Davie Fire Rescue
EMS Division
CQI Guide

Cardiac Alert 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

This section has critical information that should give you an idea of the call nature and reasonable documentation expectations. The signs & Symptoms section should indicate the alert criteria.

- Primary Impression, Secondary Impression and Chief Complaint are selected accurately
- Duration of symptoms are a logical and accurate description of the chest pain

Vital Signs

Minimum of two sets. 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.) Review for Mission LifeLine Goals: Patient contact to first 12-Lead within 10 minutes, Cardiac Alert (pre-alert) within an additional 10 minutes. Minimal on-scene time.

- All interventions are documented in a logical sequence and in accordance with protocol
- 12-lead EKG notes should show “Cardiac Alert” for the interpretation
- Cardiac Alert should be in the flowchart and be documented when the Pre-Alert was given to the hospital.

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

Files Tab

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

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Cardiac Alert Patient Care Report Guide

Patient Information

- Last Name, First Name (If John or Jane Doe, did member attempt to retrieve real name?)
- Gender, DOB, SSN, Address and phone number completed
- 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 signs & Symptoms section should indicate the alert criteria.

- 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.) Review for Mission LifeLine Goals: Patient contact to first 12-Lead within 10 minutes, Cardiac Alert (pre-alert) within an additional 10 minutes. Minimal on-scene time.

- All interventions are documented in a logical sequence and in accordance with protocol
- 12-lead EKG notes should show "Cardiac Alert" for the interpretation
- Cardiac Alert should be in the flowchart and be documented when the Pre-Alert was given to the hospital.
- If inferior wall MI is suspected, V4R 12-lead should be documented
- Nitroglycerin administered if minimum BP is documented (should not be administered if positive V4R or ED medications listed in medications history).
- Aspirin and Fentanyl should also be administered

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.

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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.

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

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?

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.

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Cardiac Arrest 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.

Patient Information
If "John Doe" is used, was there any attempt made to update the name? (If transported, contact the hospital.)

Vital Signs
Keep only accurate vitals. Multiple monitor import with empty vitals should be deleted. Confirm no "normal" vitals are listed unless ROSC was achieved. ETCO2 values should be in the vitals after an iGel has been placed.

Flow Chart
All interventions are documented in a logical sequence and in accordance with ACLS protocol. CPR, Oxygen, iGel, Mechanical CPR (AutoPulse), IO/IV, Epi (every 3-5 min), should all be listed in the flow chart in addition to other ACLS protocol items as applicable.
If ROSC achieved, was a 12-lead documented?

Initial Assessment
There should be documented abnormalities that match cardiac/respiratory arrest/unconscious.

Narrative
Narrative accurately describes the call based upon the above documented sections

Specialty Patient – CPR (CARES) Form
All cardiac arrest information matches narrative (initial rhythm, etiology, collapse time, etc.)
Etiology matches CARES definition (Cardiac, Overdose, Trauma, etc.)
CPR feedback and ITD should be no.
CPR initiated by should list who was first to do CPR (family, medical provider, law enforcement, etc.) EMS should be listed if no pre-arrival CPR was performed.
CPR Type should list Compressions external band type for the AutoPulse.
Prearrival CPR instructions should be "yes" if dispatch is giving direction PTA.
End of Event should be the final disposition of the patient in the ER or ongoing resuscitation if not pronounced.

Specialty Patient – Outbreak Screening
If this form is enabled during your review, is it completed accurately? Should be completed on all cardiac arrest.

Crew Members
All personnel should be listed here that responded to the cardiac arrest (Engine, Rescue and BC). Non-Crew members can also be listed (Davie PD) who provided care.

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Files Tab
Should show the ECG rhythms

Confirm Code Stat has been sent, if not, request it sent from archives.

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Cardiac Arrest 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 (Estimates may be used if unknown and no information is available, but attempts should be made to contact the hospital)
- SSN (if possible)
- 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 (Cardiac Arrest, Respiratory Arrest, Syncope, etc.)
- Duration of symptoms would be related to a complaint prior to the cardiac arrest or a known down time
- This section will contain different impressions and complaints depending if it was a witnessed cardiac arrest versus PTA.

Medication/Allergies/History

- These categories are completed when possible. "Unknown" is common on cardiac arrests, but whenever possible the crew should be encouraged to get a medical history as it may impact the treatment during the cardiac arrest (Bicarb, Calcium Chloride, etc.)

Vital Signs

Make sure vital signs for heart rate and blood pressure aren't documented during the cardiac arrest. The monitor import will bring in vitals during the code, but many of them should be erased or changed to "0" for vitals. 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 (CPR, i-gel, IO, Epinephrine (make sure it is 1:10,000 documented), etc.)

- All interventions are documented in a logical sequence and in accordance with protocol:
    - On most cardiac arrest, the following should be in flowchart: CPR, Oxygen, OPA, IO, Epi, i-gel, ETCO2, mechanical CPR (commonly forgotten), etc.
    - Medications documented appropriately. Confirm – Epi every 3-5 min, dosing and routes on all medications
    - If ROSC achieved, was a 12-lead EKG documented after pulses returned?

Initial Assessment

Any findings of abnormalities from a head-to-toe assessment should be documented here. Mental status, for example, should have documented "unresponsive – positive" listed.

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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 status of cardiac arrest (mentation, skin condition, etc.)

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
- Narrative is free of spelling and grammatical errors
- Narrative accurately describes the call based upon the above documented sections

Specialty Patient – CPR – Cardiopulmonary Resuscitation

This section of the report is used to report directly to CARES (Cardiac Arrest Registry to Enhance Survival) and needs to be as accurate as possible.

- Witnessed: Did the arrest happen before or after arrival?
- Etiology: An arrest is presumed to be of cardiac etiology unless it is known or likely to have been caused by trauma, drowning, respiratory causes, asphyxia, electrocution, drug overdose, poisoning/intoxication, hemorrhage/exsanguination, or any other non-cardiac cause as best determined by rescuers.
- Estimated Time: In cases of a bystander witnessed arrest (one that is seen or heard), the time of arrest can be presumed to be the time of 911 call in the absence of other information. If EMS witnesses the code, it should be based upon that exact time. If it is an unwitnessed code, a best guess should be used by adding time to the dispatched time (i.e. caller advises they last saw them 10 minutes ago, use call received time plus 10 minutes).
- Witnessed: Should be accurate based upon given information (1st responder (us), healthcare professional (not including us), law enforcement, or family.
- CPR Directions Provided: Did dispatch provide CPR direction? Please make sure this is accurate if they did or didn't as we follow-up with dispatch when they don't.
- AED: Was an AED applied PTA? PD, bystander at a commercial location, or a healthcare provider are all options. Please make sure this is only used if one is applied by a witness (not fire department, unless a chief used their AED PTA)
- CPR: This should match the narrative – did the family member, healthcare provider or PD begin CPR PTA? Type of CPR should be "compressions – external band type" for the AutoPulse.
- Discontinue Reason: This should not be completed if the patient is still having ongoing resuscitation in the ER. If we document a reason it was stopped, then we must document date and time of it stopping. If an option is selected (even if it is removed) it will be a required field. It should typically not be used.
- EMS: Make sure the initial rhythm, defibrillation information, and rhythm at ER all match what is previously documented in the narrative or flowchart.

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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
- ALS Level of Service is selected

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.

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? This call should have the Engine personnel and the BC on the report.

Insurance Details

- This section may be challenging to get for a code. But when possible, this section should be completed with as much information as possible.
- 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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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 will not be possible.
  - Section 2: An 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)