## *Quality Review Process for Agencies*

Purpose: To provide the EMS agencies in the Monroe County Medical Control Authority service area with a process for reviewing the care of the individual EMS agencies.

This process is an activity of the Professional Standards Review Organization and is included in the Confidentiality Assurance statement of protocol 6.24.

1. Each licensed life support agency shall submit quarterly Quality Review Reports to Monroe County Medical Control.
2. Quarterly Quality Review Reports will review care based on the following topics:
    a. Patient assessment
    b. Altered mental status
    c. Abdominal pain
    d. Seizures
    e. Chest pain
    f. Dead on scene
    g. Multiple trauma / Mass casualty
    h. Cardiac arrest
    i. Pediatric illness
    j. ECG*
    k. Intubation*
    l. Out-of-County Transport
    *Advanced Life Support agencies only
3. Each agency shall submit one or two reports per quarter. All applicable reports will be submitted within a two (2) year cycle.
    a. One quarterly report shall be presented in person at a PSRO meeting within each two (2) year cycle.
4. Each agency shall review a minimum of 20 Patient Care Reports per quarterly topic. If the agency has less than 20 EMS responses per specific topic, then all patient care reports for that topic shall be reviewed.
5. Quality Review Monitors for each report topic follow this procedure. Agencies shall use these monitors to document the quality review process.
6. Each agency shall submit a Quality Review Report Submission Form to Monroe County Medical Control each quarter.
7. Monroe County Medical Control will send a schedule of specific topics to be completed by each agency at the beginning of each two (2) year cycle.
8. Failure to complete the Agency Quality Review Process may result in suspension of agency medical privileges. Agency compliance will be reviewed each May prior to the Medical Director signing of the MDCH Agency Licensure Renewal.
9. Quality Review Reports documenting deficiencies / action plans shall be reviewed again in the subsequent quarter for follow up.

# Submission Form
Email to: ems@mercymemorial.org

Agency / Department: _____

Quarter 1 2 3 4 Date: _____

Reviewer / Presenter: _____

Quality Monitor Reviewed: _____

Number of Runs reviewed: _____

Findings: _____

_____

_____

Recommendations: _____

_____

_____

- Attach separate sheet if necessary

MCMCA Medical Director Signature: _____

_____approved _____declined DATE: _____

Comments:

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# Basic Patient Assessment

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Chief complaint | Yes | No |
| Narrative | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | N/A |
| Monitor | Yes | No | N/A |
| Oxygen | Yes | No | N/A |
| ECG | Yes | No | N/A |
| Glucometer | Yes | No | N/A |
| Medications | Yes | No | N/A |

Comments:
_____

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# Altered Mental Status

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Chief complaint | Yes | No |
| Narrative | Yes | No |
| Loss of consciousness | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |
| Substance abuse | Yes | No |
| Environmental clues | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | |
| Monitor | Yes | No | |
| Oxygen | Yes | No | |
| ECG | Yes | No | N/A |
| Glucometer | Yes | No | |
| Medications | Yes | No | N/A |

Comments:
_____

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# Abdominal Pain

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Chief complaint | Yes | No |
| Site of pain | Yes | No |
| Description of pain | Yes | No |
| Associated symptoms | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | N/A |
| Monitor | Yes | No | N/A |
| Oxygen | Yes | No | N/A |
| ECG | Yes | No | N/A |
| Glucometer | Yes | No | N/A |
| Medications | Yes | No | N/A |

Comments:
_____

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# Seizure Patient

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Chief complaint | Yes | No |
| Duration of seizure | Yes | No |
| Description of seizure | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | |
| Monitor | Yes | No | |
| Oxygen | Yes | No | |
| ECG | Yes | No | N/A |
| Glucometer | Yes | No | |
| Medications | Yes | No | N/A |

