Wintergreen Fire and Rescue *Standard Administrative Policy*	
Subject:	EMS Quality Management Reporting
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Signature of Approval	Curtis Sheets, Chief

Purpose:
In accordance with Virginia Code §8.01-581.17 and applicable Virginia Office of Emergency Medical Service regulations, this SAP provides guidelines for Quality Management Reporting functions. Quality Management Reporting functions are to evaluate system effectiveness and regard for established SAP's, guidelines, and standards of care.

This SAP will provide guidance for the completion of electronic patient care report (ePCR) for Emergency Medical Services (EMS) billing, ensure the compliance with treatment protocols, standardized completion of ePCRs, compliance with operational policies, and provide methods for remediation and improvement.

Policy:
The AIC will ensure completion of the ePCR and post on the ESO site by the end of the AIC's shift, for each EMS Call dispatched. The AIC will be considered the ePCR's author.

- It is important that each report be locked so it is accessible by the QM committee.
- Once the report is complete it should be synced so the report is accessible in the EHR system within ESO and available to the appropriate hospitals. The AIC may sync the call and complete on a station computer or their own laptop as long as they are at the station. Reports should not be completed at other locations away from Wintergreen Fire & Rescue staffed stations.
- If a patient is to be transported to a hospital the AIC should make every effort to leave at least an abbreviated report with the nurse at the hospital. If this isn't possible then a full report should be posted on ESO for the hospital to access no later than 12-hours from the time of the call or by the end of the AIC's current shift.

The digital ePCR will then be reviewed by the QM committee for its completion, quality of care provided, and protocol compliance.

- QM comments and requests for action:
  - The QM committee will alert the author of corrections needed for the ePCR. The alert will be sent via ESO messages to the Attendant In Charge (AIC) and Captain of the AIC. These notifications may also include the Deputy Chief and/or the Training Captain.

    - The author of the report shall make the necessary corrections to their ePCR by the end of their next scheduled shift. Preferably at the beginning of their next shift.
        - Failure to do so within six (6) days (or two scheduled shifts) will constitute non-compliance.
- It is required that each provider sign-in at the beginning of your shift (or as soon as feasible after training and truck checks) to check for QM messages and make any required corrections. Once corrected the AIC should send a reply message to the QM committee to notify them that the report has been corrected so it can be marked “Approved” for billing, if applicable.
- Captains and Lieutenants are responsible for ensuring that their crew members are completing the required corrections in a timely manner.
- Impact of non-compliance results in lack of funding to the county to support the EMS service to the community of Nelson County.
- Corrective action in the form of verbal, written, and dismissal according to the WPOA handbook may be followed for non-compliance.

On a monthly basis the Deputy Chief and Training Captain will supplement the QM committee review of ePCRs on select calls. Supplemental review will occur with ePCRs or incidents containing:

- Patient or public complaint
- Death on the scene
- Death in transit
- Vehicle extrication incidents
- Any case of inappropriate action by a health care provider
- Any instance of medication error or receipt of inappropriate orders
- Use of Aeromedical Services
- Rapid Sequence Induction (RSI) procedure
- Any patient requiring electrical therapy
- Any patient requiring use of the ventilator/BiPap
- Any report can be pulled at random to be reviewed

If appropriate, the review will be forwarded to the Chief of Fire and Rescue and/or Operating Medical Director (OMD) for further evaluation and/or action.

The OMD may conduct an incident review several times during the year in addition to this policy to focus on the following incidents:

- RSI procedures
- Incidents as deemed necessary by the Deputy Chief/Training Captain

Definitions:
Quality Assurance - The process by which the performance of individual EMS Providers will be continuously monitored to ensure compliance with treatment protocols and operational policies.

Quality Improvement - which involves a continuous cycle of evaluation, identification of strengths and opportunities for improvement, education, and training in areas needing

improvement and then re-evaluation to determine whether improvement has been achieved.

Standardized Requirements for ePCR Completion:
The following is standardized ePCR documentation for Wintergreen Fire & Rescue personnel, and to provide a comprehensive understanding of what is required for timely billing and requested by the Deputy Chief and the Operating Medical Director.

Incident Information
- Address, location, or intersection dispatched to
- Incident number should be formatted based on the CAD timesheet as follows; E22-00103 for EMS calls and occasionally F22-00123 when the call originated as a fire call. This does apply to Wintergreen and Nelson dispatched calls. This number shall replace the auto-generated incident number in ESO reports.
- Primary role of the unit should be marked according to the highest level of care on the unit at time of response.

Patient Information
- Verify if patient is a repeat patient
- Provide name, age, gender, date of birth, address, and parent/guardian for the patients under the age of eighteen, where applicable.
    - The address of the patient shall be where the patient receives their mail. Remember that no address on Wintergreen mountain can receive mail at their residence. The provider must obtain the PO box in these instances.

