

**Sandoval County Emergency Services
Monthly Quality Assurance Form**

Service: _____ Incident: _____ Call Date: _____
EMS Report # _____ Provider #(s) _____ Level of Care: FR BLS ILS ALS

General

Dispatch:

C/C or MOI:

Face sheet Complete
Narrative Complete

Times and Mileage Obtained
DCHARTE Format

Appropriate Protocol Followed
Fax Received from Dispatch
Report Signed

Scene

Multiple Pts./MCI _____ Transport Unit: _____ Appropriate Type Level _____
Special Resources: _____
Scene Time: _____ Appropriate _____ Prolonged _____
Safety Concerns: _____

Primary

Airway Self Maintained _____ Suction Adjunct: _____ Other Method: _____
Combitube/ETT size: _____ # of Attempts: _____ Placement Verification: _____

Breathing

Adequate Rate of Depth O2 Sat w/O2: _____ w/o O2: _____
Assisted with O2 Devise: _____ LPM: _____ Other: _____
BVM Rate: _____ ATV Settings-Rate _____ TV: _____

Circulation

Assessed by: _____ Pulse Location: _____ BP _____ Skin Color _____
Bleeding Control Methods: _____ Controlled _____
Cardiac Arrest _____ CPR _____ Defibrillation _____ # of Shocks: _____ Time to 1st Shock _____
Response to Defib: _____
Outcome: _____

Disability

LOC Assessed and Documented _____
GCS _____ APGAR (neonates): _____
Any Abnormal Vital Documented and Explained _____ Multiple Set of Vitals _____

Secondary

History: _____ Appropriate Pertinent Medical History and/or Mechanism of Injury based on C/C
Appropriate Exam _____ Nose to Knees (trauma) _____ Secondary (major medical) _____ Focused Exam (minor) _____
BGL in Altered LOC/Diabetic _____ Breath Sounds in Resp Distress _____ Spinal Assessment (trauma) _____
Neuros in Head/Spine Injuries _____ Abd Exam in Abd Pn _____ ECG in Chest Pn and Cardiac Arrest _____

Interventions

Proper Spinal Precautions _____ Splinting _____ Neuro Check before and after _____
Other interventions per protocol: _____
IV # of attempts: _____ Site: _____ Flow: _____ Gauge: _____ Appropriate _____ Deferred _____
Drug Interventions per protocol _____ Right drug _____ Right dose _____ Right time _____
Response to IV or Drug Therapy: _____
Any Adverse Effects: _____
Clinical Response to Field Care: _____ Improved _____ Unchanged _____ Stabilized _____ Expired _____

Signed Refusal

Multiple sets of Vitals _____ LOC and capacity to understand refusal documented _____
Significance of refusal documented _____ Follow-up instructions documented _____ Refusal form signed and witnessed _____

Patient Follow-up information: _____

Comments: _____

MD Comments: _____

EMS QA Review by: _____ Date of Review _____