Ambulance Call Report

Completion Manual

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Version 2.2

Emergency Health Services Branch
Ministry of Health and Long-Term Care

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Introduction

The Ambulance Call Report (ACR) is an essential medical record for documenting information about circumstances and events relevant to the proper provision of ambulance service.

The information contained on a completed ACR can be used in several ways. These include:

Clinical   ACR information about the call history, patient assessment findings, patient care provided and the response to treatment is very useful to receiving facilities which have to plan the ongoing care for a given patient.

Administrative   ACR information can greatly assist in effective ambulance service management and future planning.

Research   ACR information can be used to help answer quality assurance and research oriented questions, which in turn may contribute to advances in pre-hospital care.

Legal   ACR information may be required as part of a legal inquiry into events involving ambulance activities.

This manual has been prepared to assist all levels Emergency Medical Attendants (EMAs) and Paramedics in completing the ACR.

Definition of Terms

Call: refers to a request for ambulance service

Page: for ease of description within this manual, the ACR has been divided into two (2) pages. Page 1 consists of the Administration, Clinical Information and Physical Exam sections. Page 2 contains the Clinical Procedure/Treatments/Results and General Administration sections.

Section: refers to an area of the ACR where similar types of information are grouped.

Field: a specific location within a section of the ACR where an EMA/paramedic records various types of information.

Design Highlights

Sequencing of Information

The ACR has been designed to record information in a sequence that approximates the order in which call events occur.

Grouping of Information

Similar types of information have been grouped together under eight different sections:

- Administration – Patient Identification
- Clinical Information
- Physical Exam
- Clinical Treatment/Procedures & Results
- General Administration
- Hospital Administration (billing copy only)
- Aid to Capacity Evaluation (back of ACR)
- Refusal of Service (back of ACR)

Prompts

To further assist EMAs and Paramedics in completing an ACR, "prompts" have been included in specific areas. These prompts take the form of "tick" boxes that allow an EMA/Paramedic to simply mark common history and assessment findings without having to write them out, and "ghosted" script that indicates to EMAs/Paramedics specific information that should be documented in a particular area on the ACR.

Codes

Areas on the form have been designed to receive codes that assist in capturing data related to various types and categories of information. All codes have been printed on the reverse side of the ACR form for quick reference.

General Rules

- This manual is consistent with the "Ambulance Service Documentation Standards" requirements for patient care documentation.

- The ACR is to be completed for all calls categorized as response and/or return Priority Codes one (1) through seven (7) except in certain cancelled call circumstances.

- Documentation must be accurate, legible and complete. Thorough documentation enhances the credibility of information contained on the form and of the crew who complete the form. Credibility is an important consideration during calls and during post-call inquiries.

- When a patient is transported, a minimum of one form is to be completed for each patient per call. The form is to be completed **jointly** by crew members.

- Forms should be completed as soon after a call as is practical. For calls where a patient is brought to an emergency department, crews will endeavor to complete the ACR and give it to the appropriate personnel prior to leaving the hospital.

- A useful maxim to remember is **"Not documented means not done."**

- The information on the ACR is to be considered confidential once completed.

- The 24-hour clock is to be used when documenting times (midnight is 00:00 hrs).

- Use black ink (pen) and press hard enough to make the required four (4) copies.

- All "distance-travelled" readings are to be recorded from the odometer and rounded off to the nearest kilometer. If two readings are the same (such as start and pick-up), they must both be documented.

- Unless otherwise stated, all numbers and codes should be entered on a "right justified" fashion (i.e. writing left to right but ending in the last right hand box).

Distribution

The ACR is a multi-part form comprised of four copies. They are identified by name and colour as indicated on the bottom of page 2 of the form.

The copies are to be distributed as follows:

1. White copy (original) **Patient Chart Copy**. This is usually the easiest copy to read and helps ensure the receiving facility has access to the most legible record of call information. This copy is left with the receiving hospital staff (with the exception of patient refusal of service calls).

2. Blue copy **Billing Copy**. This copy is distributed according to local policy/procedure. The design of the billing copy prevents confidential patient medical information from being recorded on it.

3. Canary copy **Base Hospital Copy**. This copy is forwarded to the local Base Hospital according to local policy/procedure.

4. Pink Copy **Ambulance Service Copy**. This copy is retained by the Ambulance Service for their records.

Minimum Completion Areas

An EMA or paramedic must complete an ACR as per the Ambulance Service Documentation Standards described in Regulation 257/00.

Explanation of Sections

Administration

The patient identification fields within the Administration section must be filled out by hand, or it can be clearly stamped with a hospital patient data card.

When using a hospital patient data card, the card must include all of the information noted below with an asterisk (*). If the information required on the ACR is not on the patient data card, the missing information needs to be entered by hand by the EMA/Paramedic. If the date of birth information on the patient data card is configured differently than the YY/MM/DD format on the ACR, the date of birth needs to be written by hand in the appropriate field using the proper format. Crew members are responsible to ensure that the information is clearly legible on all ACR copies when using hospital patient data cards.

Surname*
Enter the complete surname of the patient. Pay close attention to the correct spelling.

Given Name*
Enter the complete first name of the patient. If an initial is known, it can be entered after the first name.

Mailing Address*
Enter the complete mailing address of the patient (street and city/town, province and postal code if readily available).

Hospital Registration Number*
If available, enter the unique hospital patient registration number. This will facilitate outcome audits and assist with the matching of Ambulance Call Reports with the patient's chart.

Date of Birth*
Enter the birth date of the patient (year, month, day) whenever possible.

Health Card Number*
Enter the patient's ten-digit health card number, if available. If there is a version code on the patient's Health Card, ensure that this two digit "alpha" code is entered in the box marked "Ver.".

Crew Type (located at top right corner on Page 1 of the ACR)
This area is used for quality management purposes. Each call will be categorized by the highest level of training of either of the crew members on each call. Check the most appropriate box that indicates the *highest* level of care that can be delivered by the crew.

If a flight crew is completing the ACR, both the level of training plus the "FLIGHT" box must be checked.

If an EMA/paramedic responded to the call on a first response basis, the level of training and the "FR" box must be checked.

Call Type (located at top right corner on Page 1 of the ACR)
This area is for quality management purposes only. Each call will be categorized by the paramedic/EMA to allow for more efficient sorting of Ambulance Call Reports and to further facilitate the continuous quality management process. Check the most appropriate box.

BLS Any call where no controlled acts have been provided.

SR Any call where a symptom relief medication has been provided using symptom relief protocols. If however, a medication is administered using ACP protocols check the "ALS" box.

AED Any call where an automated external defibrillator is used to analyze or defibrillate the patient. Do not mark this code for patient monitoring.

IV Any call where an intravenous is initiated, but no other ALS skills are used (e.g. no defibrillation, Symptom Relief or other medications or advanced skills).

ALS Any call where Advanced Care Paramedic designated skills are used beyond Symptom Relief, AED and IV only (e.g. endotracheal intubation).

CCT Any call where Critical Care Paramedic designated skills are used beyond the Advanced Care Paramedic designated skills set (i.e. chest tube).

If Symptom Relief and AED are used with no other Advanced or Critical Care Paramedic designated skills, check the "AED" box only.