Vitals/Flowchart/Assessments
- All procedures, medications administered, vitals, and EKG's shall be entered and time stamped under Flowchart within your report.
- All patients shall have the medical assessment completed to include a minimum of but not limited to skin condition, mental status, and neurological assessment.
- Patients with traumatic injury need to have an injury assessment completed.
- Patients with burn injury need to have a burn assessment completed.
- A weight shall be included whenever a weight-based drug is administered.
- All appropriate sets of vitals shall include a Glasgow Coma Score (GCS).
- Vital sign acquisition is recommended every 5 minutes for unstable patients, and every 15 minutes for stable patients and shall be documented in the Vitals section of your report. Vitals may be imported from the monitor under this section of your report.
- Cardiac Monitoring [4 or 5 lead] (ALS skill only), shall be noted under Flowchart and Other. When monitoring 4 or 5 lead the provider shall press the Snapshot button on the Zoll monitor which will document that current rhythm. In the event of any changes in the patient's rhythm, then press the Snapshot button again. It will record in a given timeframe before and after the event. This should be recorded/transferred under Flowchart and Other within your report.
- ECG 12-lead (BLS skill that includes lead placement, pressing analyze, reading results, and transmitting results to hospital), as soon as an Intermediate or

Paramedic provider is present and specifics are interpreted then it becomes ALS. This should be recorded/transferred under Flowchart and Other within your report.

- ECG 15-lead, or posterior leads (ALS skill only) should be documented in the Vitals section of your report. This should be recorded/transferred under Flowchart and Other within your report.
- 12-Leads shall not be administered as a tool to obtain a refusal. If a 12-lead is indicated on scene and then patient refuses care and transport then Medical Control shall be contacted for consultation prior to leaving the scene. All information regarding the refusal shall be documented.
- All 4-leads or 12/15-leads should include an interpretation within the Flowchart event for ALS or BLS providers.

Past History

- Patient allergies should be recorded when medications are administered. If unable to obtain allergies, it should be documented "unable to obtain allergies" and reason why in your narrative. All past history can be documented in the Patient tab.

Narrative

- All providers completing a narrative/report with Wintergreen Fire & Rescue shall follow the DCHARTE narrative format. Refer to Appendix A for a detailed description of what should be included in each section.
- Narratives are discoverable items and can appear in court. Narratives should not include editorial information such as "I could not get dispatch to understand that I needed a helicopter at this location" or "patient back boarded prior to my arrival although it wasn't necessary". Instances such as these should be handled by other means and not included in reports.

Forms

- Specialty patient forms shall be completed under the Forms tab for the following patient chief complaints:
    - Patients requiring an Advanced Airway
    - Burn patients
    - Stroke patients
    - Patients requiring CPR
    - Patients involved in MVC's
    - Obstetrical patients
    - Sepsis patients
    - Patients assessed for spinal immobilization
    - Trauma patients

Disposition

- The following calls are considered to be making patient contact, patient information and a signature shall be obtained. The response disposition should be chosen according to the following:

- “Patient Treated, Released (AMA)” shall be selected in the rare instances when a procedure, medication administration, and/or Advanced Life Support (ALS) has been done, such as a patient that may be unresponsive due to low blood sugar (with known history) and when given D10 they wake up and do not wish to be transported. In this and similar cases **medical control shall be contacted** due to initiation of advanced medical procedures and/or medication administration. Providers must be aware of and prevent extensive on-scene times. Document your findings using the DCHARTE format.
- “Patient Treated, Transported by Law Enforcement” should be chosen if the patient was assessed with little or no injuries found and determined the patient will be transported to an alternate facility by Law Enforcement. Document your findings using the DCHARTE format. If unable to obtain a refusal note in section “E”.
- “Patient Treated, Transferred Care to Another EMS Professional” should be chosen when care was initiated by one unit or EMS provider and care was transferred into the care of another service. For example, if a BLS provider is at a scene and treats a patient, but a separate ALS provider arrives and takes over, the BLS record would indicate this disposition. Document your findings using the DCHARTE format.
- Occasionally we are called for public service where a patient needs assistance to a chair, bed, or car. If the patient has **no injury or illness** and only needs lifting assistance, this call can be marked as “Assist, Public”. A report is required for these patients and basic patient demographics shall be obtained and narrative completed using the DCHARTE format.
- “Assist, Agency” shall be selected as the appropriate disposition if a unit of ours assisted another unit within our department. Patient demographics shall be obtained. In a cardiac arrest situation the primary lead on the call should obtain and document information for all procedures and medications administered on that unit's report.
- “Patient Refused Evaluation/Care (Without Transport)” shall be obtained and marked accordingly if:
    - If assessment completed and vital signs were obtained
    - Patient has an injury or illness that requires 911 to be activated, but decides that transport is not necessary.
    - If someone else activates 911 for a patient with an illness or injury and the patient decides that transport is not necessary.
    - At least one set of vitals and patient information/demographics shall be obtained with any patient refusal.
    - Refusal narratives shall be in the DCHARTE format.
    - Providers must be aware of and prevent extensive on-scene times.

