

# Quality Assurance Manual

Carnegie Mellon University Emergency Medical Service

January 29, 2010 - Revision 3198

# Contents

- 1 Introduction** **2**
- 2 Refusal Forms** **3**
- 3 QA Procedure** **4**
- 4 EMMA Guide** **5**
  - 4.1 Startup . . . . . 5
  - 4.2 Attendants . . . . . 5
  - 4.3 Location and Times . . . . . 7
  - 4.4 Patient . . . . . 9
  - 4.5 Situation . . . . . 11
  - 4.6 Treatment . . . . . 12
  - 4.7 Disposition . . . . . 13
- 5 Narrative Guidelines** **14**
  - 5.1 Required Information for Narrative . . . . . 14
    - 5.1.1 Dispatch . . . . . 14
    - 5.1.2 Scene Survey . . . . . 15
    - 5.1.3 HxPI . . . . . 16
    - 5.1.4 PE/Vitals . . . . . 17
    - 5.1.5 Rx . . . . . 17
    - 5.1.6 Tx . . . . . 18
    - 5.1.7 Notes . . . . . 18
    - 5.1.8 Quick Reference . . . . . 19
  - 5.2 Example Narratives . . . . . 20
    - 5.2.1 Ankle Injury with Refusal . . . . . 20
    - 5.2.2 Intox with City . . . . . 20
    - 5.2.3 Timeline Style Narrative . . . . . 21
  - 5.3 Acceptable Abbreviations . . . . . 22
- 6 Incident Reports** **23**

# Chapter 1

## Introduction

Welcome to the CMU EMS Quality Assurance Manual! This document represents the position and policies of the Quality Assurance Board. Like the training manual, this document does not set CMU EMS policy, however it does state the standards set for the organization by the QAB and attempts to inform the general body as to how the QAB operates. Questions about this document or CMU EMS Quality Assurance procedures should be directed to the QAB Chair.

CMU EMS Quality Assurance takes place primarily through the use of two documents: Incident Reports and Tripsheets. Tripsheets are required by the state and used to document patient interaction. In the event that care of a patient is not transferred, a refusal form is signed by the patient and EMS provider to document that the patient has refused further medical care. This refusal form is then kept alongside the tripsheet for the call. Incident Reports are used to document exceptional circumstances that arise during CMU EMS business.

The following chapters detail these types of paperwork and how to complete them.

## Chapter 2

# Refusal Forms

It is the expectation of the QAB that a refusal form will be signed in all cases where patient contact is made but care of the patient is not transferred to a provider of equal or higher certification level. This may take place without CMU EMS assessing a patient (full refusal) or after an assessment has been completed (refusal of transport). With the single exception of the CMU EMS incident number and times, refusal forms should not be modified after they are separated.

**Equipment Requests** Often, EMS members will be approached for medical supplies. If permitted by CMU EMS policies, an EMS member may provide the patient with medical supplies without performing any assessment of the patient. If this is the case then this interaction is not considered to be an EMS call and no documentation of the event needs to be performed. However, if any assessment (verbal or physical) of the patient takes place then the interaction is now considered an EMS call and should be handled as defined in CMU EMS policies which will include either transfer of care of the patient or completion of a refusal form.

**Full Refusal** Full refusals are when a patient refuses *all* of assessment, treatment, or transport. If EMS performs any assessment of a patient, then a call is no longer a full refusal. In the event of a full refusal, the EMS provider should make every effort to have the patient sign a refusal form. However, in this case only the patients' name and signature, as well as the signature of the EMS provider is required. If a refusal form is not signed, an Incident Report should be written to document the lack of a refusal form.

**Refusal of Transport** A patient who is assessed or treated by EMS but whose care is not transferred to a provider of equal or higher certification (such as PGH EMS) is considered a refusal of transport and must have a refusal form completed in full. A fully completed refusal form should have all applicable fields marked or crossed out if they were not completed. The refusal form should then be signed by the patient and EMS provider. Refusal forms may not be marked on after being signed except for the fields for times and the call number.

**Witness Signature** If the patient is a minor then a signature from the parent is required, or if unavailable a police officer. If medical command has allowed EMS to release the patient in to the care of a friend or other third party, then that third party should sign the refusal form as a witness. In all other cases, having a third party witness the refusal is optional but encouraged.

**EMS Provider Signature** Refusal forms must be signed by an EMS provider. This should be the provider whose certification number is written on the refusal form. Unless authorized by CMU EMS policies, no one other than Supervisors or Crew Chiefs may sign a refusal form.

## Chapter 3

# QA Procedure

A tripsheet should be written every time CMU EMS is dispatched or does a stand-by. When the tripsheet is written it should be submitted as follows.

**Tripsheet with a refusal form:** Complete a Tripsheet QA Form. Staple the paperwork in the following order (front-to-back): QA Form, Tripsheet, Refusal Form. Submit the tripsheet in Pons and place the tripsheet in “This Month’s Tripsheets” slot.

