# Policies & Procedures

**Article: 4.2**

**Effective Date: 08/30/2012**

**Revised Date:**

**EMS REPORT WRITING QUALITY ASSESSMENT/IMPROVEMENT AND CHART REVIEW**

## PURPOSE

This document is intended to provide the information necessary to properly document EMS responses made by the Valencia County Emergency Services ("Services"). The Services has established this document to meet the requirements of Federal, State, and Local government agencies.

This document shall serve as the regulation for the reporting of patient information.

## I. AUTHORITY

A. This manual is constructed under the authority of the County Fire Chief, as the appointed manager of the Department. The authority to manage the Department, being derived from County Ordinance 2005-5.

B. The Medical Director, or his designated representative, shall be responsible for oversight of the review of all EMS Reports.

C. The Deputy Chief-EMS, or his designated representative, shall be responsible for setting guidelines on the manner of documenting EMS reports.

## II. RESPONSIBILITY AND PROCEDURE

A. **EMS Reports** are defined as those documents that are to be generated after each Alarm that has been created by the Communications Center. A report shall be generated even if the responding unit is cancelled at any time after an Alarm has been generated. A completed report consists of a field worksheet, an EMSTARS report, a liability release if indicated, any relevant addendums, and a QA attachment.

1. Patient Report: A report shall be generated using the currently accepted EMS Reporting software.

   a. Primary Care Provider: the EMS Provider with the highest level of licensure *or* the provider who performed the greatest amount of assessment or patient care during the incident.
   b. Timeline for Report Submission: The primary care provider will be responsible for generating the EMS report within 48 hours of the patient contact, or before the end of the providers' shift. The patient report shall be available for review and distribution by Fire Administration within the State designated 48 hours.

c. Minimum Report Criteria: The "Patient Report" shall include, but not limited to:

1. Incident/Response Information: dispatch address, date, alarm number(s), times as recorded by Dispatch, and crew names.
2. Patient Identification: Name, address, birthdates, demographics, etc.
3. Narrative: The narrative will be written in dCHARTe format to include the following in indicated;

   - Patient Identification
   - Chief Complaint
   - Current History
   - Physical Exam
   - Past Medical History
   - Medications
   - Allergies
   - Medical Communications with Receiving Facility
   - Treatment and Response to Treatment
   - Outcome/Disposition
   - Any documented exceptions
   - End the narrative with the author's crew code.

4. Vital Signs and Other Physical Exam Findings (may include):

   Four (4) Standard Vital Signs
   - Pulse Rate and Quality
   - Respiratory Rate and Quality
   - Blood Pressure
   - Oxygen Saturation

   Other Physical Findings
   - Level of Consciousness
   - Skin Condition
   - Glucometry
   - Pupillary Response
   - Lung Sounds

5. Procedures: All procedures shall be documented in the "procedure field" of the report. Procedures should also be documented in the narrative.

6 Signatures:

- EMS field worksheets for the Services shall be signed upon their completion.
- Required Signatures:
  1. Author of the EMS Report

  2. **If the author is a probationary member then the primary EMT on scene shall read and co-sign the report, unless the probationary member has been released to author reports.**

  3. Any other responder involved with the incident may choose to countersign the report, thereby agreeing to its content

2. Prehospital Data Collection System Field Worksheet: The "field worksheet." The original of this document shall be maintained by the Service. It is understood that this record may not have the complete documentation of the patient record. A copy of this document shall be distributed to the transporting agency or to the Emergency Department staff should the Department transport a patient.

3. ECG Strip Collection Form: All Electrocardiograph strips are to be affixed to this form and the form attached to the original field worksheet. Do not attach loose strips to the field worksheet.

4. Liability Release Form: The signed original of this document shall be attached to the original field worksheet.
**A liability release, as approved by the medical director, must be completed by any patient or non-patient refusing transport and/or treatment to a hospital or other receiving facility.** The following procedure is used for the completion of the liability release and corresponding documentation, where applicable, under "E" in DCHARTE:

- Obtain and provide as much demographic information as possible.
- Complete the date, time and location fields at the top of the Liability Release.
- Compare results of patient examination, review and check off any refusal criteria that apply:
  - Any refusal criteria that cannot be checked off must be referenced under the "E" in DCHARTE.
  - Any refusal criteria that cannot be checked off must be brought to the attention of the patient and this too must be referenced under "E" in DCHARTE.
  - Non-Patient require that first two criteria to be checked off.
- Read aloud sections of the liability release that pertains to the patient:

- Note under “E” in DCHARTE that you “read aloud” that section.
- Usually, further explanation is required after reading aloud those sections. Reference under “E” in DCHARTE that you further explained the liability release.
- Finish by asking the patient if they understand and have any questions regarding the liability release. Answer any questions. Note under “E” in DCHARTE that the patient had questions and they were answered or note that the patient had no questions.

