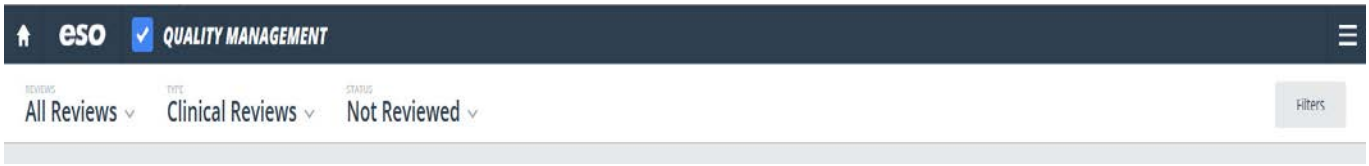
QM Procedure

The Captains are the first tier in the evaluation process and should begin the process from QM Module. Set Reviews to “All Reviews”, Type to “Clinical Reviews” and Status to “Not Reviewed.”



From the “Filters” sort the ePCRs that you wish to capture by selecting the appropriate options: Unit, Provider, Shift, etc. The Battalion will cast a wider net to review the entire shift’s progress while the Captain may keep it to a specific unit. Captains will have to keep track of those previously sent for corrections by simply selecting “My Reviews”. This can also be accomplished by keeping track of responses via messaging.

Reports in the “Show All” module will be in one of three (3) categories:

NOT REVIEWED: These reports have not yet been reviewed. If there are reports in this category from more than three (3) days prior, someone did not do their job.

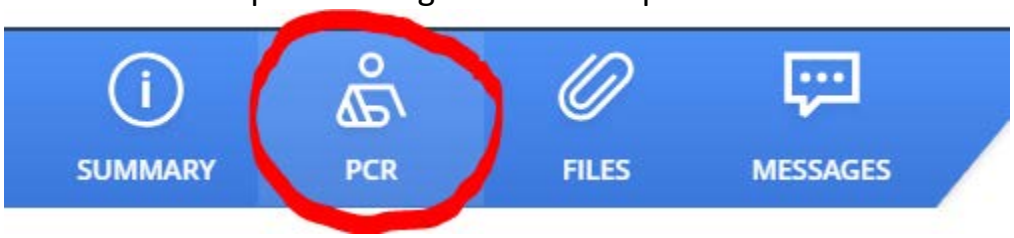
In Progress: These reports have been reviewed and deemed to be needing corrections or additional information. Reports in this category must have the appropriate feedback describing the deficiencies and a message prompting them to review the report.

Closed: These ePCRs have been “FINALIZED” **not** requiring any additional corrections or to be reviewed by additional supervisors.

Note: To check on status of previously reviewed calls needing corrections, select “My Reviews” from the task bar.

REVIEW PROCEDURE:

I. Select the report to review within the filtering options selected.
II. Select the PCR option to begin the review process.



Review each section of the report for accuracy and completeness in accordance with directives provided in reference sheets.

a. The "Clinical Impression" section has critical information that should give you an idea of the call nature and reasonable documentation expectations. The more details in this section and others, the more complete and thorough of a report.

Clinical Impression			
Primary Impression	Asthma		
Secondary Impression	Respiratory disorder		
Protocol Used	Pediatric Respiratory Distress		
Anatomic Position	Chest		
Chief Complaint	asthma		
Duration	2	Units	Hours
Secondary Complaint	difficulty breathing		
Duration		Units	
Patient's Level of Distress	Mild		
Signs & Symptoms	Respiratory - Asthma - other		
Injury	--		
Medical/Trauma	Medical		
Barriers of Care	None Noted		
Alcohol/Drugs	None Reported		
Pregnancy	No		
Initial Patient Acuity			
Final Patient Acuity			
Patient Activity	Activity, Unspecified		

b. Vital Signs: The VS sections should have information that will guide the expected treatment and care. Should support the treatment provided and vice versa; otherwise, documentation needs to reflect the reason why there was deviation from protocol.

