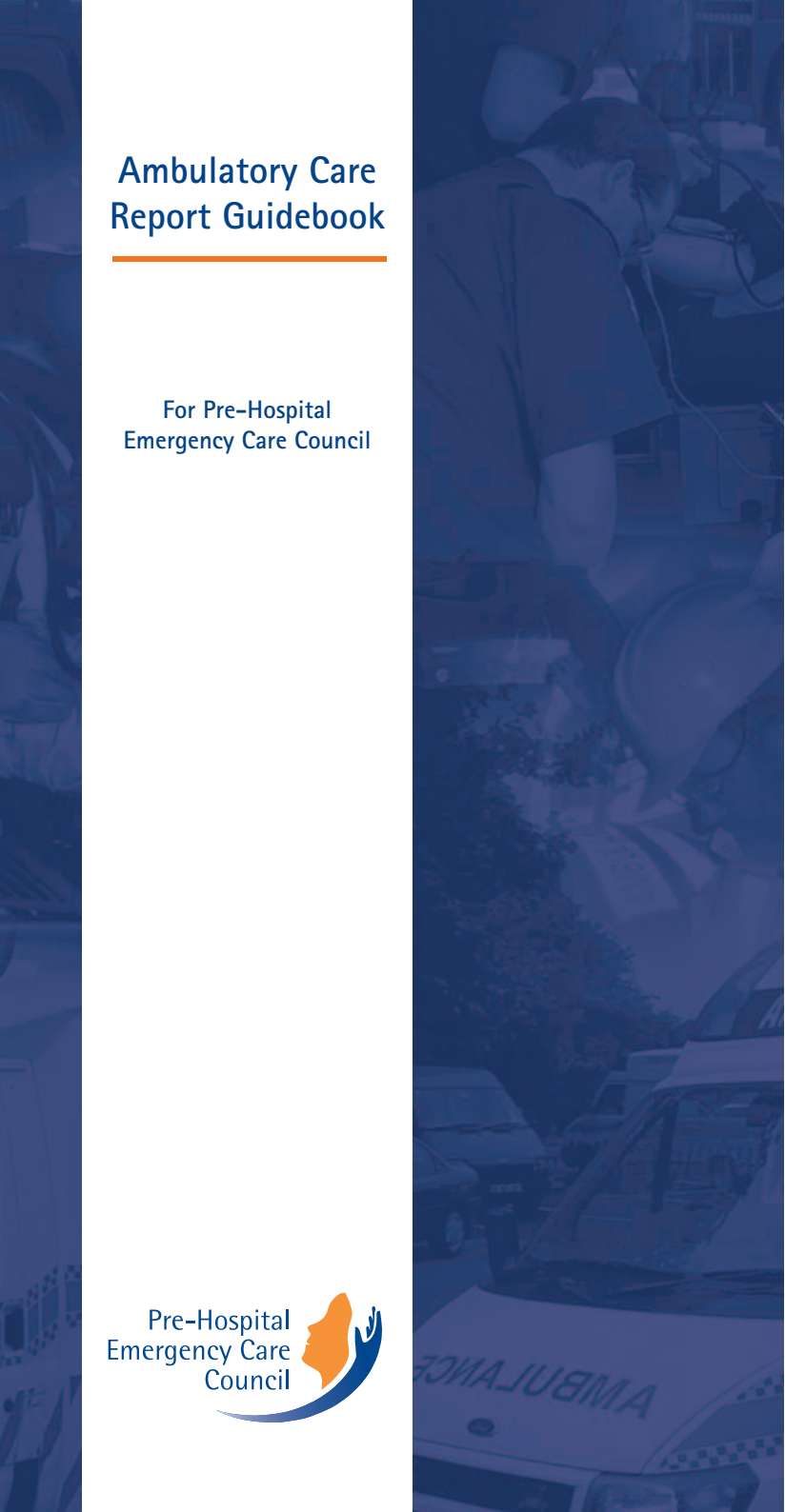
Ambulatory Care Report Guidebook

For Pre-Hospital Emergency Care Council



Pre-Hospital Emergency Care Council

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Pre-Hospital Emergency Care Council
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CONTENTS

INTRODUCTION

In order to provide safe reliable healthcare to the patient it is important that the information provided is accurate, valid, reliable, timely, relevant, legible and complete.