Service Name
Enter the name of the Ambulance Service completing the call here.

CACC
The CACC area is intended to record the identification number of the CACC or MATC that dispatched the ambulance. Local policy will determine if the I.D. number is to be used (otherwise, the area is left blank).

ARIS-dispatched services must include the 2 letter CACC code in this area e.g. 'LD' is the code for the London CACC. If the ARIS system is unavailable, the dispatcher will issue the prefix "AB" with the call number. Enter this prefix with the CACC code (e.g. 'LDAB').

Call Number/Patient Number
The call number is provided by the CACC/MATC to the crew. It matches the number on a corresponding dispatch record. The number is to be entered in a "right-justified" manner into the boxes provided. The patient number is the unique patient identifier for each air ambulance call and should not be confused with the flight number.

Call Date
Enter the date numerically as: year/month/day (YYYY/MM/DD).

Vehicle Number
Enter the vehicle number as assigned by Emergency Health Services Branch.

Service
Enter the Emergency Health Services Branch assigned Ambulance Service number.

Station
Enter the Emergency Health Services Branch assigned Ambulance Service station number (first two (2) digits) and the Paramedic level as designated by CACC (third digit). This does not apply to Air Ambulance Calls.

Station Code	Paramedic Type Code
00–99	0 - EMA
	7 - Primary Care Paramedic
	8 - Advanced Care Paramedic
	6 - Critical Care Paramedic
	9 - Preceptor

Status
This code identifies the status of the vehicle when they are being dispatched. Enter the two-digit code in the appropriate field:

00	Vehicle at Base
77	Vehicle Mobile
88	Vehicle at Standby Location
99	Vehicle at Maintenance Area

Start (km)
Enter the odometer reading, in whole kilometers, at the point the ambulance begins responding to a call.

Pick Up [PU] (km)
Enter the odometer reading, in whole kilometers, at the point where the ambulance arrived at the call scene **or** the odometer reading, in whole kilometers, at the point where a crew change occurs (Note in this instance, the start and pick up distance traveled records will be the same.). In instances where there is no pick up location (e.g. cancelled enroute), document a "0" (right justified).

Destination [Dest.] (km)
Enter the odometer reading, in whole kilometers, at the point where the ambulance arrives at the call destination (e.g. a receiving hospital). This area is also used to document the odometer reading, in whole kilometers, at the point where the ambulance arrives at a base following completion of a non-patient carrying call. If the ambulance is reassigned another call, document the mileage.

UTM Code/Flight #
The mapping system at a dispatch center uses a numeric code to identify geographic locations. EMAs/Paramedics should request the UTM code from their dispatch center to complete the form. This number includes a 2 digit zone code (eg 18) plus the 3 digit "easting" and 4 digit "northing" codes (e.g. 18 495 3208).

As air ambulance crews are not issued UTM codes from MATC this field will be used to record the flight number provided by MATC for the call.

Dispatch Problem Code [Dsp. Prb. Cde]
Enter the problem code that most appropriately applies to the information the dispatcher conveyed to you when first assigned the call from the list of codes on the back of the ACR. Four additional codes are allocated in the problem code section under the heading **DISPATCH ONLY CODES**. These codes are **not** to be used in the Primary, Secondary or Final problem code sections.

Priority Codes

The priority codes are used to identify:
a) the urgency of a response or transport
b) other use of an ambulance when a patient is not carried

Dispatch Priority Code
This is the priority code number that is assigned to the call by a dispatcher. It identifies the priority under which the ambulance responds to the call location (e.g. an urgent response would be entered as a Code "4"). Enter the appropriate Priority Code that corresponds to the assigned dispatched priority.

Code 1	**"Deferrable"** – a routine call that may be delayed without being detrimental to the patient (e.g. a non-scheduled transfer; a minor injury).
Code 2	**"Scheduled"** – a call which must be done at a specific time e.g. because of special treatment or diagnostic facilities are available at a specific time (e.g. inter-hospital transfers for MRI, a scheduled meet with an air ambulance).
Code 3	**"Prompt"** – a call that should be performed without delay (serious injury or illness e.g. stable fracture).
Code 4	**"Urgent"** – a call that must be performed immediately where the patients "life or limb" may at risk (e.g. Vital Signs Absent patient; unconscious head injury).
Code 8	**"Stand-by"** - a call where an ambulance is dispatched to a predetermined location in order to stand-by for further call reassignment.
Code 9	**"Maintenance"** – a call where the vehicle is out of service for maintenance.

Completion of an ACR is not required for standby and maintenance calls.

Return Priority Code – Patient Transport
This is the code that is assigned to the call by the ambulance crew. It identifies the priority under which the patient is transported (e.g. a prompt return to a medical facility would be entered as a Code "3"). Return Priority Codes must not be confused with the Canadian Triage and Acuity Scale (CTAS) code. CTAS coding will be discussed later in this manual.

>
> **Code 1**   **"Deferrable"** - e.g. a non-scheduled transfer; a minor injury
>
> **Code 2**   **"Scheduled"** – e.g. inter-hospital transfers for MRI, a scheduled meet with an air ambulance, patient transferred for a scheduled appointment.
>
> **Code 3**   **"Prompt"** – transport without delay (serious injury or illness e.g. stable fracture).
>
> **Code 4**   **"Urgent"** – where the patients "life or limb" is at risk (e.g. Vital Signs Absent patient; unconscious head injury).
>
> **Code 6**   **"Transport of a Dead Patient"** – "obvious" or "pronounced"

Return priorities for "Code 2" dispatched calls are **not** always return Code "2". The return priority could be a Code "1, 2, 3, or 4" based on the urgency of the transport and if the return portion of the trip is for a scheduled appointment. For example, a crew sent to meet an aircraft at a designated time would be dispatched Code "2". If the patient was being transported to a facility for a scheduled appointment, the return priority would remain a Code "2". If however, the patient was experiencing crushing chest pain, the return priority would be Code "4". An emergency call where the return priority is not a 3 or 4 (ie minor injuries only) should never be coded as 2, unless of course the patient tells you that they have a 'scheduled' appointment.

Return Priority – No Patient Transported
If no patient is carried, one of the following return priority codes should be used:

> **71**   No patient found
> **72**   Patient Refused (ensure Refusal of Service form is completed)
> **73**   Patient Dead (either pronounced or obvious)
> **74**   Patient in Police custody
> **75**   Patient transported by other ambulance (provide vehicle # in remarks section)
> **76**   Cancelled before scene or patient contact

If your ambulance is on a return leg for Dispatch Code "8" or "9", use the following applicable Return Codes.

> **8**   Standby
> **9**   Out of Service/Administration

Enter the appropriate Priority Code that corresponds to the assigned return priority for the patient/call. In the event of multiple patient transport, enter the priority for each patient (see Patient Number and Sequence).

Patients

The EMA/Paramedic will indicate the total number of patients carried in the ambulance during a given call in this field. If no patients were transported, enter "0".

Seq (Sequence Number)

The Sequence Number indicates to which of the multiple patients the ACR information refers. For example, if two patients were transported using the same call number, one patient would be Seq "1" and the other patient would be Seq "2". If no patients were transported, enter "0".