c. Flow Chart: Should reflect **ALL** skills performed, i.e., splint, cold therapy, bandaging, IV, etc. Skills should reflect who actually performed the procedure. They should be consistent with the other parts of the report; otherwise, the narrative should justify the deviation from protocol. For example, if a patient has documented wheezes, the flow chart should reflect Albuterol/Atrovent; Pt has a swollen ankle from trauma and a suspected fx, the flow chart should reflect a splint and cold therapy.

d. Initial Assessment: Should reflect pertinent negatives related to the CC and findings made during the "Head to Toe". Should also support the clinical impression, VS's, flowchart, etc.

e. Narrative: This and all sections of the report must be clearly documented with as much detail as possible.
    i. Primary Impression: Should reflect your dx and coincide with the "protocol used". This should be consistent with the other components of the report, i.e., flowchart, VS's, etc.
    ii. Secondary Impression: When a pt has other potential complications or another body system is involved.
    iii. Chief Complaint System: Body System related to the Dx.
    iv. Supporting S/S: Should reflect all found and needs to support the diagnosis (Primary Impression)
    v. Patient Complaint: Is what the patient stated was their reason for activating EMS.

vi. Narrative: Follow the narrative directives previously sent as a guide. Should reflect a synopsis of the call while describing the **E**vents, **S**cene & **O**utcome.

vii. The rest of this section is self-explanatory, consider the more detailed the report the better written it likely is.

f. BILLING: Insurance carrier name, policy number and group number is optimal.
   i. Transports related to MVAs should reflect the auto insurance policy.
   ii. Injuries occurring at a business should reflect workers comp. details.
   iii. Medical Necessity: 

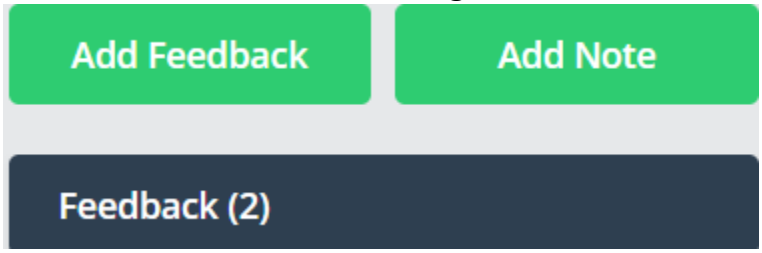
Add as many conditions that apply to the call.

g. SIGNATURES: Patient and staff signatures are very important for a variety of reasons.
   i. Refusals **need** two signatures (ideally patient and one witness that is not a member of the crew).

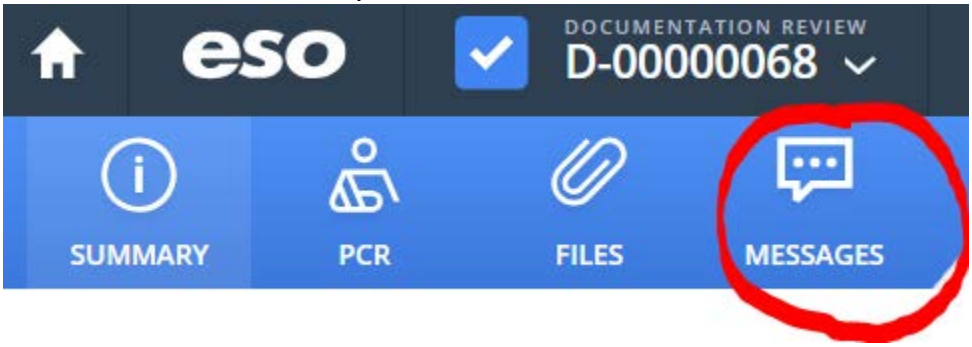
REPORT PROCESSING PROCEDURE:

I. The ePCR will be assigned into 1 of 2 categories:
   In Progress: (Returned for appended narrative)
   Closed: (Meets ePCR Standards and No further review is needed)

a. Report Requires Corrections: (3 Step Process)
   i. Add Categorized Feedback: ("other" category is at the bottom) Provide details of info needing corrections or missing.