**Tripsheet with an on-scene form:** Complete a Tripsheet QA Form. Staple the paperwork in the following order (front-to-back): QA Form, On-Scene Form, Tripsheet. Do **not** destroy any on-scene paperwork. Submit the tripsheet in Pons and place the tripsheet in “This Month’s Tripsheets” slot.

The tripsheet will be reviewed by the QAB. If the tripsheet is bounced, the tripsheet and all associated paperwork will be returned to you with errors noted on the tripsheet. You should revise the tripsheet as needed and resubmit it.

**Resubmitted Tripsheet** Remove QA Form and refusal form or on-scene paperwork. Reattach paperwork to revised tripsheet as before and paperclip old tripsheet behind revised tripsheet. Do **not** destroy any paperwork that gets returned to you. Submit the tripsheet in Pons and place paperwork in “Resubmitted Tripsheets” box.

## Chapter 4

# EMMA Guide

### 4.1 Startup

Login to EMMA with you usernumber and password. Your usernumber may be your SSN, phone number or EMT number. If you have difficulty with this step, see the QAB Chair. Select **Start a New Trip** to begin writing a new tripsheet.

### 4.2 Attendants

Click **Add or Change Name(s)**. Here you can select the people who were on the call. If an attendant who was on the call is not listed, click **Add a Temporary Crew Member**. For Temporary Crew Members, the user number should be their phone number, and **Prefix** should be 0. When done selecting the attendants, the Crew Chief on the call should be selected as both the **Crew Chief** and **Driver**.

Affil #: 02303 Organization: Carnegie Mellon Univ EMS  
 Unit #: 00 Date: 12/06/2009 Time: 23:38

Vehicle Odometer: 000000.0  
 Set Odometer

Attend #1: Musicus, Marina Crew Chief  Driver  Standby  Remove

Attend #2: \_\_\_\_\_

Attend #3: \_\_\_\_\_

Attend #4: \_\_\_\_\_

Add or Change Name(s)

Information Confirmed

Figure 4.1: Crew Selection

Change Attendants

Available:  
 Chao, Emily  
 Chinen, Alyssa  
 Chivalta, Anthony  
 Coyle, Elizabeth  
 Divone, Jake  
 Emerson, Maria  
 Eminizer, Nicholas C.  
 Fraboni, Americo  
 Gottlieb, Eric

Assigned:  
 Musicus, Marina

Add-->> Remove Clear Assigned

Add a Temporary Crew Member

OK Cancel

Figure 4.2: Add a Crew Member

Add a Temporary Crew Member

New Crew Member Name: Last, First  
 Last Name, First Name MI. (opt) Suffix

User Number: 4125551234

Prefix: 0

Password: The password for this temporary crew member is the same as the User Number. Use that number to 'sign' the trip.

Authorized by: \_\_\_\_\_  
 User Number Password

Add to Crew Never Mind

Figure 4.3: Temporary Crew Member

The screenshot shows a software interface for entering EMS trip data. At the top, there are fields for Trip Seq Num (60455813) and Affil/Unit ID (02303/00), along with a 'Show Dispatch Info' button. Below this are dropdown menus for Unit's Primary Role (Non-Transport), Nature of Dispatch (BLS Emergency), and Type of Location (Residence). A 'Response Urgency' section has 'Immediate' checked. A box on the right contains radio buttons for 'Number of Total Patients at Scene' (One is selected) and checkboxes for 'Mass Casualty Incident?' and 'Suspected Disaster?'. The 'Incident Address' section includes fields for Street Number (1060), Street Name (Morewood Ave.), Apt/Floor (612), N'hood/Municip (Pittsburgh), State (PENNSYLVANIA), and Zip Code (15213). The 'Response Outcome' is set to 'Care Transferred'. A table tracks 'Time' and 'Date' for Dispatch, Enroute, Arr Scene, Arr Patient, Dep Scene, Arr Dest, Available, and In Qtrs. 'Mileage' fields for Out, Scene, Dest, and In are present with up/down arrows. Two radio button groups allow selection of 'Response Mode to Scene' (Class 1-Priority selected) and 'Transport Mode From Scene' (N/A selected). At the bottom, 'Billable Mileage' and 'Total Mileage' are shown as 0.0. The 'Service Incident Number' is 0100012. Navigation buttons at the bottom include 'Logoff', 'Change Attendants', and 'Patient'.

Figure 4.4: Times

### 4.3 Location and Times

**Incident Address** Refer to official building address list. *Always* use “Pittsburgh” for N’hood/Municip as anything else will confuse EMMA. The zip code of CMU is 15213.

**Nature of Dispatch** BLS Emergency, unless this is an incident command tripsheet in which case you should use Not Applicable.

