Subject: Administration – Quality Assurance
Chart Audit Guidelines

Associated Policies:

I. Authority and Reference (incorporated herein by references)
- A. Division 2.5 of Health and Safety Code
- B. California Code of Regulations, Title 22
- C. North Coast EMS Policies and Procedures

II. Purpose
To provide a guideline for retrospective chart audit.

III. Procedure
- A. Audit of prehospital care records/tapes is the responsibility of the Prehospital Care Nurse Coordinator. The Prehospital Care Nurse Coordinator will:
  1. Audit all cases which are potentially high risk or problem prone, including but not limited to:
     - a. Deaths/Resuscitations - This category includes all extremely high acuity patients, all invasive airway management, use of MAST, IV/Medications, and Defibrillation/Cardioversion.
     - b. All runs with a scene greater than 20 minutes.
     - c. All runs that involved the initiation of an Incident Report, including those runs that involved either Radio Delay or Radio Failure.
     - d. All runs that involved major trauma as indicated by a trauma score of 12 or less and/or the activation of the trauma system.
  2. Audit a percentage of cases know to be high volume, including, but not limited to:
     - a. Chest pain - 25% (every 4^{th} chart).
     - b. Dyspnea - 25% (every 4^{th} chart).
     - c. Seizuires - 25% (every 4^{th} chart)
     - d. Coma of unknown etiology - 25% (every 4^{th} chart).
  3. Audit 10% of all remaining calls on a random basis.
  4. All records audited should be reviewed for complete documentation and appropriateness of information, as well as:
     - a. Assessment appropriate to chief complaint.
     - b. Correct treatment, in compliance with North Coast EMS protocols.
     - c. Evaluation of run times/scene times.

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d. Records involving new EMT's could also be reviewed for the above criteria as well as the following:
   1) Professional manner.
   2) Use of appropriate radio communication skills.
   3) Prioritization of report in compliance with communication guidelines.

B. The Prehospital Care Medical Director shall review:
   1. Cases identified under Section III. A. 1.
   2. All cases flagged by the Prehospital Care Nurse Coordinator as requiring medical review.

C. Chart audit documentation:
   1. Appropriate comments shall be made on the Chart/Tape Audit Report Form.
   2. All charts audited shall be stamped with the Medical Audit Stamp.
   3. All prehospital care records and the Chart/Tape Audit Report Form for the month being audited shall be submitted to North Coast EMS no later than the 10th of the following month.
   4. Repeated or exceptional charting problems should be documented through the Incident Report.