EMS Reporting
Quality Assurance Program

CHAPTER 7.15

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Submitted by: Technical Services	Approved by: EMS Branch

Purpose

To establish the review of field incident reports and on scene care to identify and continually measure the quality of emergency medical care being provided to the citizens of Alachua County. It is the intent of these guidelines to meet, and/or exceed the requirements of Florida Statute 401 and 64J as well as the current Protocols developed by the Medical Director.

Scope

The guidelines prescribed are applicable to all employees of the Fire Rescue department and may not be deviated from without the expressed, written permission of the current Medical Director.

General

Information received through the review of medical field incident reports and on-scene observation of care provided will be used in focused studies and education, benchmarking, and performance outcomes which will improve the overall quality of service provided by the Alachua County Fire Rescue.

Quality Assurance (QA) Categories that will be reviewed each shift and for 100% each month:

- Airway techniques (BVM, OPA, NPA, CPAP, advanced airway procedures)
- Apparent Life-Threatening Event (ALTE)
- Asystole/Pulseless Electrical Activity (PEA)
- Atrial Fibrillation (A-Fib)
- Bradycardia
- Determination of Death
- GCS <8
- Narcotic medication use (Fentanyl, Morphine, Versed)
- OB/GYN
- Pain Management
- Refusal of Care
- Sepsis
- Stroke
- Supraventricular Tachycardia (SVT)
- Ventricular Tachycardia (V-Tach)
- Ventricular Fibrillation (V-Fib) / Pulseless V-Tach
- All “alert”
    - Trauma Alert
    - Sepsis Alert

- Stroke Alert
- STEMI Alert

Rescue Lieutenants assigned to Rescue 41, Rescue 62, and the QA team will review the following reports listed for the shift prior to their assigned duty shift:

Rescue 41

- A-Fib
- ALTE
- Bradycardia
- Determination of Death
- GCS <8
- Refusals (10 per shift)
- SVT
- V-Tach with a pulse

Rescue 62

- Airway techniques (BVM, OPA, NPA, CPAP, advanced airway procedures)
- Chest pain (5 per shift)
- Non-cardiac related chest pain (5 per shift)
- Narcotic medication use (Fentanyl, Morphine, Versed)
- OB/GYN
- Pain management

QA Committee

- Will QA same shift as they are currently assigned
- All alerts
  - Trauma Alert
  - Sepsis Alert
  - Stroke Alert
  - STEMI Alert
- Cardiac arrests
- Will assure that the targeted 100% protocols to be reviewed are reviewed.
- Will QA the rest of the Refusals that R41 does not complete.
- Will QA the remaining protocols to ensure 40% or better of QA is completed for the month.

Critical Care Reports

- All Critical Care reports are to be reviewed by Critical Care Paramedics on the Critical Care Units. The only exception are reports written by Critical Care paramedics regarding cardiac arrests and alerts. All alerts and cardiac arrests are to be reviewed by the QA team.

Training

- Training department will review reports for new hire/promoted RLT for their first 3 months in the position.
- Maintain a monthly run / evaluation of the QA done.
- Send out a monthly communication with updates as to what percentage of treatment and written errors made as well as pertinent messages

regarding reports and treatment.

Patient Care Report (PCR) Review Process
A patient care report (PCR) is generated by field personnel for any EMS response by Fire and/or Rescue Unit where patient contact is made. Upon completion of the report, it is reviewed for completion and compliance of protocol according to chief complaint.

Firstpass software is used to QA 100% of all transport and refusal reports. If a report meets criteria determined by the medical director (e.g. failure to meet Firstpass benchmark, use of paralytic, cardiac arrest, etc) it will require manual review.

The Rescue Lieutenant at Station 41 and 62 will review the reports generated by the shift before their assigned duty shift. The QA team will review reports generated on their assigned shift. Upon review if a report appears to have a documentation error it shall be sent to the paramedic's District Chief for follow up. If a report appears to be a deviation of medical care protocols it shall be sent to the medical directors for review.

Firstpass Automated QA Benchmarks
The following benchmarks are automatically evaluated by Firstpass for completion. Failure to meet one of these benchmarks will trigger the need for a manual review of the PCR.

ACS
- 12 or 15 lead performed
- Aspirin administered
- Nitro not administered if MAP is less than 65
- Nitro withheld for inferior MI

Advanced Airway
- Confirmation placement of advanced airway with ETC02
- Airway not attempted more than twice
- ETC02 in vital signs after airway placement not null or less than 10

Refusals
- One complete set of VS
- Medical control contact if patient is under 1 year of ago
- SBP is over 90 unless patient is less than 10 years of age
- Heart rate less than 130
- Sp02 above 90

Stroke
- 12 lead obtained
- Scale stroke alert called with a BGL over 50 with positive stroke
- IV/IO attempted

Trauma
- IV/IO attempted
- Oxygen applied if Sp02 less than 94
- Tourniquet not used
- GCS Documented
- On scene less than 20 minutes
- Trauma alert listed in the flowchart, as appropriate.

