Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo and Mono Counties

Virginia Hastings, Executive Director
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DATE: March 20, 2009

TO: **San Bernardino County:**

ALS Providers submitting PCRs with Scantrons:
CHP Air, Colton, Combat Center and San Bernardino County Fire Departments, and SES Symons Event Safety

ALS Providers submitting PCRs electronically via email:
Chino Fire, Montclair Fire, Ontario Fire, San Bernardino City Fire and Upland Fire Departments

ALS Providers not submitting PCRs:
Apple Valley, CAL Fire Highland, CAL Fire Yucaipa, Crest Forest, Loma Linda, Marine Corp Logistics Base (MCLB), Rancho Cucamonga, Redlands and Rialto Fire Departments, and Mercy Air Service, San Bernardino County Sheriff Air, Autoclub Speedway, Mission Ambulance and Priority One Medical Transport

FROM: Virginia Hastings
Executive Director

SUBJECT: **REVISION TO THE PATIENT CARE RECORDS (PCR) TO INCLUDE STEMI**

For ALS providers who currently are not part of the MISS project and submitting paper Scantrons or data electronically to ICEMA, please revise your patient care records (01A) to include STEMI as a reason for patient destination **by no later than April 30, 2009.** We have ordered revised Scantrons for those submitting paper Scantrons to ICEMA. The revised forms should be available by April 15, 2009.

For providers who are submitting data electronically via e-mail, please revise your data set to include STEMI ("S" under "Why Selected") as a reason for patient destination **by no later April 30, 2009**. We have enclosed the revised instructions (Protocol Reference #14013). Please review these instructions with personnel responsible for the completion, collection and submitting the PCR information to ICEMA.

It is imperative now that we have designated STEMI centers in San Bernardino County so that we may evaluate the STEMI system. Data from these occurrences are captured as part of the QI process to help identify trends.

Thank you for your cooperation and assistance in collecting this information.

VH/DF/mae

Enc.

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INSTRUCTIONS FOR THE 01A NARRATIVE PCR FORM

CONTACT TIME
Record the time contact was initiated with the base hospital.

RECEIVING HOSPITAL
Record the name or appropriate abbreviation for the hospital where the patient was transported.

Mark the ONE category that best describes the reason for selection of the receiving hospital:

STEMI:	a stemi center is required
Pt. Request:	patient or patient's physician requested this facility
Diversion:	the original receiving hospital selected was on diversion for this type of call
Trauma:	transported to this facility because they require a trauma center
RCF:	radio communication failure
Peds trauma:	they require a pediatric trauma center
Reroute:	the receiving hospital destination changed while the unit was en route from scene. E.g., a change in patient condition required selection of a different facility). Not to include change in the destination based upon hospital status (see "diversion")
Closest:	the hospital is selected because it is closest to the scene
Other:	a reason other than those listed above in selecting the receiving hospital

CHIEF COMPLAINT
Use the blank space under this heading to describe details of the patient's problem. Describe the location of injury; (head, face, neck, chest, abdomen, rt. or lt. arm or leg, rt. or lt. hand or foot), or sites of pain; the type of injury or pain (e.g., fracture, laceration, etc.), and other medically relevant signs and symptoms (e.g., estimated blood loss). Include drug or alcohol use here.

MECHANISM OF INJURY
For all trauma patients, record the reported cause of injury. Categories include motor vehicle accidents (MVA), motorcycle collisions (MCA), GSW, stabbing etc. For falls, specify if more than 20 feet. Show whether injury is blunt or penetrating. If undeterminable, write "unknown." Circle "Y"-yes or "N"-no to the following questions; did the patient wear a helmet, a seat belt, have a loss of consciousness (LOC), and was an airbag inflated?

MED. HISTORY
Use this space to record the patient's medical history. History may include cardiac, respiratory, liver, kidney, or other known disease, any recent and/or related illnesses, medical conditions, hospitalizations, history of trauma, or medical treatments. Also, record the time of injury or time of onset of symptoms as stated by the patient. Check appropriate predesignated diagnosis if one applies to the patient.

MEDICATION
Write the names of all prescription or over-the-counter medications the patient is currently taking. Abbreviate as necessary. If they do not know the specific name of the drug, record the class of drug or the action it takes (e.g., insulin, diuretic, an antidepressant, antihistamine, etc.). Include dose and frequency if it is taken daily (e.g., Bid, T.i.d., QD). Bring any medication not quickly identifiable to the hospital with the patient.

ALLERGIES
Mark the box 'NKA' for no known allergies. Otherwise, record the names of any medications to which the patient has had an allergic reaction. Also record any other allergies either related to the current problem (for example, the mechanism of injury is "bite/sting" and the patient is allergic to bee stings), or environmental allergies (for example Latex allergies).

BLOOD PRESSURE
Record the time (use a 24-hour clock) and initial blood pressure reading as systolic/diastolic. Note if auscultation or palpation was used to obtain B/P. Record blood pressure readings as required by protocol. If you require additional space, use the Narrative section.

SPECIAL STUDY
Use this area whenever a special study is conducted. Mark all boxes **(M, S, or O)** that apply.
(M)Medications
(S)Skills
(O)other.

OUTCOME
Mark the box **(C, D, R, G, A, O)** next to the category that best describes this call. *BLANK IS INVALID.*

(C)canceled enroute:	Call canceled by agency dispatcher prior to arrival at a scene and if the run is canceled on scene before you make pt contact.
(D)dry run-no pt	No patient was found at the scene, the unit was unable to locate the scene or the patient, or the patient refuses to communicate so you cannot obtain any patient information.
(R)transport refused:	The patient accepted care by an EMS field provider but refused to be transported by any EMS provider, and for walk-in patients.
(G)transport-ground:	Patient received prehospital care, was transported by this or another ground ambulance, or if patient care was transferred to another unit.
(A)transport-air:	Patient received prehospital care, was transported by helicopter or fixed-wing aircraft, and for patient to loading zone and patient care to EMS air.
(O)obviously dead:	Patient showed obvious signs of death, per protocol.