Quality Health Information is the corner stone which will ensure that appropriate care at the appropriate location will be delivered to the patient and that the education and training received by the person administering the care is appropriate to the care required.

The completion of the Ambulatory Care Report will contribute in a very significant way towards improving Health Information and assisting in the continuum of patient care.

SECTION A

Patient Documentation Principles and Standards

A

SECTION A

Patient Documentation, Principles and Standards

1. Aim

The aim of this guidebook is to provide clear guidance for the accurate completion of Ambulatory Care Reports (ACR). Clear, accurate and comprehensive documentation for every patient is fundamental in maintaining a high standard of pre-hospital emergency care.

2. Authority

Organisations providing pre-hospital emergency care require their responders/practitioners whether employed, on contract or volunteering to complete Ambulatory Care Reports.

3. Purpose

Why is it important to fill out an Ambulatory Care Report?

3.1 *Clinical*

Recording pre-hospital care, interventions and medications administered to patients is an essential clinical responsibility. In cases of major trauma or immediate critical care, patient care will take precedence over full completion of the Ambulatory Care Report.

Patient pre-hospital documentation is an important part of the patient record and facilitates continuity of care in the event of the patient being transported to hospital/destination facility.

3.2 *Legal Protection*

Ambulatory Care Reports identify the care that has been provided by the responder/practitioner. A properly completed Ambulatory Care Report will give protection and be an essential aid if called to be a witness in court.

3.3 *Organisation Information*

Information recorded on the Ambulatory Care Report can be divided into two categories. One relates to the health of the patient, the other relates to the activity of the organisation by:

- providing information for research into new skills, services, equipment and other resources required in the future
- providing evidence to both seek and maintain sources of funding
- assisting in the development of education and training programmes.

The collection of information ensures that the foundations are laid to guarantee that the quality of pre-hospital care is clinically effective and continually improved which will result in a better outcome for the patient.

Inaccurate documentation is potentially damaging to patients, services, and the professional standing of the pre-hospital emergency care responders and practitioners.

4. When To Fill Out an Ambulatory Care Report

The Ambulatory Care Report must be completed as outlined below:

- All circumstances where patient is treated
- All circumstances where patient refuses treatment contrary to advice given by responder/practitioner.

SECTION B

Standards for Documentation

B

SECTION B

Standards for Documentation

5. General Standards for Documentation

There are a number of mandatory requirements when completing the Ambulatory Care Report.

These requirements relate to:

5.1 *Accuracy and Factualness*
5.2 *Completeness*
5.3 *Legibility and Correctness*
5.4 *Objectivity*
5.5 *Timeliness*
5.6 *Use of Abbreviations and Symbols*
5.7 *Numerical Accuracy*
5.8 *Errors*
5.9 *Entering PIN/Name*
5.10 *Completion Overview*

5.1 *Accuracy and Factualness*

Accuracy is an essential requirement of documentation. Responders/practitioners must distinguish between what they observe and what the patient states.

For example, a patient may state that he or she has been assaulted by three youths. This should be recorded as "patient stated that he/she was assaulted by three youths".

Unless the responder/practitioner actually witnessed the assault, the patient's complaint of the assault will be regarded as hearsay and should be reported as above.

5.2 *Completeness*

Entries should be a concise yet complete account of the interaction that occurred between the responder/practitioner and with the patient.

5.3 *Legibility and Correctness*

The need for legibility and correctness is paramount. Illegible reports can easily be misinterpreted. For instance, a poorly written 6 (six) may look like a o (zero). All entries must be made using a ballpoint pen pressing firmly to ensure all copies of the Ambulatory Care Report are legible.

The correct spelling of the patient's name is essential in order to accurately identify the patient.

It is important to ask for specific information, such as correct spelling in order to accurately record essential information.

The patient should not be made feel that they are being interrogated or that their condition is being ignored. Responders/practitioners may wish to consider reading or spelling back details to the patient in order to ensure correctness.