A separate Return Priority Code must be indicated for each patient transported (e.g. Seq "1" Return "4" / Seq "2" Return "1").

Patients should be sequence numbered in the order of the severity of their condition, with the most serious patient documented as Sequence "1".

Special Codes

Enter any and all special codes that apply to the call. Up to six (6) special codes can be recorded in the designated space provided on the ACR. If more special codes apply, record these in the "Remarks" section. Special Codes are listed under the following subheadings: Delay/Canceled Codes, Crew Change, Relay Trips, Escorts on Board, Miscellaneous Special Codes, Special Equipment Used, and Patient Not Accessible by Road. Any special notations pertaining to the special codes documented should be recorded in the "Remarks" section of the ACR.

Warning System Used

This area documents the warning system(s) used during the call. Check the appropriate box for systems used while travelling to the scene and while travelling from the scene to a destination. If the public address system is used, enter code "53" in the "Special Code" section.

Pick Up Location or Sending Facility

Enter the location at which the patient is picked up. Include as much detail as possible (e.g. street/city/location description). If the pick-up location is a highway, give the Hwy. # and the number of kilometres to the nearest crossroad, intersection or prominent landmark. If the Pick-up Location is the same as the mailing address, check the box **"Same as above □"**.

If the patient is being picked up from the facility that you have already listed under pick up location, check the "Same as above" box. If the patient is not being picked up at the sending facility then the name of the sending facility should be recorded in this area of the form (e.g. hospital, clinic, etc.).

Pick Up Code

The Pick-up Code is a two (2) digit "alpha/numeric" code that identifies the location and indicates where the patient is picked up within or at the location. In the first space provided, enter the "alpha" code from the list of "SITE" codes that best describes the pick-up location. If none of the options describe the pick-up location, enter "Z"(other) and provide details regarding the location in the "Remarks" section. The "SITE" code refers to the physical nature of the pick-up location rather than how it relates to the patient. For example, a pick-up in a hotel is coded "G" regardless of whether the patient was an employee or a guest in the hotel. In some cases, more than one code could apply. In these cases, choose the more general description (e.g. a restaurant or store in a hotel would still be coded "G"[hotel]).

The second space provided in the Pick-up Location field is for the "numeric" LOCATION code. This code describes where the patient was picked up relative to ground level. When a patient is picked up on a floor greater than or equal to three (3) floors above or below ground level, the LOCATION is recorded as "3". When the pick up location is less than three (3) floors/levels above or below ground level, a "0" should be documented. For example, "G0" implies pick up on a floor of a hotel that is less than or equal to three (3) floors/levels above or below ground level. The numeric code selected reflects the actual location of the patient and not the size of the structure. A patient picked up on the second floor of a hotel would be coded "G0" even if the hotel was 20 stories high.

Sending Hospital
Enter the appropriate hospital code that corresponds to the hospital sending the patient.

Landing Site (air only)
Enter the appropriate landing site code that corresponds to the landing site of your aircraft.

Clinical Information

The Clinical Information area is intended to record the clinically significant information about the patient. Tick boxes and prompts are included in this section to assist crews in their documentation.

Chief Complaint
Enter a description of the nature of the call for both emergency and transfer calls **as determined by the crew on arrival at the scene.** Examples: "chest pain after snow shoveling" or "Being returned from a CT Scan."

"Transfer" or "MVA" on their own are not appropriate entries in the Chief Complaint area.

Primary Problem and Secondary Problem
Enter the code which best categorizes the primary and possibly secondary patient problem of the call.

The primary problem code should reflect in general terms, *the underlying problem or most probable cause* of the patient's presentation as found by the paramedic. Looking at the chronology of the call from the patient's perspective, and deciding what happened first can often identify this.

There are two spaces on the ACR to record secondary problems. Secondary problems documented should be specific to those problems that are pertinent to the patient's current presentation. Generally these should reflect treatable problems, caused by, or in conjunction with, the primary problem. For example, a patient having an anaphylactic reaction and is short of breath would be coded "83" (Anaphylaxis) as the Primary Problem and "21" (Respiratory Distress) as the Secondary Problem.

Refer to Appendix A of this manual, Standardized Code Selection for further details on Problem Code selection.

Time of Occurrence
Enter the approximate time at which the patient's signs and symptoms necessitated a call for ambulance assistance. (i.e. time of fall, time seizure started, time of on-set of shortness of breath, etc.). This information is usually obtained from the patient, bystander/family, first response unit or another ambulance crew if present.

Trauma Injury Site/Type
If the primary or secondary problem is a trauma, the Problem Code area and the Traumatic Injury Site/Type area must be completed. For example, a knife wound to the chest would be coded as follows: Primary Problem Code "25" (chest trauma), Trauma Injury Codes: Location "15" (chest), Type "37" (penetrating/perforation), and Mechanism "63" (stabbing). A maximum of three traumatic injuries can be recorded in this area.

Incident History

Enter information specifically related to the patient's current condition and the source of the information. Sources of information may include bystanders, relatives and the patient. This information will be subjective and will include symptoms being experienced by the patient as well as events leading up to the illness/injury. A description on how and where the patient is found by the crew should be documented in this area.

Example:

"Patient's spouse advised crew that the patient had been shoveling snow for about 45 minutes (since 17:00 hrs) prior to complaining of chest pain (at 17:45 hrs). Spouse immediately called for an ambulance. Patient states that chest pain radiates down left arm and rates the pain as a 6 out of 10. Patient found sitting on steps."

Refer to the BLS Standards Appendices 12, 21 and 22 for more information regarding documentation in the incident history section.

Relevant Past History

Check the appropriate box to indicate the category of past illness. One box should always be checked. These boxes provide for quick reference in the event that medical staff are scanning the ACR and will also serve to simplify data entry for research purposes.

Use the blank lines to enter past historical information that is relevant to the current condition together with the sources of the information. For example; "Patient's spouse advised crew that the patient has had triple cardiac by-pass three years ago. The most recent episode of chest pain was two weeks ago."

Medications

Check the appropriate box to indicate medications that the patient is currently taking (include dosage if available under the medication checked). The form of medication should also be documented, (i.e. spray, tablet, paste, etc.). If the patient is taking a medication not included in the tick box options, record the medication(s) in the blank lines below the tick boxes. If you are unable to determine if the patient is taking any medications check the "Not Determined" box on the right.

Allergies

Check the appropriate box to indicate the patient's known allergies. One box should always be checked If the patient has an allergy not included in the tick box options, check "other" and record the allergy in the blank lines below the tick boxes. If you are unable to determine whether or not the patient has any allergies, check the "Not Determined" box. If you confirm that the patient has no allergies, check the "NKA" box.

Treatment Prior to Arrival

Check the appropriate box to indicate who provided treatment to the patient prior to ambulance arrival. One box should always be checked. Use the blank lines to enter a description of the treatment provided to the patient prior to the arrival of the ambulance. Also record any response to the treatment and whether the patient was moved or repositioned (e.g. "Bystanders placed patient semi-prone and wrapped in blanket at scene").