**Type of Location** For classrooms use the Office/Business designation.

**Times** Fill out: Dispatch, Enroute, Arr Scene, Arr Patient, Available. All other times should be left blank.

**Response Mode to Scene** Class 1 – Priority unless it is a self-dispatch or standby in which case it is Class 3. **Transport Mode From Scene** is always N/A.

**Service Incident Number** Call number from Pons.

**Other Responders** Select this if PGH EMS or PGH Fire responded, or there were more than four CMU EMS members on scene. To add a respondent from PGH EMS, choose ALS, select City of Pittsburgh EMS as the service and enter the unit number (such as 5107 for Medic 7), filling in any times you know. For Fire, do the same with the Fire button, but choose Other for the service and type in “PGH FD”.

Treat/No Transp.	Patient is treated by refuses transport either by CMPD or PGH EMS.
Cancelled off enroute	EMS is cancelled dispatch while enroute
Cancelled on scene	EMS is cancelled by police or other responder on-scene
Pat. Refused Treat	Patient refuses treatment but accepts transport via CMPD
Refused	Patient refuses all EMS services
False Call	We are dispatch to a call and arrive to find it is not a call (e.g. pt doing a performance art project)
No Patient Found	Where did that patient go?
P.O.V	CMPD transports a patient for us or a patient goes by other private means.
Care Transferred	Patient is transferred into care of Pittsburgh EMS
Standby	EMS performed a standby
D.O.A	EMS arrived to find a pt Dead On Arrival
Called at Scene	If <b>you</b> terminate resuscitative efforts on a patient per Medical Command or MD on scene, use this option.
Fire Call	EMS is dispatched to a Fire.
Incident Management	This tripsheet is to document Incident Command of an MCI.

Table 4.1: Response Outcomes

**Add Other Resp of Type:**

Buttons: Bystander, QRS, BLS, ALS, Rescue, Police, Fire, HazMat, Utilities, Mutual Aid, Standbys, Additional Members, Other Health Care Provider, Other.

Figure 4.5: Other Responders

**Assisted by ALS Unit from Service:**

City of Pittsburgh EMS-02023

Unit: [dropdown] Unit ID: 5107

Attendant Name(s): [dropdown]

List of Names: [dropdown]

Dispatch Time: 23:38 Date: 12/06/2009

Enroute Time: 23:38 Date: 12/06/2009

Arrive Scene: 23:45 Date: 12/06/2009

Depart Scene: 23:48 Date: 12/06/2009

First Responder?  Tracker Num: [input]

Buttons: OK, Cancel

Figure 4.6: ALS

Soc. Sec. #: <input type="text" value="123-45-6789"/>	<input type="button" value="Search Patient Name"/>	<b>Patient Name</b>		<input type="text" value="60455813"/>
Phone: <input type="text" value="(412)555-5555"/>	<input type="button" value="Search Phone"/>	Last: <input type="text" value="Mellon"/>	Suffix: <input type="text" value="Jr."/>	
BirthDate (mm/dd/yyyy): <input type="text" value="03/24/1855"/>	<input type="button" value="Search DOB"/>	First: <input type="text" value="Andrew"/>	Gender:	<input type="radio"/> Unknown
Approximate Age: <input type="text" value="154"/>	<input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Days	Middle: <input type="text"/>	<input checked="" type="radio"/> Male	<input type="radio"/> Female
		CMU Affiliate: <input type="text" value="Founder"/>	<input type="radio"/> Not Recorded	
		Race: <input type="text" value="White, Non-Hispanic"/>		
		Ack Privacy Notice On File? <input type="checkbox"/>		
<hr/>				
<input type="button" value="Set Address same as Incident"/>	Address: <input type="text" value="5115 Margaret Morrison St. A004"/>			
ZIP: <input type="text" value="15213"/>	City: <input type="text" value="Pittsburgh"/>	State: <input type="text" value="PA"/>	Country: <input type="text" value="UNITED STATES"/>	
Driver's Lic. #: <input type="text"/>	State: <input type="text"/>	Pt's Primary Care Physician: <input type="text"/>		
<hr/>				
<input type="button" value="Current Meds"/>	<input type="button" value="Allergies"/>	<input type="button" value="Immunization History"/>		
Past Medical History: <input type="text"/>	<input type="button" value="--&gt;"/>	<input type="text" value="Tuberculosis"/>		
		<input type="checkbox"/> None Known		
Med Hx Obtained From: <input type="text" value="Patient"/>	Presence of Emergency Information Form: <input checked="" type="radio"/> Unk <input type="radio"/> No <input type="radio"/> Yes			
Advanced Directives:				
<input type="checkbox"/> Living Will <input type="checkbox"/> State/EMS DNR Form <input type="checkbox"/> Family/Guardian request DNR (but no documentation)				
<input type="checkbox"/> Other Healthcare DNR Form <input type="checkbox"/> Other				
<input checked="" type="checkbox"/> Not Known <input type="checkbox"/> None <input type="checkbox"/> Not Available				
<hr/>				
<input type="button" value="Logout"/>	<input type="button" value="To Log/Times Screen"/>		<input type="button" value="To Situation"/>	

Figure 4.7: Patient

## 4.4 Patient

Fill in patient information as available. You must complete the **Past Medical History**, **Allergies**, **Current Meds** sections, however you may safely ignore the Immunization History section. For these sections, keep in mind the following terms for when information is not available.

