

# Tomé-Adelino Fire Department Emergency Medical Service Standard Operating Procedure

**Title:** Patient Reports and Internal Quality Assurance

**Authority:** Per NMAC 18.4.2.91, Quality Assurance (QA) is mandated under Section F entitled: "Medical director review of patient care" and is further required by Valencia County EMS Protocols section entitled Continuous Quality Improvement.

**Overview:** Continuous review and identification of areas of excellence as well as potential sources of risk are necessary to maximize the quality of patient care in our EMS. A procedure that sets specific standards that shall be followed in order to provide not only a subjective review but also an objective review of patient care is required. QA procedure begins with the completion of a hand-written pre-hospital patient care report in an approved format. Also included is a computer-generated pre-hospital data collection system (pdcs) report approved by the state, signed and dated by the author. A Liability Release shall be included if indicated. The QA procedure concludes with an objective and subjective review of all patient reports demonstrating areas of improvement of patient care and, if required, the taking of any remedial action required to bring any report into compliance as well as recognition of excellence in patient care.

**Reports:** A complete package of reports shall consist of a pre-hospital patient care report, a pdcs report, a Liability Release, if indicated, and a QA Review.

**Pre-hospital patient care report:** The pre-hospital patient care report is a hand-written report taken in the field and is typically completed as a matter of course during patient assessment and treatment. Pre-hospital patient care reports shall be completed for patients and non-patients. The pre-hospital patient care report shall have the following minimum requirements where applicable and/or attainable:

- Rescue unit number,
- Provider names with level of licensure,
- Patient demographic information including patient's name, age, sex, address, phone number, date of birth, Social Security Number,
- Patient's chief complaint,
- Brief history of the present illness or injury including scene assessment and mechanism of injury,
- Patient's major past illnesses,
- Patient's mental status,
- Patient's baseline vital signs including (where indicated) respiration rate and depth, pulse rate and quality, blood pressure, oxygen saturation, skin perfusion, pupil reactivity, capillary refill, body temperature and blood glucose level,
- Pertinent findings of a physical examination,
- Description of any emergency medical care that has been provided for the patient including that provided by any first response,
- Patient's response to any medical care received.
- As time permits, a copy of the pre-hospital patient care report shall be provided to any transport/receiving entity for inclusion in the patient's permanent medical records.

**The pdcs Report:** The pdcs report is a computer-generated report format provided by the State of New Mexico to meet state and federal reporting requirements. A completed pdcs report shall have the following minimum requirements:

- All fields, as configured by the particular pdcs program, shall be completed as completely as practicable.

- Patient and non-patient narrative shall follow the DCHARTE format.
  - D = Dispatch. Include time of dispatch, address of dispatch and nature of call as reported by dispatch.
  - C = Chief Complaint. State chief complaint in the patient's own words as much as possible.
  - H = History. Include any and all information included in the patient SAMPLE history as well as patient responses to OPQRSTU questions as applicable. Trauma scenes shall have a detailed description of the scene including any mechanism of injury.
  - A = Assessment. Include both primary and secondary assessments (scene surveys). Vitals need not be duplicated in this area if the pdcs report provides separate fields for vitals. Address any vitals where the pdcs does not provide a specific field. Address any vitals that were not within normal limits.
  - R = Treatment. Describe in detail any and all treatment rendered. Describe the patient response to each treatment.
  - T = Transport. Describe when the transport unit arrived or when patient arrived at the final destination. Describe what type of communication took place between the lead medical rescue personnel and the transport/receiving personnel at time of transfer. Indicate whether a copy of the pre-hospital patient care report was provided to the transport/receiving facility. Indicate the patient's condition at time of transfer.
  - E = Exception. Use this section to describe any factor of the patient contact that was an exception to the normal. Use this section to describe all required non-transport information if the patient decided to refuse transport (See Liability Release requirements in this SOP.)
  - In addition to the above, indicate at the end of the DCHARTE the disposition of the Protected Health Information (PHI) Notice that must be supplied to every patient. Indicate who signed for the PHI Notice or how the PHI Notice was otherwise conveyed to the patient.
- Time requirements for completion of the pdcs report:
  - All pdcs reports shall be completed within 72 hours of the initial dispatch time.
  - In the event that, due to a personal time constraint, the pdcs report cannot be completed within 72 hours, the hand-written pre-hospital patient care report shall be fully executed with notes of sufficient detail to complete the report at a future time.
  - In the event that, due to a personal time constraint, the pdcs report cannot be completed within 72 hours, the medical personnel assigned to complete the pdcs report shall attach a note to the pre-hospital patient care report indicating a date certain when the pdcs report shall be completed.