Extended notes for any care rendered prior to the arrival of an ambulance should be carried over to the "Procedures" section of the form. To extend notes, ensure that the box "Further Clinical Information, see procedures" is checked. Treatment prior to arrival notes should be clearly identified as such in the "Procedures" section. Critical care inter-facility transfers may require extended notes. These notes can be documented in the "Procedures" section.

Cardiac Arrest Information

Arrest Witnessed By
Identifies whether or not the arrest was witnessed and by whom. Check the appropriate box. An arrest is considered witnessed when a patient is seen or heard to collapse. You may only select one box in this area.

CPR Started By
Identifies who initiated CPR on the scene. Check the appropriate box. If there was a valid DNR in effect for the patient but CPR was initiated, check the box that indicates who started CPR as well as the DNR box. Otherwise, only one check box should be checked. If no CPR was started, do not check any box in this section.

Duration of CPR Prior to arrival of transporting crew.
Enter the length of time from Call Received to the time of arrival of the transporting crew.

This box is to be completed only by the transporting crew.

Est. Time of Arrest.
If a bystander or crew is able to provide an estimated time of arrest, record it in this field.

Time to first shock delivered to patient by any provider.
Enter the length of time from Call Received to the time of the first shock by any provider.

Further references in completing the Clinical Information section can be found in the BLS Standards in General Standard of Care, Section 1 and Appendices 12, 21, 22, 23, and 24.

Physical Exam

Ghosted prompts, tick boxes and blank lines are provided to assist EMAs/paramedics to record both the physical examination that is performed on the patient and the resultant findings. Record both positive and pertinent negative findings. For example, "Patient complained of pain upon palpation of upper left leg" is a positive finding. "No wheezes heard on auscultation" in a patient who is short of breath and has a history of asthma is an example of a pertinent negative finding.

Age	Gender	Weight (kg)	C.T.A.S.	☐ 1 - Resus ☐ 2 - Emerg. ☐ 3 - Urgent ☐ 4 - Less Urg. ☐ 5 - Non-Urg.	Skin (Initial Assessment)

Skin (Initial Assessment)

Colour	Temp	Cond.
☐ Flush	☐ Hot	☐ Dry
☐ Normal	☐ Normal	☐ Normal
☐ Pale	☐ Cool	☐ Wet .
☐ Jaundiced		
☐ Cyanosed		

DECEASED   ☐ Pronounced Dead By BHP   ☐ Obviously Dead

General Appearance

Head/Neck   Trachea ☐ - Midline   Shifted ☐ - R ☐ - L   JVD ☐ - Elevated ☐ - Not Elevated

Chest   Air Entry: ☐ = Bilaterally   Decreased ☐ - R ☐ - L   Breath Sounds: ☐ - Clear ☐ - Wheezes ☐ - Crackles ☐ - Rub ☐ - Absent

Abdomen   ☐ - Soft ☐ - Rigid ☐ - Distended ☐ - Tender   ☐ - Mass ☐ - Pulsatile   ☐ - RU ☐ - LU ☐ - LL ☐ - RL ☐ - Center

Back/Pelvis ☐ - Unremarkable

Extremities ☐ - Unremarkable   Peripheral Edema ☐ - Absent ☐ - Present   Pedal Pulse ☐ - Absent ☐ - Present

☐ Further Physical Findings, see procedures

Age
Enter the patient's age in years unless the patient is two years of age or younger. If the patient is less than 2 years of age, enter the age in months with an "M" beside the numbers (e.g. 20M). If less than three months, enter the number of weeks (e.g. 11 weeks). If less than one month, enter the number of days (e.g. 24 days). If unable to determine the exact age, indicate that the age is being approximated.

Gender
Complete the box by indicating a "M" for male, and a "F" for female.

Weight (kg)
Enter the approximate patient's weight in kilograms. (2.2 lbs. = 1 kg.)

CTAS

It is important that the Canadian Triage and Acuity Scale (CTAS) score be carefully considered and recorded on the ACR. The CTAS is used to assign a level of acuity to a patient. Acuity refers to the gravity of the situation – the potential for death and/or irreversible illness. CTAS is a tool that more accurately defines the patient's need for care. The intent of using the CTAS acuity scale is to better communicate the severity of the patient's problem in a common language to both dispatch and the emergency department. Assignment of the CTAS level is to be based upon not only the presenting complaint identified on the initial assessment made by the paramedic, but also on their examination findings, and response to treatment.

The CTAS level applied at the time of departure from the scene is reported to the emergency department through CACC. The emergency department should be updated to any changes to the patient's acuity level while enroute.

The box you check should reflect the acuity of the patient's problem as determined by the crew at the time of their departure from the scene.

Level 1 - Resuscitation
Conditions that are threats to life or limb (or imminent risk of deterioration) requiring immediate aggressive interventions.

Level 2 - Emergent
Conditions that are a potential threat to life, limb or function, requiring rapid medical intervention or controlled acts.

Level 3 - Urgent
Conditions that could potentially progress to a more serious problem. May be associated with significant discomfort or affecting ability to function at work or activities of daily living.

Level 4 - Less Urgent
Conditions that relate to patient age, distress, or potential for deterioration or complications that would benefit from intervention or reassurance within 1-2 hours.

Level 5 - Non Urgent
Conditions that may be acute but non-urgent, as well as conditions which may be part of a chronic problem with or without evidence of deterioration

Note: A CTAS score is not expected if the patient is pronounced deceased by a Base Hospital Physician or if the patient is obviously dead.

For more detailed information on CTAS, refer to The Canadian Triage and Acuity Scale for Ontario Paramedics Training Program.(Emergency Health Services Branch – 2001)

Deceased
Check the appropriate box to indicate if a patient has been pronounced deceased by a base hospital physician or if the paramedic has determined the patient obviously dead at scene.

Pronounced Dead by BHP: Should be used for a patient pronounced dead by a base hospital physician. Can also be used for a patient pronounced dead by a duly licensed physician at the scene.

Obviously Dead: The patient is deemed to be "obviously dead" at the scene.

Refer to Basic Life Support Patient Care Standards Appendix #64: Policy 4.4 Transportation of Patients with Vital Signs Absent.

Skin (Initial Assessment)
Check the appropriate boxes to indicate skin colour, skin temperature and skin condition on initial assessment. For Temp and Cond., select only one box for each. More than one (1) box can be selected for "Colour".

For subsequent skin assessment, document in the Procedures Area recording time taken and using the Vital Signs Procedure Code of 010 with specific findings.

General Appearance
Provide a description of the patient to ensure that the reader has a picture in their mind of how the patient was found. Include where they were found (e.g. on the floor, in the car, etc.) level of consciousness, level of distress (mild, moderate, severe), and a general description of their condition as it relates to their mental status (e.g. patient confused or disoriented) or injuries.

Head/Neck

Trachea
Check the most appropriate box to indicate the location of the trachea. Use the blank lines to enter any further remarkable/pertinent negative findings on the head and neck.

JVD
Check the most appropriate box to indicate whether the patient's jugular veins are elevated or not elevated.

Chest

Air Entry:
Check the appropriate box to indicate normal or decreased air entry in the lungs. Use the blank lines to enter any further remarkable/pertinent negative findings regarding the patient's chest assessment and air entry.