- Other liability release notations to be included under “E” in DCHARTE:
  - Document patient’s mental status.
  - Document Patient understands their condition.
  - Document follow-up recommendations made by EMS to patient.
  - Document witness signature sources if you are not able to get signatures other than EMS personnel as witnesses.

B. **Quality Assurance Procedure:**

The continuous quality assurance procedures is necessary in order to identify areas of excellence as well as potential sources of risk and is necessary to continue to improve the quality of patient care in EMS. Completing the QA is a time sensitive function and therefore the following procedures are to be implemented:

- Each District Chief will assign a QA Officer for that district. The QA Officer will follow the Guidelines for Quality Assurance as approved by the Medical Director. QA Officers may assign other personnel to help in the QA process.
  - Personnel cannot review their own reports. Other personnel as assigned will complete those reports.
  - Personnel can review reports in which they participated in patient care but did not complete the report.
- Reviews are to be done as soon as possible after completion of the EMSTARS report.
- All reviews must be done using the Valencia County EMS Protocols and utilizing the QA/QI documentation form as provided by EMSTARS.
- If any report is found to have a significant variance, the QA Officer must be notified as soon as practicable. If the QA Officer feels that there are areas of omission or other areas where reworking the report would have improved the final product, the reviewer must notify the author of this via the QA/QI documentation form in EMSTARS.
- The QA Officer may notify the Deputy Chief-EMS to review an EMS chart if they have concerns with patient care assessment and/or treatment.
- All QI procedures fall under strict HIPAA guidelines.

## III. RECORDS AND FORMS

- Paperwork Relevant to EMS Reporting: Each station shall maintain a stock of paperwork relevant to EMS Reporting.

B. Filing and Storage: EMS Reports shall be filed and stored in a "secure" location at each Station. The location shall be accessible to Department Officers as well as administrative staff. The location shall not be made accessible to the public.

C. Contingency for Electronic Reporting System Failure:

1. Should the EMS Reporting System become unavailable due to electronic failure the user shall contact their district officer.

2. The primary care provider shall generate a handwritten EMS Report utilizing the Valencia County Addendum form.

3. The report must be entered into the EMS Reporting System once it becomes available.

D. Distribution of Reports:

1. Public Requests for EMS Reports: Any requests to view or obtain copies of EMS Reports must be made in writing to the Deputy Chief-EMS. No exceptions will be made.
2. Printing of EMS Reports: Any EMS Report that is printed from EMSTARS needs to be documented under the QA/QI section that the report has been printed and for what purpose.

## IV. DEFINITIONS

Terms contained within the definitions or within this manual are intended to be gender neutral. For those occasions where the word he or his is used, it is implied that she or her can be substituted without changing the intent.

A. County Fire Chief : refers to the Department head appointed by the County Manager or the Board of County Commissioners to be responsible for the administration of the Service, and in his absence, his designated representative.

B. Deputy Chief-EMS: refers to the individual in the Department who functions as the manager of the EMS Division.

C. Medical Director: is the licensed Emergency Physician who is responsible for issuing the protocol, guidelines, and standing orders for Emergency Medical Technicians operating under the control and/or authority of the Department. The Medical Director is responsible for establishing acceptable practices for EMS Documentation.

D. District Chief: A volunteer duly elected by the membership of the fire district, approved by the Board of County Commissioners, who is responsible for the day-to-day operational activities of the fire district's county-owned fire station(s), apparatus, equipment and supervision of the volunteer personnel, in accordance with adopted rules and regulations.

E. Regional Supervisor (Paid): refers to any line supervisor (Lieutenant or Commander) who is responsible for management of personnel assigned to field positions. This person is the first point of contact for issues arising regarding the interpretation of this manual.

F. Emergency Medical Technician (EMT) means a provider who has been licensed by the State of New Mexico to provide patient care in accordance with the current EMS scopes of practice (7.27.2.14 NMAC).

G. Employee: refers to any member of the Department who receives compensation in the form of wages earned, and who is subject to provisions of the Valencia County Personnel Rules and Regulations.

H. Volunteer: refers to unpaid member who has a field service association with the Department.

# EMS REPORT WRITING QUALITY ASSESSMENT/IMPROVEMENT AND CHART REVIEW

## Guidelines for Quality Assurance Update 10/2001

This represents the cases for mandatory forwarding to Dr. Froman for Quality Assurance Case Review.

- All Code-Blues
- All Level one and two Trauma
- Long response and scene times
- MCI's
- All complaints dealing with patient care.
- Mutual-Aid Transports (Rescues, or other ambulance services)
- Prolonged extrication
- Random calls:
  - Rescues with a higher call volume 3%
  - Rescues with a lower call volume 5%
- Random cancellations:
  - Rescues with a higher call volume 3%
  - Rescues with a lower call volume 10%
- Medication Administrations
- Flagged reports