- “None Stated by Patient” means you asked the patient and they stated that they had none.
- “Not Known” means that you asked bystanders used some other resource other than the patient and determined that none was present.
- Blank means that you did not attempt or were unable to determine presence.

**CMU Affiliate** e.g. student, staff, faculty, none

**Presence of Emergency Information Form** Should be Not Known.

Current Medications:  -->

None Known

12/06/2009--  
None Stated by Patient  
02/06/2008--  
Ibuprofen--50 MG,Oral,3x/day  
02/05/2008--  
Alcohol

Date of Current Medication: 12/06/2009

Medication	Dosage	Route	Frequency
None Stated by Patient			

OK

Figure 4.8: Medications

Allergies (Envr):  None  Food  Latex  Insect Sting  Chemical  Other

Not Known

Not Avail

Allergies (Meds):  -->

None Known

Figure 4.9: Allergies

Time Arr Patient: 23:40 12/06/2009 Incident Type: Medical

Patient Condition on Scene: Minor

Chief Complaint: Vomiting Duration: 6 Hours

Primary Location: Abdomen Organ System: Gi Primary Symptom: Nausea/Vomiting

Optional Secondary Complaint: Other Symptoms

Provider Impression: Most important: General Illness Second important: Third important:

Injury Site/Type Situation of Injury Safety Devices

HazMat? MVC? Contributing Factors

Alcohol/Drug Use Indicators:
 

- None
- Smell of Alcoholic Beverage on Breath
- Pat. Admits to Alcohol Use
- Pat. Admits to Drug Use

Response Outcome: Care Transferred Transported How?: Released to ALS

Pat. Cond. Prior to Transport: Stable Transporting Service?: City of Pittsburgh EMS (0202)

How Patient Moved To Ambulance:
  By stretcher  By Stairchair  Assisted/Walk  Carried  Other
 Time Care Transferred: 23:48 12/06/2009

Position of Patient During Transport:

Research Survey Field Title: Research Code: USERDEF2:

Logoff To Patient Screen To Log/Times Screen To Treatment Screen

Figure 4.10: Situation Screen

## 4.5 Situation

This screen allows you to describe the patient’s condition, complaints and symptoms. Most of this data is used only to provide the state and region with statistics, however you should still try to complete it accurately.

Fields regarding transport to the ambulance and patient transport can be safely ignored. For trauma patients, the **Injury Site/Type**, **Situation of Injury**, **Contributing Factors**, and **Safety Devices** screens should be consulted for applicable fields. **MVC?** should not be clicked unless this is a Motor Vehicle Collision.

**Incident Type** What type of call is this? If in doubt, Medical may be a good choice for e.g. intox patients.

**Primary Location, Organ System, Primary Symptom** Try to use your best judgement here, Global and Not Applicable are often good choices.

**Provider Impression** What do you think was the most important problem that this patient presented with?

**Transported How?** If PGH EMS transported, use Released to ALS and fill in **Transporting Service** and **Time Care Transferred**. If CMPD transported, use Police.



Figure 4.11: Treatment

Time: 23:40   Vitals Date: 12/06/2009   Patient's Age: 50 years

Pulse: 120   Quality: Strong Regularity: Regular Resp: 16   Quality: Normal Regularity: Regular

BP: 126 / 82  Palpated Method: Manual Cuff

Electronic Monitor Rate:  SPO2: 98  Ambient  O2 ET-CO2:  Pain Rating: 5/10

Thrombolytic Screen:

Temp: 99.5 Method: Oral

**Glasgow Coma Scale**

Eyes: 4-Opens eyes spontaneously

Verbal: 5-Oriented and approp.

Motor: 6-Obeys Commands

Coma Score: 15

GCS Qualifier: GCS w/o interventions

Memo:

Figure 4.12: Vitals

## 4.6 Treatment

The treatment screen allows you to construct a timeline of assessments and treatments performed during the call. You will see this timeline pre-populated with some of the times you entered in previous screens.

**Vitals** You must have at least one vitals entry. All vitals entry should list the patients GCS at that time. **GCS Qualifier** is always **GCS w/o interventions**. **Electronic Monitor Rate**, **Thrombolytic Screen**, and **ET-CO2** may always be ignored.

**Complete Exam** You must have at least one complete exam screen. For each part of the complete exam, if something was not assessed choose **Not Done** if available, otherwise leave the field blank.

**BLS** Any BLS treatments performed should be documented using this button. (CMU EMS does not perform **ALS** treatments, so you will never need to use that button.)