Breath Sounds:
Check the appropriate box to indicate the quality of breath sounds. Use the blank lines to enter any further remarkable findings regarding the patient's breath sounds that are not covered by the tick boxes.

Abdomen
Check the appropriate box to indicate abdomen exam findings and section of abdomen that has abnormal characteristics. Use the blank lines to enter any further remarkable findings regarding the patient's abdomen.

Back/Pelvis
Record any positive or pertinent negative findings with regards to the back or pelvis (e.g. pain and/or crepitus noted on palpation of the pelvis).

Extremities
Check the appropriate box to indicate absent/present peripheral edema and peripheral pulses in the extremities. Use the blank lines to enter any other findings with regards to the patient's extremities.

If you require additional space to document physical exam, check the "Further details, see procedures" box and complete documentation in the "Procedures" section.

Further information for completing a physical exam can be found in the BLS Standards, General Standard of Care, Section 1 and in Appendices 33, 65, 66, 67, 72, and 73.

ACR - SECOND PAGE

Call Number if more than 1 page

The call number must be entered into this box if more that one form is used. If a second form is required to complete information that is documented on page 2 of the ACR, the first page need not be completed a second time. The "Call Number if more than 1 page" box eliminates the need to copy the demographic information a second time. Any number of supplemental pages can be completed on a call. Page numbers must be assigned. For example, if an additional second page is completed the first form would have recorded, page 1 of 2, and on the second you would enter page 2 of 2. The call number must be entered on all additional sheets.

Call Number if more than 1 page		Page of							Eye Opening	Coma Scale — Verbal Response	Motor Response
				1 2 3 4 5 6 7 8					4 Spontaneous 3 To Voice 2 To Pain 1 None	5 Oriented 4 Confused 3 Inappropriate words 2 Incomprehen. Sounds 1 None	6 Obeys Commands 5 Localize (pain) 4 Withdraw (pain) 3 Flexion (pain) 2 Extension (pain) 1 None

Time	Procedure Code	Route	Treatment/Procedure/Medication									Result													Crew Mbr. Initials	Crew Mbr. No.
			Pulse			Respirations			Blood Pressure							GCS			TOTAL GCS	Pupils						
			R	Rh	V	R	Rh	V	Systolic	Diastolic	Temp	ECG CODE	02 Sat	CO2	E	V	M		R +/−	L +/−					

CLINICAL TREATMENT / PROCEDURES & RESULTS

Clinical Treatment/Procedures & Results

All clinical treatments, procedures, treatments and results are to be recorded in this section of the Ambulance Call Report. All entries should be documented in chronological order. Document treatment/procedures/medications and results across the vertical ghost lines. When recording vital signs and coma scale findings, record the findings within the ghosted lines for ease of reading.

Time
Enter the time at which a medication is administered or a treatment or procedure is performed. Medication and procedures should be recorded in the chronological order performed. Times are mandatory. Enter the time in the 24 hour format. If the time is an estimate use "~" or "approx" as well as the time.

Procedure Codes
Enter the appropriate code for each medication or procedure. Codes are listed on the reverse side of the ACR. To assist in completing the ACR, procedure codes are subdivided into IV Procedures, Miscellaneous Procedures/Therapy, Routes of Administration, Procedures/Therapy, Airway/Breathing procedures and Medications.

Refer to Appendix A of this manual, Standardized Code Selection for further clarification on the documentation of codes.

Route
Whenever a medication is given, the route of administration must be recorded and the appropriate "Routes of Administration" code assigned.

Treatment/Procedure/Medication
Enter a written description of the treatment/procedure/medication.

Vital Signs
Vital signs are recorded in the Treatment/Procedure/Medication/Results section. In the left-hand column, enter the time at which the vital signs were measured. Enter the vital sign code in the procedure code column. Ghosted lines are used to separate vital signs entries. The vital signs section is intended to record information regarding the patient's pulse, respiration, blood pressure, temperature, ECG, O_2 saturation, Endtidal CO_2, Glasgow Coma Scale, and pupils. As a minimum, all patients must have an entry made regarding their pulse, respiration, skin and blood pressure. Other areas are to be completed if appropriate and available. A minimum of two (2) sets of vital signs should be taken for every pre-hospital patient.

If the minimum vital sign assessments are not taken, document the reasons in the "Remarks" section of the ACR. Approximations of vital signs are acceptable if documented as such.

Pulse: Enter a numeric value whenever possible, otherwise enter an indication about the rate (e.g. slow, normal, rapid). Enter pulse rhythm (e.g. regular or irregular) and the pulse volume (weak, strong, full or bounding).

Respiration: Enter a numeric value whenever possible. Enter the respiratory rhythm (e.g. "R" [regular] or "I" [irregular] or "A" [agonal]) and volume (e.g. "F" [full], "S "[shallow] or "D" [deep]).

Blood Pressure: Enter the patient's auscultated blood pressure. If the measurement is taken by palpation indicate the diastolic as a "P". If time or the situation dictates that the BP could only be estimated by pulse location, document it as such by placing a ">" in front of the systolic pressure. For example, if the patient has a radial pulse, document the blood pressure as ">90".

Temp: Enter the patient's temperature in °C when appropriate and available.

ECG Code: Enter the patient's ECG rhythm code and as space permits write out the ECG interpretation.

O$_2$ Sat: Enter the patient's O$_2$ saturation where applicable and available.

CO$_2$:   Enter the patient's Endtidal CO$_2$ reading as appropriate and if available.

GCS: The Glasgow Coma Scale provides a standardized method of recording the patient's level of awareness. Three indicators are assessed: eye opening; verbal response; motor response.

Enter the number that corresponds to the patient's response for each indicator. The numeric value that matches response is listed at the top of page 2 of the ACR. Enter the total number value for the three indicators in the column marked "Total GCS".

If an indicator cannot be assessed, (e.g. eyes bandaged; patient intubated) enter "N/A". Enter reason for not assessing the indicator in the "Remarks" section of the ACR.

Result
Enter a description of the result of the medication or procedure (e.g. "patient reported less pain"). If no result is evident, enter "no change". Results are written across ghosted lines.

Crew Member Initials
Each crew member must initial any treatments/procedures considered a controlled medical act that they provide to the patient. If a procedure is performed by a person outside of the immediate crew (e.g. physician or registered nurse), that person should initial the procedure and sign the ACR in the appropriate area ("Crew Member 3 or 4"). If that person is unwilling to sign the call report and appropriately initial the ALS procedures, the crew will mark an "X" in the initials box and record the name of the person who performed the procedure in the next line of the procedures section.

Crew Member Number
Enter the number of the crew member administering a medication or performing a procedure (both BLS and ALS). "Crew Member 1" is the attendant and "Crew Member 2" is the driver. "Crew Member 3 or 4" is any other paramedic, EMA, paramedic student, RN, RT, physician etc.

For any Controlled Act performed, only one EMA/paramedic, the one who performed the actual controlled act, should be recorded as the crew member performing that procedure.

Fluid Balance
An accurate measuring and recording of fluid intake and output can be a valuable aid in detecting imbalances and in determining the amount needed for fluid replacement when a fluid volume deficit is found. Fluid measurement should take place prior to transport and enroute.