5.4 *Objectivity*

Written reports must be objective and not include opinions or value judgements. Any opinion that is not supported by fact should be avoided. For example, the statement that the patient "appears to be intoxicated" or "under the influence of a substance" may be recorded as appropriate:

- "Patient's gait unsteady"
- "Patient's speech slurred"
- "Patient's breath smells of alcohol"

5.5 *Timeliness*

The Ambulatory Care Report should be completed in real-time or as close to the event as is possible. Reports that are not completed soon after the event may lack accuracy due to difficulties in recall.

5.6 *Use of Abbreviations and Symbols*

Only accepted medical abbreviations and symbols should be used.

5.7 *Numerical accuracy*

Numerical accuracy is essential when recording numbers.

5.8 *Errors*

Errors made during the completion of the Ambulatory Care Report should be addressed as follows:

- Cross through the incorrect entry with one line only
- Initial the correction and
- Write the correction close to the error or use an arrow to identify what the correction refers to.

Do not ***obliterate an error***. Do not ***use correction fluid***. The original errors ***must remain legible***.

5.9 *Entering PIN/Name*

The responder/practitioner attending i.e. the main caregiver to the patient for the duration of the incident should enter their PIN/Name in the designated 'responder/practitioner attend' box.

The responder/practitioner support assisting i.e. the responder/practitioner in the care of the patient should enter their PIN/Name into the designated 'responder/practitioner support' box.

5.10 *Completion Overview*

A logical and sequential check of the report prior to completion will enable the identification of missing or incorrect information and confirmation that the record of the patient care is accurate and complete.

SECTION C

Guide for Completion of the Ambulatory Care Report

C

SECTION C

Guide for Completion

6. Step by Step Completion Guide

The Ambulatory Care Report must be completed as outlined in steps below:

6.1 *Incident Information*
6.2 *Patient Information*
6.3 *Clinical Information*
6.4 *Care Management*
6.5 *Medication Treatment*
6.6 *Vital Observations*
6.7 *Declined Treatment*

Background

All incident information must be entered using both alphabetical and numerical entries as appropriate. Some of the details may be captured by the Communications Centre and relayed to the responder/practitioner.

Incident times are required principally for the collection and measurement of onset and presentation time details which will assist in the continuity of patient care.

6.1 INCIDENT INFORMATION

INCIDENT INFORMATION

Venue	Post No	Location
1	2	3 WHERE IN VENUE

Venue Address	Event Type
4	5

Date of Call 6	Time of Call 7	Time at Patient 8
DD MM YYYY	HH MM	HH MM

9 INCIDENT NUMBER

Responder / Practitioner Attend

10 NAME / PIN

Responder / Practitioner Support

11 NAME / PIN

1 Venue
2 Post Number
3 Location
4 Venue Address
5 Event Type
6 Date of Call
7 Time of Call
8 Time at Patient
9 Incident Number
10 Name of Responder or PIN of Practitioner attending
11 Name of Responder or PIN of Practitioner supporting

1 Venue

Venue

In free text enter Name of the Venue.

2 Post No

Post No

In free text enter the Number assigned to the post in the venue.

3 Location

Location

WHERE IN VENUE

In free text enter location of incident at the venue.

4 Venue Address

Venue Address

In free text enter the address of the venue.

5 Event Type

Event Type

In free text enter type of event, e.g concert, match.

6 Date of Call

Date of Call

DD	MM	YYYY

This is the date of the call.

How to enter:

Enter date of day followed by month and year.
For example: 23rd January 07 as: 23 01 2007.
If numeric is singular it must be preceded by a zero.

Additional information:

This is the specific day, month and year the call is received as opposed to the dispatch date.

7 Time of Call

Time of Call	
HH	MM

The time of call is provided by the Communications Centre.

How to enter:
Enter time as 24 hour time entry HH:MM:
If numeric is singular it must be preceded by a zero.

8 Time at Patient

Time at Patient	
HH	MM

Time of arrival of responder/practitioner at patient.
If the patient presents at a first aid post
- time at patient is recorded only.

How to enter:
Enter time as 24 hour clock entry HH:MM:
If numeric is singular it must be preceded by a zero.

9 Incident Number

	INCIDENT NUMBER

In free text enter incident number.