**Med Cmd** Every tripsheet must have at least one Medical Command entry. This should state that either no protocol was required, a protocol was used, or online medical command was contacted. Questions about how to complete this screen should be directed to the EMT on the call.

**Mellon, Andrew Jr. 1**      Gender: **M**      Age: **154 Years**      **60455813**

Response Outcome: **Care Transferred**

Hydraulic rescue tool utilized       Universal precautions utilized

Ack Privacy Notice?: Yes  **No**       Ack Privacy Notice On File?

Suspected Contact with Blood/Body Fluids, EMS Injury, or Death:      No       Yes       Not Applicable       Not Known       Not Available

**Barriers to Patient Care:**

- None
- Not Applicable
- Unconscious
- Developmentally Impaired
- Hearing Impaired
- Language
- Physically Impaired
- Physically Restrained
- Speech Impaired
- Unattended

This PCR Needs Review:      No       Yes       Not Known

Reason for Choosing Destination:

How Patient Was Transported From Amb.:        Medical Records Transferred to Drop-off Location

**Drop-Off Location:**

Type of Drop-off Location:

Street Num:       St. Name:       Apt/ Floor:

Zip Code:       City: **Not Known**      State:

**Personal Protective Equipment Used:**

- Gloves
- Level A Suit
- Level B Suit
- Level C Suit
- Mask
- Other
- Not Applicable
- Not Known
- Not Available

*Logoff*      *To Log/Times Screen*      *To Treatment Screen*      *To Narrative Screen*

Figure 4.13: Disposition

## 4.7 Disposition

This screen provides some fields for entering information about patient outcome. Important fields are **Universal Precautions Utilized** which should always be checked (you did use universal precautions, right?) and **Ack Privacy Notice** which should always be checked **No** as CMU EMS does not have a privacy notice. The field **Suspected Contact ... or Death** should be answered to the best of your utility, as should **Barriers to Patient Care** and **Personal Protective Equipment**, **This PCR Needs Review** can be left **Not Known**. All other fields can be left blank.

# Chapter 5

## Narrative Guidelines

### 5.1 Required Information for Narrative

In each section, the necessary information is listed, followed by an example. Wording in **bold** in the example boxes should be copied verbatim whenever applicable.

#### 5.1.1 Dispatch

- **Dispatch** time, location (as reported by CMPD), and patient description.
- **Other Information** other information provided in the dispatch if present, such as: if the medics have already been dispatched, if EMS is informed that the scene may not be safe.
- **Crew Chief Requests** such as: city units, AED, car bag, splint bag, etc.

	DISPATCH:
Dispatch	<b>CMU EMS was dispatched at 0024 to Doherty Apartments BB2 for a 19yo F, intoxicated, conscious.</b>
Other Information	EMS was notified that the call was made by a third-party.
CC Requests	A1 requested a car bag at time of dispatch.

### 5.1.2 Scene Survey

- **Arrival** time and location of the patient, if different from location of dispatch.
- **Patient** age, sex, and the position the pt was in when you found them.
- **Initial Impression** a disposition of the patient. Were they INAD (In No Apparent Distress)? Were they crying? Did they acknowledge your presence when you entered the scene? Paint a picture of how you found your patient.
- **Chief complaint** the initial thing that the pt or bystander said was wrong.
- **Scene Description** everything pertinent you observe in the scene including *any bystanders*, including notable absences. If the call was for an intoxicated pt, was there any alcohol bottles on scene? Was there vomit on the floor?
- **CAO and GCS** If not 4x4 or 15 respectively, you must expand them to include the component scores (e.g. GCS 9 (V3,M3,E3)).
- Any scene safety concerns they should be documented here along with how they were handled.

	SCENE SURVEY:
Arrival	<b>CMU EMS AOS at 0024</b> to the stairwell outside Doherty Apartments BB2
Patient	to find a 19yo F, sitting on the steps outside the door to room BB2,
Initial Impression	INAD.
Chief Complaint	Pt complained of Naus and Vom.
Scene Description	EMS observed an empty vodka bottle on the ground near pt's feet.
Bystanders	One bystander was present on scene who identified himself as pt's boyfriend.
CAO & GCS	<b>CAO 3x4 (-events), GCS 15.</b>

### 5.1.3 HxPI

- **Background** everything the pt told you about the incident. This should be in the form of “pt stated ...”, with pt’s exact words in ”s if you recorded them. Be very careful not to confuse your impressions or beliefs about what may have happened with what the pt told you. The things that the pt stated need not be consistent with what you observed. If this is the case, explain that and why they are inconsistent. Make very certain that anything you write here would be easily understood by someone with no knowledge of our service. Relevant medical history should be explained here.
- **Events** any notable events that happened while on scene. If you can estimate the time of these events, do so.
- **Neck/Back Injury** If traumatic injury, head, neck, back pain denied or confirmed.
- **Pertinent Negatives** the pt *denied* or complained of CP, SOB, LOC. If you asked the pt about naus, dizz, vom, include those as well.
  - **CP** if present, state: time started, cause, provocation, radiation, severity, quality, etc.
  - **LOC** if present, state: approximate time(s), duration of unconsciousness, etc.
  - **SOB** if present, state: severity, quality, etc.
  - **Vom** if present, state: how many times, how much, when, presence of blood, description, etc.
- **Medical History** Allergies, Medications, Past Medical History

