

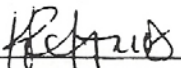
Subject: Administration – Quality Assurance
Chart Audit Guidelines

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 4th chart).
 - b. Dyspnea - 25% (every 4th chart).
 - c. Seizures - 25% (every 4th chart)
 - d. Coma of unknown etiology - 25% (every 4th 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.

Approved: 

Approved as to Form: 