Universal
- Two sets of vital signs with one GCS and AVPU

- No sustained Hypotension SBP less than 90
- No sustained hypoxia spo2 less than 90%
- No sustained tachycardia heart rate over 130
- Rocuronium not given
- Succinylcholine not given
- Ketamine not given

The following steps shall be followed for each patient who receives care according to the QA SOG categories: Review each report for the following:

- Addresses any scene times greater than 20 minutes
- Does the report adhere to established protocol for the chief complaint? If not, does the report provide reasoning for deviation from protocol and/or need for medical control contact?
- Indicates the use and proficiency of all interventions (successful/unsuccessful, number of attempts, etc.)
- Patient outcome: improves, maintains, or worsens
- Appropriate facility destination decision
- Meets Standard of Care requirements as set forth in Florida Statute 401 and 64J as well as the current Protocols developed by the Medical Director
- Completion of report

EMS Report Documentation

The following areas of the EMS Run Report document shall be reviewed as basic criteria for all reports:

- Patient Identification on ALL pages
- Patient Demographic Information (for Pediatric patients includes parent demographics)
- Identification of Chief Complaint
- Patient History/Pertinent negatives
- Physical Examination Results
- Selects appropriate protocol for chief complaint
- Documentation of ALL treatment
- Medically Appropriate Care
- Narrative which documents all pertinent patient care along with any unusual occurrences or deviations

Each report will be graded for treatment given and documentation. Treatment will be categorized based on the criteria for **Exceptional, Acceptable, Minor Deviation, and Major Deviation** from protocol. The **written report** will be categorized as **outstanding, good, or Deficiency Class I, II, III, or IV.**

Treatment Exceptional

- Treatment went above and beyond. A call that exceeded expectations.

Acceptable

- No deviation from protocol in treatment.
- Minor
- Deviation from protocol without contacting Medical Control or providing justification.

Patient outcome is not compromised.
- Destination facility and transfer of patient care to staff not documented.
- No documentation of ETOH, drugs or competency on refusal of care.

Major
- Missing “alert” notifications per protocol.
- Improper rhythm recognition with concurrent treatment and or non-treatment.
- Incorrect medications or dosage
- Treatment without justification
- Lack of documentation on treatment that hindered patient care
- Waiver without medical control contact or justification.
- Failure to obtain waiver without justification.

Written Report

Class I
- Missing signatures, one crew member signed more than once
- Missing treatment times in flow sheet
- Grammar and spelling errors
- Improper NFIRS completion
- Does not document parent or guardian contact information for minor patient

Class II
- Wrong protocol selected
- Missing EKG, attached documents not legible
- Face sheet missing
- Missing alert times

Class III
- Poorly written narrative
- No clear Chief Complaint listed
- No OPQRST for pain
- For cardiac arrest, data card not uploaded

Class IV
- Incomplete report and or narrative
- Missing treatments and documentation of patient care

Good
- Report is complete and has all required information per nature of call and protocol

Outstanding
- All required information
- Report is complete and has all required information per nature of call and protocol
- Narrative is very clear on patient complaint and treatment
- All required signatures
- All required attachments

Providing Feedback to the Patient Care Report (PCR) Originator

Each report will be reviewed based on the treatment provided, quality of the written report, and completion of the PCR as a whole.

The deviations and deficiencies noted by the reviewer will be noted in the "Comments" section in the Quality Assurance section of ESO Administrator. The following should be included when applicable:

- Deviations and deficiencies noted should be listed from Highest Class to Lowest Class
- Reviewer initials and date of review
- Send a "Field Request" to the PCR originator with feedback of the report/ deficiencies noted.
- Request an addendum if changes/ updates need to be made to the report. **This applies to Minor deviations and Class I, II, III, IV deficiencies noted.**
- Document the treatment and written deficiencies to the PCR originator's personal quality assurance log.

Procedure for Major Treatment Deviation(s):

- Do not send a Field Request for Addendum to the PCR originator.
- Add concerns / deviations to the comment section.
- An email with "high importance" will be sent to Training, the Medical Director(s), and the Assistant Chief of EMS immediately upon reviewing the report. The email will contain the run report number and the reason for concern of a Major treatment deviation noted by the reviewer.
- Document the treatment and written deficiencies to the PCR completer's personal quality assurance log.

A log will be created for every employee for the purpose of tracking quality assurance issues. Each log will be reviewed by the QA team and Training every 3 months for the purposes of developing training and revision of protocols. A copy of the **Quality Assurance Log** is provided in *Appendix A.*

An **ACFR Correction Worksheet** will be completed for individuals who consistently make written deviations with no improvement in report writing as well as Major Deviations from protocol. A copy of the ACFR Correction Worksheet is provided in *Appendix B.*

A Quality Assurance training program is provided on Target Solutions in the File Center. It is titled "ACFR EMS QA Process." If assistance locating this training is required, please contact the Training Division.

Appendix A
Appendix B