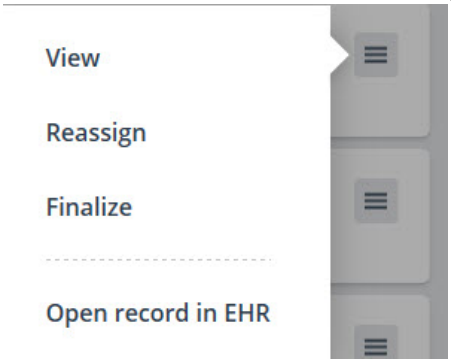
   ii. Send a message with details of the missing info. Can include other personnel or the shift BC in the message if necessary. This messaging should be vague and should not include details of the corrections needed. The feedback option is reserved for ePCR correction details.



When the report is corrected, the user will reply that corrections have been completed or ePCR has been updated. This should prompt you to ensure the corrections were made and to change status to "Approved".

b. If the call is good and does not need to be reviewed by others, change the status to Closed.

c. If the call needs to be reviewed by the BC, reassign to the on-duty BC.



d. BC Review
    a. BC goes to QM and sorts the calls by Shift and/or Review Status.
    b. If the call needs to be corrected: Follow instructions from above.
    c. If the call is good and does not need to be reviewed by others, change the status to "Finalized".

This guide will continuously be updated as our CQI policy and procedures are finalized.

Davie Fire Rescue
EMS Division
CQI Guide

ALS Quick Reference

This guide should assist the QM reviewer identify common errors with this report type and focus on items particular to this report. The full report guide should be referred to for all information needed to complete a CQI review.

Vital Signs
Minimum of two sets with more documented if any unstable vitals are listed. Empty vitals imported from the monitor should be erased.

Flow Chart
All treatments and an ALS Assessment should be documented in the flow chart. If any treatment is mentioned in the narrative, it should also be documented in the flow chart (4-lead, 12-lead, Oxygen, etc.)

Initial Assessment
There should be documented abnormalities that match the chief complaint/primary impression.

Ongoing Assessment
The ongoing assessment should either be more complete than the initial or update the initial findings.

Narrative
SOAP is the preferred narrative style, but some report writers use chronological style.

- All treatments documented are in the flow chart

Specialty Patient – Outbreak Screening
If this form is enabled during your review, is it completed accurately? None should not be documented in each section. This form should only be used if a complaint is discovered that matches the outbreak. i.e. COVID-19 if symptoms of SOB, Fever, Cough, Sore Throat, or Diarrhea – the form should be completed. If none of those symptoms exist, “Unable to Obtain and Not Indicated” should be selected.

Destination Details

- Correct facility is selected (compare to narrative or known knowledge of transport)
  - Memorial Regional South has been selected instead of Memorial Regional Hospital.
  - Chart numbers should be entered for all HDE hospitals.

Files Tab (in QM)

- All EKGs should be uploaded and attached to the report.

Davie Fire Rescue
EMS Division
CQI Guide

ALS Patient Care Report Guide

Patient Information

- Last Name, First Name (If John or Jane Doe, did member attempt to retrieve real name?)
- Gender, DOB, Address completed
- Phone number (important on refusals)
- SSN (important for transports)
- Resident Status (does this match the home address)? If a Davie address, resident status should be "resident within EMS service area."

Clinical Impression

This section has critical information that should give you an idea of the call nature and reasonable documentation expectations. The more details in this section (and others) indicates this report is complete and thorough.

- Primary Impression, Secondary Impression and Chief Complaint are selected accurately
- Duration of symptoms are a logical and accurate description of the injury/illness

Medication/Allergies/History

- Categories are completed thoroughly and without spelling errors. Doses are preferred for all medications when possible.