10 Responder/Practitioner attending

Responder / Practitioner Attend
NAME / PIN

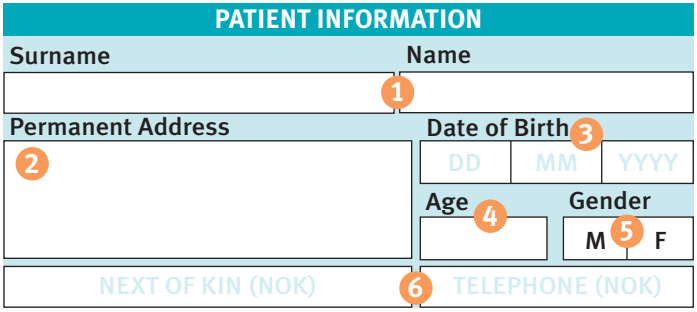
In free text enter Name of responder or PIN of practitioner attending to care of patient.

11 Responder/Practitioner supporting

Responder / Practitioner supporting
NAME / PIN

In free text enter Name of responder or PIN of practitioner supporting.

6.2 PATIENT INFORMATION



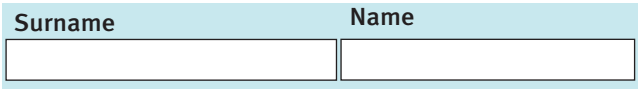
1 Enter Patient Name
2 Enter Patient Permanent Address
3 Enter Date of Birth
4 Enter Age of Patient; if entering an estimated age, indicate by the addition of "approx"
5 Enter Patient Gender
6 Enter Patient Next of Kin & Tel

Where information is unknown record 'U'

Background

All patient demographic details should be entered as alphabetical and numerical as required.
This information enables the healthcare team address the patient by name and ensures that the details of care and treatment provided are recorded on the correct record.

1 Name



Enter surname followed by first name.

2 Permanent Address

Permanent Address

This is recorded as the permanent or usual residence of the patient.

3 Date of Birth

Date of Birth		
DD	MM	YYYY

Enter date of day followed by month and year.
For example: 4th May 1970 as: 04 05 1970.
If numeric is singular it must be preceded by a zero.

4 Age

Age

Enter age in weeks, months or years as appropriate.
E.G. 2/52 for a 2 week old infant, or 8/12 for an 8 month old or 22 for a 22 year old.
If entering an estimated age indicate by the addition of (approx).

If unknown record 'U'.

5 Gender

Gender	
M	F

Tick M/F as appropriate.

6 Next of Kin and Telephone Number

NEXT OF KIN (NOK)	TELEPHONE (NOK)

Enter name of the patient's next of kin/nearest relative/guardian who can be contacted if necessary. Record telephone number including area code. If 'Next of Kin' is not the appropriate person to contact, enter 'person to contact' name in **Additional Information** section.

If unknown record 'U'.

6.3 CLINICAL INFORMATION

CLINICAL INFORMATION

Patient's Chief Complaint | Time of Onset | Date of Onset

1 | HH MM | DD MM YYYY

Primary Survey

A ☐ Clear ☐ Partially Obstructed ☐ Obstructed

C **C Spine** ☐ Suspect ☐ Not Indicated

B ☐ Normal ☐ Abnormal ☐ Fast ☐ Slow ☐ Absent

C

PULSE	☐ Present ☐ Regular	☐ Absent ☐ Irregular	Rate: RATE	Haemorrhage ☐ Yes ☐ No
SKIN	☐ Normal Cap-Refill	☐ Pale ☐ <2 Sec	☐ Flushed ☐ >2 Sec	☐ Cyanosed

2

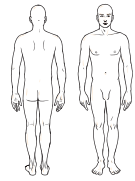
D Loss of Consciousness Before Arrival ☐ Yes ☐ No ☐ Unknown **AVPU**

E

☐ A Abrasion ☐ P Pain
☐ B Burn ☐ R Rash
☐ C Contusion ☐ S Swelling
☐ D Dislocation ☐ N Numbness
☐ # Fracture ☐ W Wound