Fluid - Intake

> **Fluid:** Record, by name, all fluids the patient has received by means of IV, interosseous infusion, nasogastric tube or by mouth (e.g. name of crystalloid or colloid infusion, water, juice, and/or formulas). Record all fluids as appropriate.

> **Pre Trans:** Record the volume of each of the fluids that the patient has received within the 24 hours prior to the call (inter-facility transport) or volumes of fluid administered by the crew at the scene (eg 500 NS bolus).

> **Enroute:** Record the volume(s) of fluid administered to the patient during transport.

> **Total:** Total the fluid volume(s) for each of the fluids the patient received. E.g. Pre Trans + Enroute = Total Per Fluid.

> **Total Fluid Intake:** Below the columns "Pre-Trans", "Enroute", and "Total" add the fluid volume for each column.

Fluid – Output

    Pre Trans: Record the fluid output of the patient in the 24 hours prior to the call (inter-facility transport).

    Enroute: Record the fluid output of the patient during transport.

    Total: Record the total fluid output of the patient
    (Pre-Trans + Enroute = Total Output).

    Fluid Balance: The difference between Fluid Intake and Fluid Output is recorded.

General Administration

Remarks/Orders
Enter any significant information about the call that has not already been recorded in another area of the ACR (e.g. clinically significant information, name of physician at scene). If given direct orders by a Base Hospital Physician, the orders should be recorded section.

Patient Outcome in Emergency
Check the appropriate box that indicates the disposition of the patient once in the emergency department. **This area will only be completed if the crew is present when the decision is made.**

Pronounced: Check this box if you are aware that the patient is pronounced dead in the emergency department.

Tertiary Trans: Check this box if you or another crew must transport the patient to a tertiary center after your arrival at the emergency department.

Discharged: Check this box if you are aware that the patient is discharged from the emergency department.

Admitted: Check this box if you are aware that the patient is admitted to hospital from the emergency department.

Final Primary Problem
This area is intended to record the final assessment of the patient's condition at the point of turning care of the patient over to the hospital or other personnel. Enter the corresponding problem code for the Final Primary Problem. The final problem code should be the condition that, in the opinion of the paramedic, is the priority at the time transfer of care occurs. The Final Primary Problem may or may not be the same as the Primary Problem (e.g. Primary Problem is VSA, Final Primary Problem may be Post Arrest if you have defibrillated the patient back to a profusing rhythm).

Problem Code
Enter the corresponding problem code for the Final Primary Problem. See description above.

Final Status
Enter the final patient status code in this area. The final patient status code represents the patient's status at the destination when compared with first contact by the ambulance crew. The final patient status should be determined both by objective (e.g. "vital signs") and subjective (e.g. "patient says they feel better") criteria.

Base Hospital No.
Enter the base hospital number the crew is affiliated within this area (Master Numbering System hospital number).

Base Hospital
Enter the name of the base hospital that the crew is affiliated with.

Base Hospital Physician Name (if patch)
Enter the name of the base hospital physician, if contact was made. This field is completed even if no orders are given by the base hospital physician.

Hospital No.
Enter the hospital number for the receiving facility in this area if appropriate.

Receiving Facility/Destination
Enter the name of the facility that received the patient from the crew.

Receiving Facility Signature
Have an appropriate staff member, from the receiving facility, sign the ACR to acknowledge transfer of patient care.

Crew Member 1 (Attendant) No.
Enter the attendant's assigned EHS Emergency Medical Attendant/Paramedic identification number.

Crew Member 1 Name
Enter the attendant's name. At a minimum the name must include the first initial and full last name.

Signature No. 1
The attendant enters his/her signature in this area.

Crew Member 2 (Driver) No.
Enter the driver's assigned EHS Emergency Medical Attendant/Paramedic identification number.

Crew Member 2 Name
Enter the driver's name. At a minimum the name must include the first initial and full last name.

Signature No. 2
The driver enters his/her signature in this area.

Crew Member 3 (Other) No.
Enter the third crew member's assigned EHS Emergency Medical Attendant/Paramedic identification number if applicable.

Crew Member 3 Name
Enter the third crew member's name.

Signature No. 3
The third crew member enters his/her signature in this area.

Crew Member 4 (Other) No.
Enter the fourth crew member's assigned EHS Emergency Medical Attendant/Paramedic
identification number if applicable.

Signature No. 4
The fourth crew member enters his/her signature in this area.

Third and fourth Crew Member boxes can be used to document the following:

- **Assisting EMA/Paramedic**
- **Student/Preceptor**
- **Field Evaluator**
- **Physician/RN/RT**

- **Firefighter**
- **Police Officer**
- **Family Member**

Altitude (Air Only)
Enter the cruising cabin altitude from the altimeter or request the cruising altitude from the pilots
(e.g. "1400 ft.").

Landing Site - (D)   (Air Only)
Enter the appropriate landing site code from the Canadian Flight Supplement and/or user manual.

Travel Conditions
Enter the appropriate travel condition code.

Call Events (Times)
Time of call events should be completed on all calls.

Call Received
The time dispatch received the request of service.

Crew Notified
The time the crew was notified of the call by dispatch.

Crew Mobile
The time the crew became mobile to the call scene.

Arrived Scene
The time the crew arrived at the call scene.

Arrived Patient
The time the crew came into contact with the patient.

Depart Scene
The time the crew departed the scene.

If there is a large discrepancy in time between departing the location where the patient was found to when the crew departs scene in the ambulance, make record of this in the remarks section with a time if appropriate. Enter the time the crew departs the scene in the ambulance.

Arrive Destination
The time the crew arrived at the transport destination (e.g. hospital).

Depart Destination
The time the crew departed the transport destination.

Arrive Base
The time that the crew arrives back at their assigned base.

Aid to Capacity Assessment (Back of ACR)

A patient is presumed to be capable unless a crew has reasonable grounds to believe the patient is incapable to consent to the specific treatment proposed, on the basis of:
- Confused or delusional thinking
- Unable to make a settled choice
- Severe pain, acute fear/anxiety
- Judgement impaired by drugs or alcohol
- Other observations causing concern

The patient should be able to demonstrate this understanding and acknowledge the consequences of the decision, and this decision should not be based on delusional belief.

Indicate to whom this assessment refers if not the patient (e.g.: parent, or substitute decision-maker).

Enter the name of the substitute decision-maker on the line provided (the remainder of this capacity evaluation will then pertain to this substitute decision-maker).
If a substitute decision maker (e.g. authorized guardian, attorney for personal care, spouse or partner, child or parent, sibling, other relative) is present, he/she has the same authority as the incapable patient would have, if capable.

Patient verbalizes/communicates understanding of clinical situation.
Does the patient understand the condition he/she has that requires treatment?

Patient verbalizes/communicates appreciation of applicable risks.
Does the patient understand the nature and the risks of their condition and the risks/benefits of the proposed treatment?

Patient verbalizes/communicates ability to make alternative plan for care.
Does the patient have a plan for self care after your departure?

Responsible adult on scene.
If the patient continues to refuse treatment you may release the patient into the care of an apparently responsible adult. For the individual assuming responsibility for the patient, provide instructions regarding observation and patient management, physician follow-up, possible complications and other information as deemed appropriate.