Vital Signs

Minimum of two sets on all transports. Unstable patients should have vitals frequently assessed and documented. Empty vitals imported from the monitor should be erased.

Flow Chart

All treatments and an ALS Assessment should be documented in the flow chart. If any treatment is mentioned in the narrative, it should also be documented in the flow chart (4-lead, 12-lead, Oxygen, etc.)

- All interventions are documented in a logical sequence and in accordance with protocol

Initial Assessment

There should be documented abnormalities that match the chief complaint/primary impression. An injury to the face should have the category HEENT, abnormality for Head/Face documented. If "No Abnormalities" is selected, this would be a documentation error and an appended narrative should be requested.

- "Not Assessed" is appropriate for multiple categories depending on the complaint. As an example, a localized trauma should not have a Pelvis/GU/GI assessment completed.

Ongoing Assessment

The ongoing assessment should either be more complete than the initial or update the initial findings. Review this section to make sure nothing is selected "No Abnormalities" that contradicts the initial assessment findings. As an example, a fractured extremity should not be marked on an ongoing assessment as No Abnormalities.

Davie Fire Rescue
EMS Division
CQI Guide

Narrative

SOAP is the preferred narrative style, but some report writers use chronological style. Please review the narrative and confirm:

- All treatments documented are in the flow chart
- All injuries/complaints in this section are accurately documented in the clinical impression section of the report
- Narrative is free of spelling and grammatical errors
- Narrative accurately describes the call based upon the above documented sections

Narrative – Refusal

- Did the patient meet "High Risk Refusal" guidelines? If so, did the report writer document the BC was notified and hospital contacted following protocol?
- Did the narrative end with a clear documentation of the risks being explained to the patient regarding signing a refusal?

Specialty Patient – Outbreak Screening

If this form is enabled during your review, is it completed accurately? None should not be documented in each section. This form should only be used if a complaint is discovered that matches the outbreak. i.e. COVID-19 if symptoms of SOB, Fever, Cough, Sore Throat, or Diarrhea – the form should be completed. If none of those symptoms exist, "Unable to Obtain and Not Indicated" should be selected.

Incident Details

- Address matches call location, not patient address
- Level of Service is selected appropriately

Destination Details

- Correct facility is selected (compare to narrative or known knowledge of transport)
  - Memorial Regional South has been selected instead of Memorial Regional Hospital.
  - Chart numbers should be entered for all HDE hospitals.

Incident Times

- Times are all completed accurately.
- Was there any delay in En Route, total response time, or making patient contact?

Crew Members

- Are all crew members involved with patient treatment documented?

Insurance Details

- Is this section completed with as much information as possible for all transports?
- Important for billing: Review Dispatch Nature, Response Urgency, Job Related Injury, Employer (if workers comp related).

Mileage

- Do the miles accurately report the transport?

Davie Fire Rescue
EMS Division
CQI Guide

Delays

- Based upon the documented times, should there be any delays documented?

Additional Agencies

- Were any additional agencies involved with the patient care?

Signatures (Refusals)

- Notified by section should have the report writers' signature
- Patient signature should be obtained
- Witness should be (in order or preference) Family or Close contact or PD or Partner

Patient Transport Details

How was the patient moved to ambulance, patient position during transport, how was patient moved from ambulance and condition at destination are all important items for billing. Please make sure these accurately reflect how the patient was transported.

- Billing Authorization
  - Section 1: Patient Signature should be obtained. PREFERRED
  - Section 2: If not able to sign based upon condition, Authorized Rep. Signature should be obtained (this should not be our personnel's signature) ACCEPTABLE
  - Section 3: EMS Personnel signatures are the least preferred and should be avoided when possible. This should be rarely used. DISCOURAGED

Facility Signatures

- Should be obtained for all transports - this documents the transfer of care.