INSTRUCTIONS FOR THE SCANTRON PCR DATA COLLECTION FORM

WHY SELECTED
Mark the category **(S, T, P, D, C, E, R, O)** that most closely matches the reason for selection of the receiving hospital. If the base hospital indicates a reason, mark the hospital's determination of "why selected."

(S)Stemi:	a stemi center is required.
(T)major trauma:	a trauma center is required.
(P)patient request:	patient or patient's physician requests transport to a specific facility
(D)diversion:	the original receiving hospital selected was on diversion
(C)closest:	the hospital is closest to the scene.
(E)peds trauma:	pediatric trauma center is required.
(R)reroute:	the receiving hospital destination changed while the unit was enroute (e.g., a change in patient condition required selection of a different facility). Does not include change in a destination based upon hospital status
(O)other:	a reason other than those listed was used in selecting the receiving hospital.

ICEMA# (*Fieldname*: ICEMA#2)
Mark six boxes **(0-9)** to indicate the ICEMA number printed on the upper left corner of the 01A Narrative form for this patient. An ICEMA number is required here, **except for dry runs or canceled calls**.

ATTENDANT #1 CERT NO (*Fieldnames*: CERT#1A/CERT#1B)
Mark the first box **(E, L, P or M)** to indicate the level of accreditation/certification for primary patient caregiver reporting on this run. P for paramedic, E for emergency medical technician or M for mobile intensive care nurse (on interfacility transfers). Mark the ICEMA accreditation/certification numbers **(0-9)** in the remaining boxes. If your ICEMA number is less than five digits, use leading zeroes before the number as needed to fill the boxes. **Provisional paramedics or MICNs who are third members of the ambulance crew sign the 01A narrative form, but enter no data on the F-1612 data form.**

ATTENDANT #2 CERT NO (*Fieldnames*: CERT#2A/CERT#2B)
Mark the first box **(E, L, P, or M)** to indicate the type of accreditation/certification for the secondary patient caregiver reporting on this run. Mark the ICEMA accreditation/certification number **(0-9)** in the remaining boxes. If your number is less than five digits, use leading zeroes before the number as needed to fill the boxes.

FIELD NAME	*STARTING POSITION IN DATA FILE*	*DEFINITION*	*LENGTH*	*VALID CHARACTERS*
OUTCOME	197	Enter category that best describes call. **BLANK IS INVALID**	1	C,D,R,G,A,O
INS45	198	End of field	1	Comma
WHY SELECTED (add 'S' as valid code)	**199**	**Enter category that matches reason for selecting Receiving Hospital**	**1**	**S**,T,P,D,C,E,R,O
INS46	200	End of field	1	Comma
ICEMA#2 (ICEMA#)	201	Enter ICEMA 01A report form number by unit recording this run	6	Numerics: 0-9
INS47	207	End of field	1	Comma
CERT#1A (Attendant #1 Cert No.-Alphas)	208	Enter type of accreditation/certification for primary patient caregiver reporting on this run.	1	E,L,P,M
CERT#1B (Attendant #1 Cert No.-Numerics)	209	Enter ICEMA five-digit accreditation/certification number for primary patient caregiver reporting on this run.	5	Numerics: 0-9
INS48	213	End of field	1	Comma
CERT#2A (Attendant #2 Cert No.-Alpha)	214	Enter type of accreditation/certification for secondary patient caregiver reporting on this run.	1	E,L,P,M
CERT#2B (Attendant #2 Cert No.-Numerics)	215	Enter ICEMA four or five-digit accreditation/certification number for secondary patient caregiver reporting on this run.	5	Numerics: 0-9
INS49	220	End of field	1	Comma
PROVIDER B (This Form by-Provider)	221	Enter the valid provider code for the agency reporting this run	3	Numerics: 0-9
INS50	224	End of field	1	Comma
UNIT B (This Form by-Unit)	225	Enter the valid unit code for the agency reporting this run	3	Numerics: 0-9
INS51	228	End of field	1	Comma
SCANTRON#/LITHOCODE	229	Binary Summation Leave 6 spaces blank	6	Leave no marks in this field
INS52	235	End of field	1	Comma
TRANSP CODE1 (OTHER TRANSPORT-Top right of Scantron form)	236	Enter the type of unit for another provider on scene. *Enter this information only if a second unit is on scene and makes patient contact*	2	MA,MS,ME,AM,SQ,E
INS53	238	End of field	1	Comma
TRANSP CODE2	239	Enter the type of unit for the agency reporting this run	2	MA,MS,ME,AM,SQ,E
INS54	241	End of field	1	Comma
SP STUDY (Special Study)	242	Enter category ONLY if reporting data for a special study	3	M,S,O
INS55	245	End of field	1	Comma
RELEASE SIGNED	246	Enter if AMA was signed on 01A Form	1	Y
INS56	247	End of field	1	Comma
IO ATTEMPT (Attempts Placed-IO)	248	Enter the number of IO attempts	1	1,2,3
INS57	249	End of field	1	Comma
IO2 ATTEMPT (Attempts Placed-IO-Y)	250	Enter ONLY if IV placed successfully	1	Y

INSTRUCTIONS FOR THE PCR DATA SET SENT VIA EMAIL