% BURN

% BURN | RA RL LA LL



CLINICAL IMPRESSION

CARDIAC	☐	OBS/GYNAE	☐
MEDICAL	☐	RESPIRATORY	☐
NEUROLOGICAL	☐	TRAUMA	☐

3

GENERAL	☐ Syncope/Collapse	☐ Nausea/Vomiting
☐ Abdominal Pain	☐ Behavioural Disorder	☐ Poisoning
☐ Allergic Reaction	☐ Illness Unknown	☐ Other General

CLINICAL INFORMATION

Patient's Medical Observations

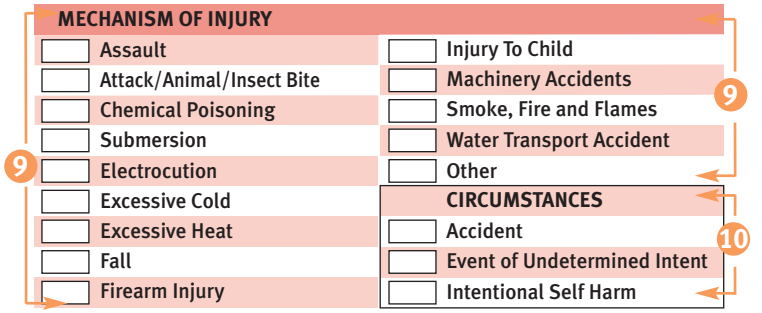
A ALLERGIES 4 ☐ NKA ☐ Unknown

M MEDICATIONS 5 ☐ None ☐ Unknown ☐ As supplied

P PAST MEDICAL HISTORY 6 ☐ None ☐ Unknown

L LAST INTAKE 7 ☐ Unknown
DESCRIBE HH MM

E EVENT 8



1 Patient's Chief Complaint
2 Primary Survey
3 Clinical Impression
4 Allergies
5 Medications
6 Past Medical History
7 Last Intake
8 Event
9 Mechanism of Injury
10 Circumstances

1 Patient's Chief Complaint

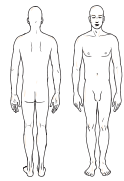
CLINICAL INFORMATION					
Patient's Chief Complaint	Time of Onset		Date of Onset		
	HH	MM	DD	MM	YYYY

This is the patient's primary presentation - the reason why the patient is seeking pre-hospital emergency care.

The complaint will be recorded as described or indicated by the patient and if this is not available, as observed by family member/bystander.

How to enter:
Enter patient's complaint, time and date of onset/occurrence. If unknown record 'U'.

2 Primary Survey

A	☐ Clear	☐ Partially Obstructed	☐ Obstructed		
c	**C Spine**	☐ Suspect	☐ Not Indicated		
B	☐ Normal	☐ Abnormal	☐ Fast	☐ Slow	☐ Absent
C	**PULSE** ☐ Present ☐ Regular	☐ Absent ☐ Irregular	Rate RATE	Haemorrhage ☐ Yes ☐ No	
	SKIN ☐ Normal Cap-Refill	☐ Pale ☐ <2 Sec	☐ Flushed ☐ >2 Sec	☐ Cyanosed	
D	Loss of Consciousness Before Arrival ☐ Yes ☐ No ☐ Unknown	**AVPU**			
E	☐ A Abrasion ☐ B Burn ☐ C Contusion ☐ D Dislocation ☐ # Fracture	☐ P Pain ☐ R Rash ☐ S Swelling ☐ N Numbness ☐ W Wound			
	% BURN % BURN RA RL LA LL				

This is the summary of injuries or abnormal findings following the completion of the primary survey. This information should be entered in real time.

How to enter:

Tick appropriate box as outlined below:

A Airway Tick box as appropriate

c spine Tick box as appropriate

B Breathing Tick box as appropriate

C Circulation Tick box as appropriate
Pulse: Tick box as appropriate and indicate Rate
Haemorrhage: Tick box as appropriate
Skin: Tick box as appropriate
Cap-Refill: Tick box as appropriate

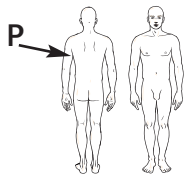
D Disability Loss of consciousness before arrival & tick as appropriate

AVPU: Indicate AVPU level

E Expose Tick box as appropriate

Include % Burns based on Wallace Rule of Nines if appropriate.