Comments:
_____

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# Chest Pain

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Site of pain | Yes | No |
| Time of onset | Yes | No |
| Duration of pain | Yes | No |
| Description of pain | Yes | No |
| ASA taken prior to EMS | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | |
| Monitor | Yes | No | |
| Oxygen | Yes | No | |
| ECG | Yes | No | |
| ECG interpretation | Yes | No | |
| ASA given | Yes | No | |
| Medications | Yes | No | N/A |

Comments:
_____

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# Dead on Scene

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| No vital signs (BP, pulse, RR) | Yes | No |
| Skin color / assessment | Yes | No |
| Pupils | Yes | No |
| Rhythm (asystole in 3 leads) | Yes | No |

History Documentation:

| | | |
|---|---|---|
| History of event | Yes | No |

Notification of Authorities Documentation:

| | | |
|---|---|---|
| Medical Control / ED Physician | Yes | No |
| Police / Medical Examiner | Yes | No |

General Documentation:

| | | |
|---|---|---|
| Time of Death | Yes | No |
| Name of who pronounce | Yes | No |
| Disposition of body | Yes | No |

Comments:
_____

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# Multiple Trauma / Mass Casualty

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |
| GCS | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Scene / Environment | Yes | No |
| Vehicle damage / Intrusion | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | |
| Monitor | Yes | No | |
| Oxygen | Yes | No | |
| ECG | Yes | No | N/A |
| Glucometer | Yes | No | |
| Medications | Yes | No | N/A |
| Special Procedures | Yes | No | N/A |

Comments: _____

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# Cardiac Arrest

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Witnessed | Yes | No |
| Bystander CPR | Yes | No |
| AED | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | |
|---|---|---|
| IV | Yes | No |
| Monitor | Yes | No |
| Oxygen / Airway | Yes | No |
| Defibrillation | Yes | No |
| ACLS protocol | Yes | No |

Comments: _____

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# Pediatric Illness

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Chief complaint | Yes | No |
| Narrative | Yes | No |
| PMH / Birth history | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | N/A |
| Monitor | Yes | No | N/A |
| Oxygen | Yes | No | N/A |
| Glucometer | Yes | No | N/A |
| Medications | Yes | No | N/A |

Comments: _____

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# ECG

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Chief complaint | Yes | No |
| Narrative | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | N/A |
| Monitor | Yes | No | N/A |
| Oxygen | Yes | No | N/A |
| ECG interpretation | Yes | No | |
| Glucometer | Yes | No | N/A |
| Medications | Yes | No | N/A |

Comments:
_____

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# Intubation

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Gag reflex | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Number of attempts | Yes | No |
| End titled CO2 | Yes | No |
| Breath sounds | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | |
| Monitor | Yes | No | |
| Pre-oxygenation | Yes | No | |
| ECG | Yes | No | N/A |
| Glucometer | Yes | No | N/A |
| Medications | Yes | No | N/A |

Comments: _____

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# Transfer out of County

Run #_____ Date: _____ Age: _____ Sex: _____
Date of Audit: _____ Auditor Initials: _____

Patient Assessment Documentation:

| | | |
|---|---|---|
| Vital signs (BP, pulse, RR) | Yes | No |
| Pulse Oximetry | Yes | No |
| Skin color / assessment | Yes | No |
| Mental status | Yes | No |
| Pupils | Yes | No |
| Rhythm | Yes | No |

History Documentation:

| | | |
|---|---|---|
| Chief complaint | Yes | No |
| Narrative | Yes | No |
| PMH | Yes | No |
| Medications | Yes | No |
| Allergies | Yes | No |

Treatment Documentation:

| | | | |
|---|---|---|---|
| IV | Yes | No | N/A |
| Monitor | Yes | No | N/A |
| Oxygen | Yes | No | N/A |
| ECG | Yes | No | N/A |
| Glucometer | Yes | No | N/A |
| Medications | Yes | No | N/A |

Transfer Documentation:

| | | | |
|---|---|---|---|
| Patient request | Yes | No | N/A |
| Trauma | Yes | No | N/A |
| Cardiac | Yes | No | N/A |

Comments: _____

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