b. Note Suspected Injuries
- C. Inform Patient
 - 1. Advise Patient of Risks
 - 2. Allow for Informed Refusal
 - 3. Document all Information Given by Provider
- D. A3E3P3 (Acronym)
 - 1. Assess – For Injuries
 - 2. Advise – Of Options
 - 3. Alleviate – Problems/Fears
 - 4. Explicit – Be Direct/Honest
 - 5. Exploit – All Avenues

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6. Explain – Ramifications
7. Persuade – To be Transported
8. Protocol – Follow Protocol
9. Protect – Yourself, Crew and Patient

VI. Abbreviations, Acronyms and Symbols (1-2-6)

A. Abbreviations

1. Medically Accepted
2. Shorthand

B. Acronyms

1. SAMPLE

- a. Signs/Symptoms
- b. Allergies
- c. Medications
- d. Past Medical History
- e. Last Oral Intake
- f. Events Leading to Injury or Illness

2. OPQRST

- a. Onset
- b. Provocations
- c. Quality
- d. Region/Radiation
- e. Severity
- f. Time

3. DCAPBTLS

- a. Deformities
- b. Contusions
- c. Abrasions
- d. Punctures
- e. Burns
- f. Tenderness
- g. Lacerations
- h. Swelling

4. TTFN
 - a. To Whom Care was Transferred
 - b. Time
 - c. Fluid Infusion
 - d. Necessary Status Update

C. Symbols

1. Not many in EMS
2. Listed in Handout
3. Physical Therapy Symbols
 - a. Right
 - b. Left
 - c. Increase
 - d. Decrease
4. Other Symbols
 - a. At
 - b. Degree
 - c. Equal to
 - d. Times

Summary:

Session 1

Lesson 1:2 Written Narrative Completion

Student Performance Objective (SPO):

Given information and knowledge about narrative formats and abbreviations, the student will be able to formulate effective written narratives utilizing medically accepted abbreviations in accordance with medically accepted narrative formats.

Review/Main Points:

V. Written Narrative Completion

T-MRD-1-2-7

- Effective Narrative
- CHART format
- SOAP(IER) format
- Chronological format
- Refusal Documentation
- Abbreviations, Acronyms and Symbols

Evaluation:

Oral Review: Under each review point, recall and list three features from the discussion. Make a note of these points or highlight points in your notes as you may use them for exam review.

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