Shade or mark the diagram and place the appropriate letter beside the site of injuries, e.g. P = Pain



3 Clinical Impression

CLINICAL IMPRESSION			
CARDIAC	☐	OBS/GYNAE	☐
MEDICAL	☐	RESPIRATORY	☐
NEUROLOGICAL	☐	TRAUMA	☐

GENERAL	☐	Syncope/Collapse	☐	Nausea/Vomiting
☐	Abdominal Pain	☐	Behavioural Disorder	☐	Poisoning
☐	Allergic Reaction	☐	Illness Unknown	☐	Other General

This is the early clinical impression of what is the presenting illness/injury based on the combination of information available following primary survey.

How to enter:

Enter your clinical impression by ticking appropriate box in appropriate section and expand Clinical Impression in free text if appropriate.

It is imperative that a clinical impression based on the history taken from the patient and your best clinical judgement is recorded.

Additional Information:

The compiling of the clinical details from the patient and the scene facilitates the use of appropriate CPGs in response to the patient's presentation. It also facilitates the monitoring of clinical practice and review of the educational programme where necessary.

4 Patient Allergies

A	ALLERGIES	☐ NKA ☐ Unknown	

Account of drug and agent allergies recounted by patient which is known to them.

How to enter:

Tick box as appropriate and list allergies if known.

Additional Information:

Known drug sensitivities will highlight contraindication of certain drugs or groups of drugs. May also indicate a cause of anaphylaxis if history is suggestive of exposure to an agent.

5 Medications

M	MEDICATIONS	☐ None ☐ Unknown ☐ As supplied	

Record of drugs as recounted by the patient or as seen by practitioner.

How to enter:

Tick box as appropriate or list drugs as seen or recounted by the patient.
Record 'as supplied' for medications collected by responder/practitioner.

Additional Information:

Compliance with medication should be ascertained. It could have an impact on chief complaint if the routine tablets have not been taken e.g. daily warfarin, or insulin dependent diabetics who have skipped a meal, etc.

It is best practice for the responder/practitioner to establish if the patient is taking any medications that may interact with others which should be considered prior to administration.

6 Past Medical History

P	PAST MEDICAL HISTORY ☐ None ☐ Unknown	

This is recorded as the relevant medical history reported by the patient or next of kin or noted on assessment.

How to enter:

Tick box as appropriate or enter free text as recounted by the patient.

Additional Information:

Record only the pertinent history to the condition presenting. Past medical history can often provide the background to the current medical complaint and can act as an aid in the selection of the relevant CPG.

7 Last Intake

L	LAST INTAKE ☐ Unknown DESCRIBE	HH MM

This is the record of time and description of last food or drink taken as recounted by the patient.

How to enter:

Enter time as 24 hr clock entry HH:MM:
Free text description of food or drink.
Tick unknown if information unknown.

Additional Information:

This can have significant clinical importance particularly in the case of a patient with an altered level of consciousness, potential airway problems, potential surgery and during transport.

8 Description of Event:

E	EVENT

This is the summary of the event/activity and place of occurrence immediately prior to incident/injury.

How to enter:

Enter free text description of event which occurred, as assessed by responder/practitioner.

Additional Information:

There is always an event/activity associated with each incident/injury. It is important that this information is captured for the completeness and accuracy of the clinical information captured on the ACR.

9 Mechanism of Injury:

MECHANISM OF INJURY	
☐ Assault	☐ Injury To Child
☐ Attack/Animal/Insect Bite	☐ Machinery Accidents
☐ Chemical Poisoning	☐ Smoke, Fire and Flames
☐ Submersion	☐ Water Transport Accident
☐ Electrocution	☐ Other
☐ Excessive Cold	
☐ Excessive Heat	
☐ Fall	
☐ Firearm Injury	

This is the mechanism by which the injury occurred, as assessed by the responder/practitioner.

How to enter:

Tick appropriate mechanism of injury box.
For example if gun shot wound, tick firearm injury, if child has injuries, tick injury to child, if patient has been assaulted, tick assault.