	HxPI:
Background	Pt’s boyfriend stated that she had been drinking at an off-campus party and walked home with her boyfriend 30 minutes prior to EMS AOS. Pt’s boyfriend stated that she consumed “8 or 9” shots of vodka and that she had vomited once before EMS AOS. When EMS asked pt where she had been that evening pt was only able to respond that she “had a good time” and was unable to further articulate what she meant.
Neck/Back Injury (if applicable)	Pt was unable to state if she had fallen or hit her head that evening. Boyfriend stated that he did not believe she had fallen or hit her head, but was not certain. Pt denied any head or neck pain.
Events	While EMS on-scene at approx 0035, pt vomited one time a clear fluid with red chunks.
Pertinent negatives	<b>Pt denied CP, LOC, SOB, Naus, Dizz, Vom.</b> Bystander denied pt having LOC.
PMHx	Pt stated that he had no allergies, relevant medical history and took no medications regularly.

### 5.1.4 PE/Vitals

- **Vitals** “Pt refused all measurement of vitals.” Otherwise, state “**Vitals as listed in timeline.**” Vitals not in timeline or requiring further explanation should be discussed here.
- **Physical Exams** any physical exams performed. This should include the scope of the exam (head-to-toe, focused), the attendant performing the exam, a description of injuries including any findings or negative findings and answers to OPQRST (questions about pain). You must specify the pain scale as “**on a scale of 1-10 with 10 being the worst**”.
- **Other Injuries** “Pt did not complain of any other DCAPBTLs nor did EMS note any.”

	PE/VITALS:
Vitals	<b>Vitals as listed in timeline below.</b>
Physical Exam	A2 performed a focused physical exam on pt’s L arm and found a laceration starting on the anterior side of elbow and continuing distally 2”. Laceration had ceased bleeding and appeared to be shallow. Pt rated pain from laceration as a 3 <b>on a scale of 1-10 with 10 being the worst.</b>
Other Injuries	<b>Pt did not complain of any other DCAPBTLs nor did EMS note any.</b>

### 5.1.5 Rx

If no treatment was performed write “**No Rx indicated, none was provided.**” If treatment was indicated but could not be provided, provide an explanation for this.

- **Treatments** details of application, the attendant number administering the treatment, +PMS before and after, if applicable, and any effect of the treatment on the patient (improved, worsened, unchanged).
- **Protocols** applicable protocols (number & name). Include that the protocol was initiated and/or completed and what actions were taken per protocol. If a protocol is not initiated or completed, this must be explained.

	Rx:
Treatment	A2 splinted pt’s arm with a SAM Splint, securing with cravats above and below site of deformity. A2 noted +PMS before and after splinting. Pt stated that treatment helped to alleviate pain.
Protocols	Protocol 702 (ALOC) <b>initiated and completed in full</b> with application of O2 at 15 LPM via NRB by A2.

### 5.1.6 Tx

How you complete this section will be determined by patient disposition. If the patient went with the medics, use the Care Transferred section below. If the pt did not go to the hospital or went with CMPD, use the Refusal section below.

#### Care Transferred

- If the medics took a refusal, state this as the **disposition**.
- State how the pt was transported to the ambulance if this occurred while EMS was still on scene.

	Tx:
Other Responders	PGH FD E18 AOS @ 0055. PGH EMS 5107 AOS @ 0100.
Transfer of Care	<b>Care transferred to Medic 7 with a full report by A1.</b>
Disposition	Medic 7 Tx pt to UPMC - Mercy.
Clear	<b>CMU EMS COS WFI</b> at 0110.

#### Refusal

- Follow the **bold** text very closely.

	Tx:
Right to A Tx Decision	<b>A2 informed pt of right to Tx to H via A. Pt refused Tx to H via A. CMPD also offered Tx to H after refusal, which pt accepted.</b>
Med Command (if called)	A2 contacted medical command at AGH via cellular and spoke to MCP 1234 to request permission to allow pt to refuse transport as pt was not CAO4x4. MCP stated that pt may refuse if a friend agreed to watch pt for the night, Rec# 1234.
Instructions	<b>A2 advised pt of risks of LOC, Naus, Vom, Death. Pt verbalized understanding of those risks. A2 gave pt instructions to sleep on their side A2 told pt to call EMS back if condition or refusal decision changes. A2 and pt signed written refusal.</b>
CMPD Tx	CMPD unit 3909 Tx pt to UPMC - Shadyside.
Clear	<b>CMU EMS COS WFI</b> at 0110.