Responses in shaded areas require consideration of incapacity.

If you have checked "No" to any of the questions indicated in the "Aid to Capacity Evaluation" then you must consider whether this patient is capable of being left at the scene and not transported.

A person of any age may be capable to consent to some things and incapable of consent with respect to others, depending on the complexity of the treatment (i.e. they may understand what you tell them about oxygen but not about a higher level medication).

Document all findings related to the assessment and the proposed treatment and all findings with respect to the patient's capacity.

Refusal of Service (Back of ACR)

This area is located on the reverse side of the ACR form. In the event that a patient refuses care and/or transport, the crew is to request the patient or the patient's substitute decision-maker complete and sign the appropriate areas of the top part of the form. If witnesses are available, the crew is to request the witnesses to complete the appropriate area of the top part of form.

If the patient, the patient's substitute decision-maker and/or witnesses refuse to sign the form, the crew should document this occurrence in the "Remarks" section of the ACR.

The crew always completes the bottom portion of the "Refusal of Service" section.

Hospital Administration (Blue - Billing Office Copy)

The hospital administration section of the ACR is normally completed by hospital staff.

If notations are to be made directly on the Billing Office Copy (e.g. physician signature for a non-essential call), the Billing Office Copy should either be removed first or the yellow and pink copies should be moved from beneath the billing copy. If this is not done, any notations made on the billing copy will be visible on the other copies of the ACR.

Appendix A
ACR Completion Manual

Standardized Code Selection

Appendix A

Standardized Code Selection

Selection of proper codes while completing the ACR is of primary importance in the data extraction process. Accurate data will reflect both on ambulance system's demographics and an individual paramedic's practice. Both are key in the planning process for resource allocation, program expansion, quality assurance and educational requirements. It is important that this process is standardized throughout the province to ensure that provincial data is accurate. The following information is intended to assist EMAs and Paramedics in using a standardized approach to selecting the most appropriate codes when completing an ACR.

Not all fields requiring codes are included in this appendix. Many of the fields are self-explanatory and are adequately covered in the Ambulance Call Report Completion Manual. Expanded explanations and examples are provided for those areas of the ACR that are more open to interpretation. For ease of reference, this appendix has been organized such that codes are discussed in the order that they are found on the ACR.

Pick-up Location Codes

Two (2) codes are documented for the pick-up location on each call, the "SITE" as well as the "LOCATION" of the patient within the site.

"SITE" refers to the physical properties or function of the pick-up site (i.e. apartment building, hotel, shopping mall, highway). When choosing a "SITE" code, chose the code that relates to the physical nature of the pick up site, *not* as it relates to the patient.

"LOCATION" refers to where the pick-up point of the patient is in relation to ground level. Patients picked up at a location between less than three (3) stories below ground level and less than three (3) stories above ground level are coded "0". Patients picked up three (3) or more stories above or below ground level are coded "3".

<u>**Example**</u>**:**
The "SITE" code for a hotel is "G" (HOTEL) regardless of whether the patient is a guest or an employee of the hotel. If the patient is picked up on the second floor of the hotel, the "LOCATION" would be coded as "0", even if the building itself was six stories high. The "SITE" is coded in the first space provided in the Pick-up Code area of the ACR and the "LOCATION" in the second space. The proper coding for the example would then be "G0".

If there are two codes that can apply to the pick-up site, such as a restaurant or store within an airport, choose the more general description, in this case, "A" (AIRPORT/HELIPORT).

Problem Codes

The following rules are provided to assist EMAs and Paramedics in determining the most appropriate codes when documenting Problem Codes on the ACR.

Rule 1: Initial <u>Primary Problem</u> code should reflect the working assessment/underlying problem.

Rule 2: <u>Secondary Problem</u> codes should reflect treatable problems resulting from the underlying Primary Problem.

Rule 3: <u>Final Primary Problem</u> code should reflect the problem that, in the opinion of the EMA/paramedic, is the priority as the ambulance arrives at the hospital.

Rule 4: If at <u>any</u> time, from the time the call was received at dispatch, the patient was in cardiac arrest, the <u>Primary Problem</u> must be recorded as "01" (VSA – cardiac /medical) or "02" (VSA - traumatic).

Rule 5: If at any time the patient was in cardiac arrest and regained a palpable pulse (return of spontaneous circulation), "55" (Post Arrest) must be recorded as one of the <u>Secondary Problem</u> codes.

Primary Problem Codes

The selection of the primary problem code should reflect in general terms, ***the underlying problem or most probable cause*** of the patient's presentation as found by the ambulance crew. Looking at the chronology of the call from the patient's perspective and deciding what happened first can often identify this.

Consider the following scenario:

An ambulance crew attends to a patient with a history of diabetes who is experiencing a seizure. Further assessment reveals that the patient is hypoglycemic. The crew feels strongly that the seizure may be a result of the hypoglycemia.

The primary problem best describing the patient's condition is "83" (Diabetic Emergency), since it is the hypoglycemia that is the likely underlying problem. In this case "46" (Seizure/Post Ictal), which is the treatable problem resulting from the diabetes, is recorded as a secondary problem.

If there are two problem codes that can be considered underlying problems, the EMA/paramedic can also select the most immediate condition requiring the most immediate treatment, to help make a choice for the primary problem code.

If there is no appropriate code in the problem code list, the EMA/Paramedic should then select the code for the condition requiring the most immediate treatment (i.e. the "ABC's"), even if the crew cannot treat the problem themselves. For example, a crew may select "hypotension" as a problem even though they themselves cannot start an IV.

Consider a patient with multiple system trauma such as a pedestrian who has been struck by an automobile. The patient presents as unconscious with an obvious closed head injury, a fractured pelvis and profound hypotension. There is no code for multiple system trauma and in this case, the EMA/Paramedic must decide whether the head injury or the fractured pelvis with the likely resultant hypotension is more critical and therefore the Primary Problem.

If the hypotension requires aggressive treatment, then selecting the codes as follows is reasonable.

Primary Problem Code: "66" (Musk/Skel)

Secondary Problem Codes: "42" (Head/Brain Trauma)
                                        "32" (Hemorrhage)

If the hypotension were only mild and the closed Head Injury was the most critical in the crew's opinion, then selecting the codes as follows is reasonable.

Primary Problem Code: "42" (Head/Brain Trauma)

Secondary Problem Codes: "66" (Musk/Skel)
                                        "32" (Hemorrhage)

Secondary Problem Code

There are two spaces on the ACR to record secondary problems. These should only be recorded when necessary and be specific to those problems that are pertinent to the patient's presentation. Generally these should reflect treatable problems, caused by, or in conjunction with, the primary problem.

If more than one Secondary Problem Code is recorded, enter the codes in order of treatment priority (Airway, Breathing and Circulation).

The following examples help illustrate appropriate coding of Secondary Problems.

Example #1   A patient suffered a stroke during a meal and the airway required management because food was obstructing the airway.

Primary Problem Code: "41" (Stroke/TIA)

Secondary Problem Code: "11" (Airway Obstruction)

Example #2 A patient has a significant rectal bleed. The patient is hypotensive however, is fully alert and oriented.