- The following are considered when there is no patient contact and no patient information is required.
    - “Standby-Public Safety, Fire, or EMS Operational Support Provided” should be selected when an EMS unit is dispatched to standby at a fire or

hazardous material scene and no medical attention is necessary. This may also be used for any Squad 1 response.
    - “Canceled on Scene/No Patient Found” is used when your patient has fled the scene or is no longer at the address you were called to. If you have made contact with a patient and they have <u>no injury or illness</u>, then refer to above, “Assist, Public”.
    - If the call was canceled, then mark report as “Canceled (Prior to Arrival at Scene)”
    - If you arrive on scene of an MVC and command has reported no injuries and <u>no patient contacts have been made</u>. This can be marked as “Canceled on Scene/No Patient Found”.
- Patient dead at scene; there should be a minimum of patient demographics and one set of vitals where necessary to confirm death:
    - If a cardiac arrest patient or obvious death without transport then mark the report as “Patient Dead on Scene - No Resuscitation Attempted (Without Transport)”.
    - If a cardiac arrest patient with extended downtime or obvious death and you are requested to transport the patient to a funeral home or morgue then mark the report as “Patient Dead on Scene - No Resuscitation Attempted (With Transport)”.
    - If a cardiac arrest patient and treatment given without transport then mark the report as “Patient Dead on Scene - Resuscitation Attempted (Without Transport)”.
    - Contact Wintergreen PD for officers to respond for any incident on the Wintergreen Master Plan and stay on scene if no calls pending to await a decision for transport. It will be the decision of the family and/or the Police Department as to which Funeral Home is needed or if the patient is to go to the Morgue.
    - Contact Nelson Dispatch for a Deputy to respond for all deceased patients outside of the Wintergreen master plan. EMS units may go in service once Nelson Sheriff’s Department has arrived on scene and EMS is released. It will be the decision of the family and/or the Sheriff’s Department as to which Funeral Home is needed or if the patient is to go to the Morgue.

Signatures

- Providers shall make all reasonable attempts to obtain patient signatures or obtain authorized representatives’ signatures. Causes for a lack of patient signature may include:
    - Patient limitations (i.e. quadriplegia, etc.), altered mental status, and/or injuries that prevent signing.
        - First, the provider should attempt to get an authorized representative to sign and complete Section II under Signatures.
        - If unable to get an authorized representative then complete Section III and obtain a signature from a hospital representative.
        - It shall be documented under section “E” of the narrative when the patient is unable to sign.

- Patient is a minor; the provider should get the parent of the patient to sign and complete Section I under Signatures. If the parent is unavailable then complete Section III under Signatures and have a hospital representative sign. Document under section “E” of the narrative why the patient is unable to sign.

Appendix A

DCHARTE narrative format explanation

D – Dispatch Information
What were you sent for? What unit(s). Lights and siren? Where did you go? Where did you find the patient?
C – Chief Complaint
Usually one sentence, in the patient's own words, put inside quotes. If patient cannot tell you, you can describe why he/she needs assistance.
H - History
History of both this specific medical problem or traumatic event. Include SAMPLE and OPQRST history.
A - Assessment
Where you found the patient. How old is the patient? A&O, ABC's, on-scene vital signs, other assessment details. Answers to any questions you asked the patient. Document both positive and negative findings.
R - Treatments
Any treatments you performed. Differentiate between on scene and transport treatments/procedures. Vital signs were taken? Patient monitoring, 12-lead(s) and interpretation. Document medication verification (5 R's).
T - Transport
Did the patient want to be taken to a facility for further assessment and treatment? How did the patient get from where you found them to the ambulance? How were they secured? How did you get the patient to the hospital (lights and siren)? Any changes during transport? Was hospital contact made by radio/cell phone? On arrival, where was the patient left (ED room bed, triage, hall bed)? Patient condition at time of transfer? Document the report you gave to RN or Doctor at the ED. Where was report given to RN or Doctor (bedside or hall)?
E - Exceptions
Anything odd that happened. Example: Reason patient couldn't sign forms. Patient refused back boarding. Note: A refusal of any kind even if transporting requires a signature for what part of care was refused.

Reminder, you are painting a picture of the patient. If you don't write it down, it wasn't performed. Remember, in X years, when this patient sues you and/or our agency for something they and their lawyer feel you did wrong, this is your primary (only?) evidence of what happened on the call.