### 5.1.7 Notes

- Note any discrepancies or omissions on the refusal form and how they should be corrected.

### 5.1.8 Quick Reference

DISPATCH	Dispatch, Crew Chief Requests, Other Information
SCENE SURVEY	Arrival, Patient, Initial Impression, Chief Complaint, Scene Description, Bystanders, "CAO 4x4 & GCS 15"
HXPI	Background, Events, Pertinent Negatives, "Pt denied CP, SOB, LOC." Allergies, Medications, Medical History
PE/VITALS	Vitals, Physical Exam, Other Injuries, "Pt did not complain of any other DCAPBTLS, nor did EMS note any."
RX	Treatment, Protocols
TX	<p><b>Refusal:</b> Right to A, Tx Decision, Med Command, Instructions, CMPD Tx, Clear "A1 informed pt of right to Tx to H via A. Pt refused Tx to H via A."</p> <p><b>Care Transferred:</b> Other Responders, Transfer of Care, Disposition, Clear</p>

## 5.2 Example Narratives

### 5.2.1 Ankle Injury with Refusal

**Dispatch** CMU EMS dispatched @ 1900 to the UC Gym for a 20 y/o M with an ankle injury.

**Scene Survey** CMU EMS AOS at 1903 t/f no pt. Bystanders stated that pt went into the locker room. EMS found 20 y/o M in the Men's locker room sitting on a bench, in apparent distress. Pt complained of an ankle injury. CAO 4x4, GCS 15.

**HxPI** Pt stated he was jumping up for a basket and landed on his R ankle. Pt stated that his ankle rolled medially upon landing. Pt stated that he had two prior sprains to same ankle. Pt denied head/neck pain, CP, SOB, LOC.

**PE/Vitals** Vitals as listed in timeline. A2 performed a focused exam on pt's R ankle and found pain and tenderness on the lateral side of pt's R ankle just inferior to the joint. A2 observed swelling on the lateral side of ankle. A2 noted +PMS in the R ankle. Pt rated pain as a 6 on a scale of 1-10 (with 10 being the worst). Pt demonstrated ability to bear weight on injured ankle. Pt did not complain of any other DCAPBTLS nor did EMS note any.

**Rx** A2 wrapped pt's R ankle with an ace bandage and applied an ice pack to lateral side of pt's R ankle. A2 noted +PMS after treatment. Pt reported approx 3 minutes after application that pain was less severe.

**Tx** A2 advised pt of right to Tx to H via A. Pt refused Tx to H via A. CMPD offered Tx to H, after refusal, which pt accepted. A2 explained risks of pain, swelling, Fx, LOF to pt. Pt verbalized understanding of these risks. A2 gave pt instructions for RICE and to go to H. A2 told pt to call EMS back in condition or refusal decision changes. A2 and pt signed written refusal. CMPD 3904 Tx pt to UPMC - Shadyside. CMU EMS COS WFI @ 1915.

### 5.2.2 Intox with City

**Dispatch** CMU EMS dispatched @ 0300 to Morewood Gardens 605 for a 20 y/o F intox.

**Scene Survey** CMU EMS AOS at 0304 t/f a 18yo F vomiting in the bathroom. CAO 1x4 (-events,-place,-time) GCS 14 (E3 V5 M6).

**HxPI** Pt's roommate stated that the pt had 10 glasses of Bordeaux at a wine and cheese party earlier that evening. The roommate said that the pt came back half an hour ago and began vomiting. When asked where she was, pt stated that she was at Cinderella's Palace in Disney World. Pt was unaware of anything that happened earlier in the evening. Pt denied CP/LOC/SOB/Dizz. Pt confirmed Naus, Vom. EMS noted that vomit was clear with red chunks.

**PE/Vitals** Vitals as listed in timeline. Pt did not complain of any DCAPBTLS nor did EMS note any.

**Rx** Protocol 702 - ALOC initiated and completed in full with application of O2 via NRB at 15 lpm by A2. Pt appeared to increase in alertness as a result of treatment.

**Tx** PGH EMS Medic 5107 AOS @ 0315. Care transfered to Medic 5107 with a full report by A2. Medic 5107 Tx pt to UPMC - Presby. CMU EMS COS WFI @ 0320.

### 5.2.3 Timeline Style Narrative

**20:08** CMU EMS dispatched to Forbes Ave near the UC Circle for a pedestrian struck. At time of dispatch A1 request a carbag, and that PGH EMS be dispatched.

