

Monthly “QA Audit/Review Worksheet” Directions

Directions for Monthly QA report. Please place a “✓” in the appropriate square if the reply is “yes”. If the answer is “no” please place and “X” in the appropriate square. Should a “yes” or “no” answer not be applicable, please leave the square blank or refer to the specific directions below.

- Squad- the squad name (EMS Unit # if applicable)
- Month/Year- the month and year of run being audited/reviewed.
- QI Person/ Persons- the names of those individuals auditing/reviewing the run sheets.
- Please list page number and number of pages of the total report. (Exam. Page 1 of 4)
- ACR#- the seven digit number provided on the ACR or the squad assigned number.
- Chief Complaint- is it documented in the narrative? (✓ or X)
- Narrative- is there a written narrative? (✓ or X)
- Vital signs & times- are the vital signs & times documented?
- MD/MICN/EMT signatures- are all the required signatures present? (✓ or X) *Note MICN’s must have a physician co-sign.
- No Transport- was this a “No Transport” call? (✓)
- Nursing/Clinical transport- was this call transported from a nursing home or medical clinic/ doctors office? (✓)
- Scene Time > 20 min- if scene time is longer than 20 mins.please mark (✓).
- Appropriate BLS- was appropriate Basic Life Support performed? (✓ or X)
- Appropriate ALS- was appropriate Advance Life Support performed per protocol? (✓ or X)
- Code/ DOA/ DNR- (if applicable) list “M” for a Medical code, “T” for a Trauma code, “D” for a DOA and “N” for DNR.
- CVA/ Seizures- (if applicable) list “C” for CVA or “Sz” for seizures.
- Trauma- was trauma the cause of complaint? (✓)
- Cardiac- was cardiac problem(s) the primary complaint? (✓)
- Respiratory- was respiratory problems the primary complaint? (✓)
- Substance abuse/Overdose- was this the primary complaint? (✓)
- IV (S or U)- list “S” if the IV was successful or “U” if it was unsuccessful.
- Medications, doses & times- if medication(s) was/were administered, was/were the medication dose(s) and time(s) of medication administration documented, place a “✓”. If medication was given but dose(s) & time(s) were not documented place an “X”. Leave this item blank if no medications were given.
- Intubation (S or U)- (if applicable) list “S” if the intubation was successful or “U” if it was unsuccessful.
- Orders Denied or Varied- (if applicable) please mark (✓).
- Restraints/commitment- (if applicable) list a “✓” if during this call orders for restraints and/or commitment paperwork were requested.
- Second-line call or standby- (if applicable) if this is a second-line call list “SL” or if it is a standby list “✓”.
- Comments: Any concerns that you feel need to be brought to the attention of the QA Coordinator and/or the ALS Medical Director, please note them on the back of the worksheet. Please attach an additional page if more room is necessary.
- Please place the total number of ACR’s being reviewed.
- Please place the number of ACR’s that involve ALS care.

If you would have any questions, please do not hesitate to call Jane Pollock, Pitt County ALS QA Coordinator at 816-2154. Thank you for your support and cooperation in helping provide a good quality management program.