



Davie Fire Rescue  
EMS Division  
CQI Guide

## Trauma Alert Quick Reference

### Patient Information

- Last Name, First Name (If John or Jane Doe, did member attempt to retrieve real name?)  
If Air Rescue transported, attempt to contact hospital for updated name.

### Clinical Impression

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

### 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.)

- All interventions are documented in a logical sequence and in accordance with protocol
- Trauma Alert should be a listed flow chart item and reflect time the hospital was pre-alerted.

### 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. 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

### Specialty Patient – Outbreak Screening

If this form is enabled during your review, is it completed accurately?

### Destination Details

- Chart numbers should be entered for all trauma alerts (contact hospital if Air Rescue transports patient for the chart number)



Davie Fire Rescue  
EMS Division  
CQI Guide

**CUTT Form**

- Should be attached to this report with the criteria circled.

**Files Tab**

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



## Trauma Alert Patient Care Report Guide

### Patient Information

- Last Name, First Name (If John or Jane Doe, did member attempt to retrieve real name?)  
If Air Rescue transported, attempt to contact hospital for updated 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 injury and 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.)

- All interventions are documented in a logical sequence and in accordance with protocol
- Trauma Alert should be a listed flow chart item and reflect time the hospital was pre-alerted.

### 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



## Davie Fire Rescue EMS Division CQI Guide

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

### **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 trauma alerts (contact hospital if Air Rescue transports patient for the chart number)

### **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).



## Davie Fire Rescue EMS Division CQI Guide

### 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? (Broward Sheriff's Office Fire Rescue when Air Rescue 85 is utilized)

### 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)

### CUTT Form

- Should be attached to this report with the criteria circled.

### Files Tab

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