10 Circumstances:

CIRCUMSTANCES
☐ Accident
☐ Event of Undetermined Intent
☐ Intentional Self Harm

This is the best assessment possible of the circumstances under which the event occurred, based on scene assessment and patient findings.

How to enter:

Tick appropriate box as outlined below:

- If following assessment of scene and patient it appears that the event was accidental, tick 'Accident'
- If following assessment of scene and patient it appears that the patient intended to self harm, tick 'Intentional Self Harm'
- If following assessment of scene and patient the intent of the event cannot be determined, tick 'Event of Undetermined Intent'.

Additional Information:

This information is correlated with Event Details, Mechanism of Injury and Incident Location to determine ICD-10-AM codes. This coded information can then be used to facilitate a process of clinical audit and continuous improvement in pre-hospital emergency care.

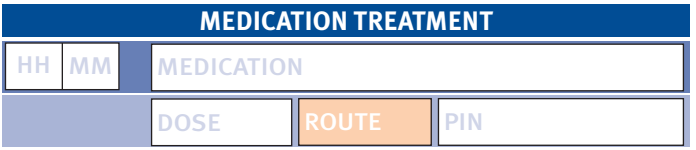
6.4 CARE MANAGEMENT

CARE MANAGEMENT	
☐ Observe and Supportive Care	☐ Wound Closure
☐ Skin Dressing	☐ RICE

How to enter:
Tick as appropriate each item of care administered.

Additional Information:
Accurate clinical record keeping of care provided has a positive influence on the continuum of care for patients. This facilitates assessment of care management, the use of equipment and PHECC CPGs appropriate to presenting complaint (Chief Complaint) and the Clinical Impression. It will also provide evidence for training needs (skills audit).

6.5 MEDICATION TREATMENT

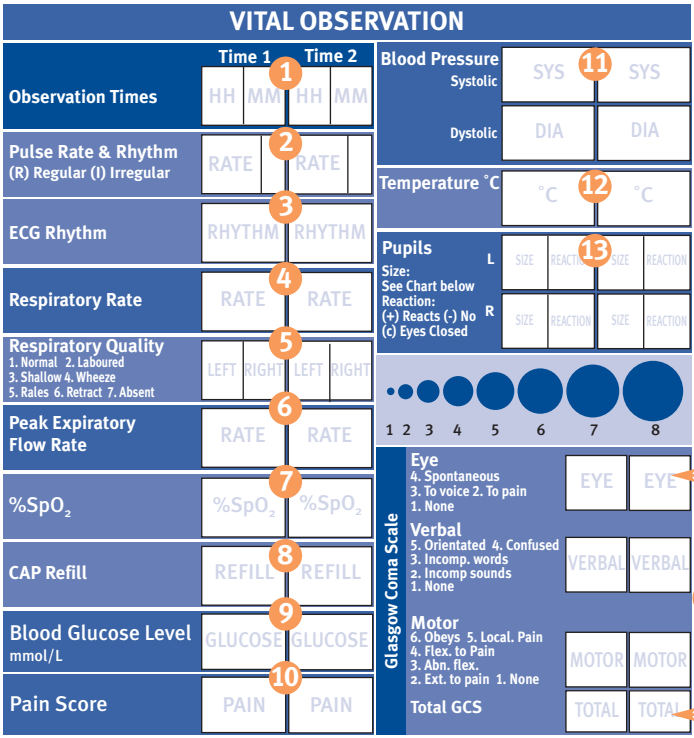


Name of medications given to patient, time given, dose, route, medication code and name of responder/PIN of practitioner who gave the medication.

How to enter:

- Record time and name of medication given
- Enter dose and route of medication
- Enter PIN of the administering practitioner or in free text enter Name of administering responder as appropriate.

6.6 VITAL OBSERVATION SHEET



1 Observation Times
2 Pulse Rate & Rhythm
3 ECG Rhythm
4 Respiratory Rate
5 Respiratory Quality
6 Peak Expiratory Flow Rate
7 % SpO_2
8 Cap-Refill
9 Blood Glucose
10 Pain Score
11 Blood Pressure
12 Temperature
13 Pupils
14 Glasgow Coma Scale

Background

A record of the vital signs and physical assessment of the patient gives base line evidence of how a patient presents and will highlight deterioration and or improvement in response to immediate care.