Primary Problem Code: "63" (GI Problems)

Secondary Problem Code: "32" (Hemorrhage/Hypovolemia Major)

Example #3 A patient has been stung by a bee. His face is edematous and he is markedly short of breath.

Primary Problem Code: "85" (Anaphylaxis)

Secondary Problem Code: "21" (Respiratory Distress)

Example #4 A patient calls complaining of chest pain. The cardiac monitor reveals ventricular tachycardia. The patient is hypotensive and dizzy. Further questioning indicates that the patient initially suffered dizziness and palpitations. The chest pain began after about 15 minutes of palpitations.

Primary Problem Code: "53" (Arrythmias/Palpitations)

Secondary Problem Codes: "51" (Ischemic Chest Pain)
                                  "33" (Hypotension)

Example #5 You and your partner attend at a motor vehicle collision. The driver presents with shortness of breath and a flail chest.

Primary Problem Code: "25" (Chest Trauma)

Secondary Problem Code: "21" (Respiratory Distress)

Final Primary Problem

The final problem code should indicate the condition that, in the opinion of the EMA/Paramedic, is the priority on arrival at the hospital. This may or may not be the same as the initial primary problem code. If this is difficult to determine, or there is no obvious problem that requires immediate management, the EMA/paramedic should refer to the general rules for selection of a primary problem code.

Example:

Your patient, who you determined to be hypoglycemic, fell and fractured their wrist. You successfully treat the low blood sugar. The patient is now awake and fully alert. Here, the hospital is likely to manage the patient's fractured wrist first, therefore the Final Problem Code should be "66" (Musk/Skel Trauma).

If however, this patient developed chest pain prior to arrival at the hospital, the Final Problem Code documented should be "51" (Ischemic Chest Pain).

If there was nothing that required immediate attention, (no fracture, no chest pain), you would code the Final Primary Problem as "83" (Diabetic Emergency).

Unique Problem Code Situations

Combination Medical/Trauma Call Coding

If a patient has a combination of both medical and trauma conditions, the selection of the primary problem becomes a subjective decision made by the EMA/Paramedic. It must be decided which problem is the most critical to the patient.

Example:

A diabetic patient sustains a fall during a seizure. The patient's blood sugar is determined to be 1.3 mmol/L.

If the patient falls from a chair and sustains a fracture of their wrist during the fall, but is still hypoglycemic, the Primary Problem would be "83" (Diabetic Emergency) and the Secondary Problems would be "46" (Seizure) and "66" (Musk/Skel).

Consider the same patient falling off a roof and fracturing their pelvis. As a result, the patient was found to be hypotensive. The EMA/paramedic treating this patient should consider the trauma and resulting hypovolemia as more critical then the diabetes. Therefore, the appropriate coding would be "66" (Musk/Skel (66)" as the Primary Problem and the Secondary Problem codes would be "Hemorrhage/Hypovolemia (32) and "Diabetic Emergency (83)"

Cardiac Arrest Coding

All patients who suffer a cardiac arrest are to be coded either "01" (VSA: CARDIAC/MEDICAL) or "02" (VSA: TRAUMATIC) as the Primary Problem. These codes are utilized if the patient was in cardiac arrest at *any* time. This includes the time period prior to the arrival of the ambulance crew, regardless if the patient is VSA or not when they arrive. A good example would be where a first responder defibrillates a patient and the patient regains a palpable pulse before the ambulance crew arrives.

One of the two (2) VSA codes is also to be documented as the Primary Problem if the patient suffers a cardiac arrest after the crew has arrived, regardless of the chief complaint on arrival of the ambulance crew at scene.

In the case of a cardiac arrest due to drowning, "02" (VSA: TRAUMATIC) is coded as the Primary Problem. "13" (Drowning) is coded as a Secondary Problem.

Return of spontaneous circulation, for the purposes of using the "55" (post arrest) code, is defined as the return of a palpable pulse at any time during the call and for any length of time. This code can only be used as a Dispatch Problem Code (Dsp. Prb. Cde.), Secondary Problem Code or Final Primary Problem Code. It is never be used as a Primary Problem. If a cardiac arrest patient arrives at the hospital with a palpable pulse, the Final Problem Code is recorded as "55" (Post Arrest).

Other Problem Code Clarifications

"12" (AIRWAY OBSTRUCTION /ANATOMICAL-MEDICAL AND OTHER)

This code is used to indicate an *actual obstruction* (either partial or complete) to the airway from an anatomical or medical perspective (e.g. edema/epiglotitis). It is not intended to indicate situations where simple airway maintenance can be achieved by positioning or use of an airway device.

"13" (DROWNING)

This code is used if a patient is removed from the water and is VSA. Since a cardiac arrest is coded as the primary problem, "13" (DROWNING) will be coded in the Secondary Problem boxes.

"14" (NEAR DROWNING)

This code is used if a patient is removed from the water yet has vital signs on assessment. In most instances, "14" (Near Drowning) is coded as the Primary Problem (i.e. the working assessment/underlying problem) and any problems resulting from the drowning will be coded as secondary problems.

Procedure Codes

Procedure codes are for the most part self-explanatory with the following exceptions.

<u>"181" (CHEMICAL RESTRAINT)</u>

The code for chemical restraint is to be used in conjunction with any drug that is used as a chemical restraint.

<u>Example</u>: If a patient was given the drug Midazolam as a sedative prior to cardioversion, the procedure code would be "603" (Midazolam). If however, a patient is given Midazolam for the purposes of restraining the patient, then the procedures coded would be "181" (Restrain Patient – Chemical) *and* "603" (Midazolam).

<u>"306" (DEFIBRILLATION-MANUAL), "307" (DEFIBRILLATION-SEMI AUTOMATIC) &</u>
<u>"308" (ANALYZE – AUTOMATED DEVICE (analyze, no shock delivered)).</u>

Code "308" (ANALYSE – AUTOMATED DEVICE (analyze, no shock delivered)) is only intended for use when the result of the analysis is No Shock Indicated. If codes "306" or "307" are used, it is ***not*** necessary to precede this code with the analyze code (as was past practice).

<u>"352" (BLOOD SAMPLING – GLUCOSE DETERMINATION)/"353" (BLOOD SAMPLING -</u>
<u>VENOUS) & "354" (BLOOD SAMPLING – ARTERIAL)</u>

"352" (GLUCOSE DETERMINATION) is used when a small blood sample is obtained to determine blood sugar (e.g. for use with a glucometer). This sample can be from a finger stick' or from the hub of the IV catheter.

"353" (BLOOD SAMPLING - VENOUS) is used when blood is drawn from a vein into a collection container (e.g. vacutainer).

"354" (BLOOD SAMPLING - ARTERIAL) is used when an arterial blood sample is drawn either from an existing arterial line or as an arterial blood gas sample.

<u>"380" (ALTERNATIVE AIRWAY)/"381" (UNSUCCESSFUL ALT. AIRWAY)</u>

These codes are used for any type of alternative airway, other than an endotracheal tube (ETT), that either go past, or, have the potential to go past the vocal cords. These types of airways are controlled medical acts. Current examples include, but are not limited to, the Combitube® or PTL airways.

Insertion of the Laryngeal Mask Airway (LMA) has it's own code, "171", since it is not a controlled medical act.