**Liability Release:** A Liability Release, as approved by the medical director, shall be completed for any patient or non-patient refusing transport and/or treatment to a hospital or other receiving facility. The following procedure shall be used for the completion of the Liability Release and corresponding documentation, where applicable, under "E" in DCHARTE:

- Complete all demographic information required.
- Complete the date, time and location fields at the top of the Liability Release.
- Compare results of patient examination, review and check off any refusal criteria that apply.
  - Any refusal criteria that cannot be checked off must be referenced under "E" in DCHARTE.
  - Any refusal criteria that cannot be checked off must be brought to the attention of the patient and this too must be referenced under "E" in DCHARTE.
  - Non-patients require only the first two criteria to be checked off.
- Read aloud any and all sections of the Liability Release that pertains to the patient.
  - Note under "E" in DCHARTE that you "read aloud" those sections.

- Usually, further explanation is required after reading aloud those sections. Reference under “E” in DCHARTE that you further explained the Liability Release.
- Finish by asking the patient if they have any questions regarding the Liability Release. Answer any questions. Note under “E” in DCHARTE that the patient had questions and they were answered or note that the patient had no questions.
- Other Liability Release Notations to be included under “E” in DCHARTE:
  - Document patient’s mental status.
  - Document patient’s understanding of condition.
  - Document follow-up recommendations made by EMS to patient.
  - Document witness signature sources if you are not able to get signatures other than EMS personnel as witnesses.

**Continuous Quality Assurance Procedure:** The Continuous Quality Assurance Procedure is necessary in order to identify areas of excellence as well as potential sources of risk and is necessary to maximize the quality of patient care in our EMS. Completing the QA form is a time sensitive function and therefore the following procedure shall be implemented:

- Department-level personnel assigned by the department head shall review all reports where patient assessment or treatment was initiated.
  - Reviewer cannot review reports created by reviewer. Other personnel shall complete those reports.
  - Reviewer can review reports in which they participated in patient care.
- Review shall be done as soon as practicable after completion of the pdcs report.
- In no event shall any report be reviewed later than the 5<sup>th</sup> of the month following the month where the patient contact took place.
- All reviews shall be done using the QA Review form and the reviewer shall complete all fields. The QA Review form shall be attached to the complete patient record.
- If any report is found to have a significant variance, the department head shall be made aware immediately.
- If any report is found to have, in the opinion of the reviewer, areas of omission or other areas where reworking the report would improve the final product, the reviewer shall make the author aware of this fact in a manner approved by the department head.
- Any report requiring amendment shall be amended within 72 hours of having received notification.
- The reviewer shall then complete a new QA Review.
- The complete patient record shall be arranged in the following order, from top to bottom:
  - QA Review form,
  - Hand-written pre-hospital patient care report,
  - Computer-generated pdcs report,
  - Liability Release(s) as applicable,
  - Any additional field notes or information provided by the patient,
  - Any previous QA Review.
- QA Review forms are not required on reports where department personnel did not perform any patient assessment or treatment.
  - Those reports should be reviewed for proper explanation regarding why department personnel took no action.
  - Those reports found to be deficient in the explanation shall be returned to the author for amendment.
  - All timelines mentioned above apply to these types of reports.
- All QA Reviews shall be reviewed by the original author to note comments made. Original author shall indicate, either by initials or signature and date at the lower portion of the QA Review Form, that they acknowledged the review.