How to enter:

Record observations numerically, as they are carried out on patient.

Additional Information:

Observations must be carried out regularly. The frequency of the observations will be determined by the patients need in response to the care management provided. All entries must be recorded in real time.

1 Observation Times

	Time 1		Time 2	
Observation Times	HH	MM	HH	MM

How to enter:

Enter the time using the 24-hour clock entry HH:MM:

2 Pulse Rate & Rhythm

Pulse Rate & Rhythm (R) Regular (I) Irregular	RATE		RATE	

How to enter:

Enter the pulse rate per minute and comment on whether the pulse is regular-R or irregular-I.
If unable to palpate, record ‘o’.

3 ECG Rhythm

ECG Rhythm	RHYTHM	RHYTHM

How to enter:
Enter the heart rhythm as interpreted.

4 Respiratory Rate

Respiratory Rate	RATE	RATE

How to enter:
Enter the respiratory rate per minute.

5 Respiratory Quality

Respiratory Quality 1. Normal 2. Laboured 3. Shallow 4. Wheeze 5. Rales 6. Retract 7. Absent	LEFT	RIGHT	LEFT	RIGHT

How to enter:
Indicate the respiratory quality in both lungs by inserting the appropriate numeral.

6 Peak Expiratory Flow Rate

Peak Expiratory Flow Rate	RATE	RATE

How to enter:
Enter reading recorded on Peak Flow Meter.

7 $\%SpO_2$

$\%SpO_2$	$\%SpO_2$	$\%SpO_2$

How to enter:
Enter figure displayed on monitor.

8 Cap Refill

How to enter:

Enter as appropriate < 2 sec or > 2 sec.

9 Blood Glucose Level

How to enter:

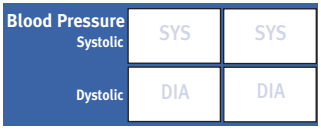
Enter the blood sugar level as recorded with a glucometer.

10 Pain Score

How to enter:

Enter the number as indicated by the patient, where 0 = no pain and 10 = the highest level of pain.

11 Blood Pressure



How to enter:

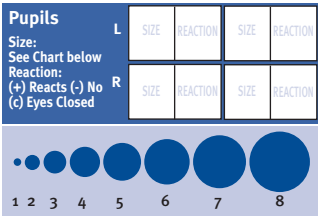
Enter both Systolic and Dystolic as recorded, where measured by palpation enter "P" in the Dystolic Box.

12 Temperature

How to enter:

Enter measurement, or enter the skin temperature by palpating the skin surface, using the following abbreviations:
C = cool or cold, N = normal,
H = Hot or above normal.

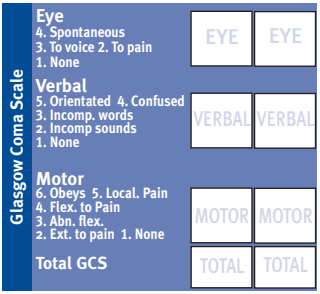
13 Pupils



How to enter:

Enter the size of the pupils before testing reaction to light, and the reaction of both left and right.

14 Glascow Coma Scale



How to enter:

Insert the appropriate numerical for each response; best eye response, best verbal response, best motor response and the GCS total.

6.7 DECLINED TREATMENT

DECLINED TREATMENT

AID TO "DECISION MAKING CAPACITY"

1. Patient verbalises/communicates understanding of clinical situation?	☐ Yes	☐ No
2. Patient verbalises/communicates appreciation of applicable risk?	☐ Yes	☐ No
3. Patient verbalises/communicates ability to make alternative plan of care?	☐ Yes	☐ No

I/We witness that the patient has declined treatment.

I/We have advised the patient to consult with his/her own doctor as soon as possible or should his/her condition deteriorate to call 999 for emergency medical assistance.

PIN (1)/Name (1) PIN (2)/Name (2)

and report Decline of Treatment and or Transport.

Background

In the event of the patient refusing treatment and or transport this section must be completed by two responders/practitioners where possible.

How to enter:

- Tick as appropriate
- In free text enter Name of responder or PIN of practitioner who have attended the patient.

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