Provider Signatures

- Appear to accurately match all providers signatures along with their badge number.
- Review the certification level of each member to make sure it is accurate (particularly if a firefighter has recently been cleared as a paramedic)

Files Tab

- All EKGs should be uploaded and attached to the report.

Davie Fire Rescue
EMS Division
CQI Guide

BLS Quick Reference

This guide should assist the QM reviewer identify common errors with this report type and focus on items particular to this report. The full report guide should be referred to for all information needed to complete a CQI review.

Clinical Impression

Primary Impression: Does not match an ALS complaint (no trouble breathing, chest pain, AMS, signs of shock, complicated childbirth, multiple injuries, injuries needing pain control, etc.)
Patient Chief Complaint: Does not match an ALS complaint (see above).
Patient's level of distress: Should not be higher than mild.
Initial Patient Acuity: Should be green.

Vital Signs

No unstable or abnormal vital signs documented.
AVPU: Should be Alert (or normal for patient)
Blood Pressure: No systolic greater than 220 mm Hg or Diastolic greater than 120mm Hg.
Heart Rate: Not faster than 100, slower than 60.
SPO2: Should be greater than 94%
GCS: Should be 15 (or normal for patient)

Flow Chart

BLS Assessment should be listed

Initial Assessment

Injuries: If trauma, no injuries meet level 2 criteria or Trauma Alert. Compare to updated CUTT.
Abnormalities: No new abnormal findings should be present that require an ALS assessment/treatment.

Narrative

Narrative paints the picture of the patient, scene and does not document any findings that should require an ALS assessment or treatment performed.

Specialty Patient

Trauma (if applicable) criteria should state a trauma level of BLS
Outbreak Screening Form should list the exposure and if none, the form should say "Unable to Obtain – Not Indicated."

Destination Details

The correct facility is selected and matches the narrative

Delays

Review the times to see if any delays should be documented here.

Signatures

All obtained per the BLS Transport Guide.

Davie Fire Rescue
EMS Division
CQI Guide

BLS Patient Care Report Guide

Patient Information

- Last Name, First Name (If John or Jane Doe, did member attempt to retrieve real name?)
- Gender, DOB, Address completed
- Phone number (important on refusals)
- SSN (important for transports)
- Resident Status (does this match the home address)? If a Davie address, resident status should be "resident within EMS service area."

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- Primary Impression, Secondary Impression and Chief Complaint are selected accurately
- Duration of symptoms are a logical an accurate description of the injury/illness

Medication/Allergies/History

- Categories are completed thoroughly and without spelling errors. Doses are preferred for all medications when possible.

Vital Signs

Minimum of one set shall be obtained on all refusals. Minimum of two sets on all transports. Unstable patients should have vitals frequently assessed and documented. Empty vitals imported from the monitor should be erased.

Flow Chart

All treatments and a BLS Assessment should be documented in the flow chart. If any treatment is mentioned in the narrative, it should also be documented in the flow chart (cold pack, bandaging, irrigation, backboarding, C-collar, etc.)

- All interventions are documented in a logical sequence and in accordance with protocol

Initial Assessment

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Incident Details

- Address matches call location, not patient address
- Level of Service is selected appropriately

Destination Details

- Correct facility is selected (compare to narrative or known knowledge of transport)
    - Pay careful attention to freestanding ERs. FMC has been selected instead of FMC Freestanding. Memorial Regional South has been selected instead of Memorial Regional Hospital.
    - Chart numbers should be entered for all HDE hospitals.

Incident Times

- Times are all completed accurately.
- Was there any delay in En Route, total response time, or making patient contact?

Crew Members

- Are all crew members involved with patient treatment documented?

Insurance Details

- Is this section completed with as much information as possible for all transports?
- Important for billing: Review Dispatch Nature, Response Urgency, Job Related Injury, Employer (if workers comp related).

Mileage

- Do the miles accurately report the transport?

Delays

- Based upon the documented times, should there be any delays documented?

Additional Agencies

- Were any additional agencies involved with the patient care?

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