**20:09** EMS AOS to find a 20 y/o M lying in the center inbound lane of Forbes Ave, directly inform of the Alumni House. CMPD had closed Forbes Ave from Beeler St. to Morewood Ave. EMS noted a Blue Jeep Wrangler pulled over on the side of the road approx 200' further inbound from the Pt's location. A CMPD officer was talking with the driver of the vehicle, who refused all EMS Care. A2 noted a pair of sneakers in center of the road; one shoe was approx 50' from the pt and the other 100', both outbound on Forbes. Pt was only responsive to Painful stimuli. CAO 0x4, GCS 7 (E1, V2, M4). A2 applied Manuel C-Spine stabilization per Protocol 261 (Spinal immobilization).

**20:10** A1 initiated a full head to toe exam, noting no DCAPBTLS on the Head, Neck, Face or shoulders. A1 found there to be no fluids coming form the pt.s ears, nose or mouth. A1 found the trachea to be deviated to the R, but found no JVD. At this time A3 sized and applied a cervical collar to the Pt.s Neck. A2 noted Pt's resps to be 30 bpm, and very shallow.

**20:11** A1 continued head to toe assessment noting unequal chest rise, tenderness on the L side of the pt chest. A1 found the abdomen to be soft in all 4 quads, and pelvis was stable. A1 noted no DCAPBTLS and +PMS in all 4 extremities. Per Protocol 202 (Oxygen Admin) A2 admin O2 via BVM @ 25 LPM, with breaths being delivered over 1 second every 5 to 6 seconds.

**20:12 to 20:15** A1, A2, A3 and CMPD Security Guard Stellitano proceeded to apply a LBB to Pt.

**20:14** PGH FD E18 AOS. A1 sized and inserted a NPA, which the pt accepted.

**20:15** A1, A2, and A3 completed application of LBB. A3 noted +PMS upon completion of spinal immobilization. A1 performed a focused physical exam of the pt.s l chest noting a 4" by 6" flailed chest segment. The segment was mid-axillary, approx 6" superior to the base of the ribcage. A1 noted that the segment had paradoxical movement with respects to the rest of the chest.

**20:16** A3 applied a Lg trauma dressing to the area, to pad the area and restrict further movement. A1 noted decreased lung sounds in the L chest, otherwise lung sounds were unremarkable. A2 continued to ventilate the pt via BVM @

**20:17** PGH EMS 5201 and PGH EMS Supervisor 503 AOS. Care transferred to 5201 with full report by A1.

**20:18** PGH EMS 5107 AOS

**20:25** PGH EMS 5107 Tx pt to Presby

**20:30** CMU EMS COS WFI

## 5.3 Acceptable Abbreviations

ALOC	altered level of consciousness	AOS	arrived on scene
BP	blood pressure	BVM	bag-valve mask
BZK	benzalkonium chloride – a disinfectant	CAO	conscious alert & oriented
C-Collar	cervical collar	COS	clear of scene
CMPD	Carnegie Mellon Police Department	CP	chest pain
c-spine	cervical spine precautions	DCAPBTLS	deformities, contusions . . .
Dizz	dizziness	EPI	epinephrine
F	Female	Fx	Fracture
GCS	glasgow coma scale	HxPI	history of present illness
INAD	in no apparent distress	L	left
lac	laceration	LOC	loss of consciousness
LOF	loss of function	lpm	liters per minute
M	male	MCP	medical command physician
Med Cmd	medical command	Naus	nausea
NRB	non-rebreather mask	O2	oxygen
palp	palpation	PERRL	puples equal, round, reactive to light
PGH	Pittsburgh	PMHx	past medical history
PMS	pulse, motor, sensation	pt	patient
R	right	Rec	record
resps	respiration	RICE	rest, ice, compress and elevate
Rx	treatment	SOB	shortness of breath
SPO2	saturation percentage of oxygen	t/f	to find
Tx	transport	Vom	vomiting
WFI	without further incident	WNL	within normal limits
y/o	year old		

## Chapter 6

# Incident Reports

CMU EMS Incident Reports document extraordinary circumstances that arise during CMU EMS operations. Specific circumstances that require an incident report are specified in the CMU EMS policies, however such a circumstance is not required for an incident report to be written. Any member may write an incident report any time they feel that there are events or circumstances which deserve documentation or investigation by the QAB.

Incident reports provide a section for the author of the report to provide a narrative of the events. It is recommended that the narrative contain three sections: a **facts** section which states objectively the facts of the incident, a **assessment** section which documents the author's interpretation of the facts of the incident, a **recommendations** section which documents any actions which the author feels should be taken in response to the incident.

To submit an incident report:

1. Download and complete the incident report template. It is available on the CMU EMS wiki at <http://wiki.cmuems.org>.
2. Have a supervisor or QAB member read over your incident report to ensure that it is complete and filled out correctly. (Optional, but highly recommended)
3. Email completed incident report to current QAB Chair.
4. Print and sign incident report and placed signed copy in the QAB box in the appropriate slot.

You may attach additional documents to the incident report as needed. If the documents can not be pasted as an additional page in the incident report, simply staple them behind your signed copy and turn the whole thing into the QAB box. Please let the QAB Chair know if there are attached documents.