First Aid Response

Information Management

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Module 9

Learning Outcomes

Knowledge Objectives (by the end of this Unit, you will be able to…)

1. Explain the rationale for recording patient health information
2. Outline what information is required on the Ambulatory Care Report (ACR) (or other patient care record) and how it should be entered
3. Explain the essential elements of a verbal handover report to other pre-hospital First Aid Response teams
4. Explain the management and storage for ACRs or other patient care/accident/incident record in line with relevant legislation

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Learning Outcomes

Attitudinal Objectives (by the end of this Unit, you will be able to…)

1. Understand how recording data contributes to a high standard of patient care
2. Explain why documentation should be completed in a timely manner but should not distract from care and communication with the patient

Skills Objectives (by the end of this Unit, you will be able to…)

1. Complete an ACR (or other patient care record) for a given patient scenario
2. Demonstrate a “hand over” report to other member of the EMS

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Why record information

- For what reasons do we record patient & incident information?

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Why record information

- Clinical
  - Clinical responsibility
  - In cases of life-threatening conditions patient care will take precedence
  - Patients record: documentation of out-of-hospital events
  - Time of occurrence of critical events (accurate assessment of condition)

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Why record information…

- Records
  - Recording interventions and medications administered to patients pre-hospital is an essential clinical responsibility of all pre-hospital emergency care practitioners
- Legal Protection
  - Legal document
  - Identifies the care that has been given
  - A properly completed ACR will provide protection and will be essential if called as a witness to court

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Remember.....

Important!

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

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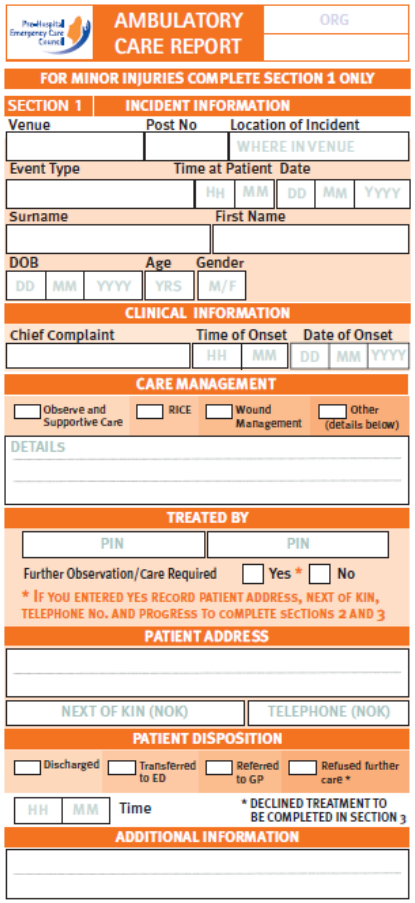
ACR



AMBULATORY CARE REPORT

ORG

FOR MINOR INJURIES COMPLETE SECTION 1 ONLY

SECTION 1 INCIDENT INFORMATION

Venue | Post No | Location of Incident (WHERE IN VENUE)

Event Type | Time at Patient | Date (HH MM DD MM YYYY)

Surname | First Name

DOB (DD MM YYYY) | Age (YRS) | Gender (M/F)

CLINICAL INFORMATION

Chief Complaint | Time of Onset (HH MM) | Date of Onset (DD MM YYYY)

CARE MANAGEMENT

☐ Observe and Supportive Care ☐ RICE ☐ Wound Management ☐ Other (details below)

DETAILS

TREATED BY

PIN | PIN

Further Observation/Care Required ☐ Yes * ☐ No

* If you entered YES record patient address, next of kin, telephone no. and progress to complete sections 2 and 3

PATIENT ADDRESS

NEXT OF KIN (NOK) | TELEPHONE (NOK)

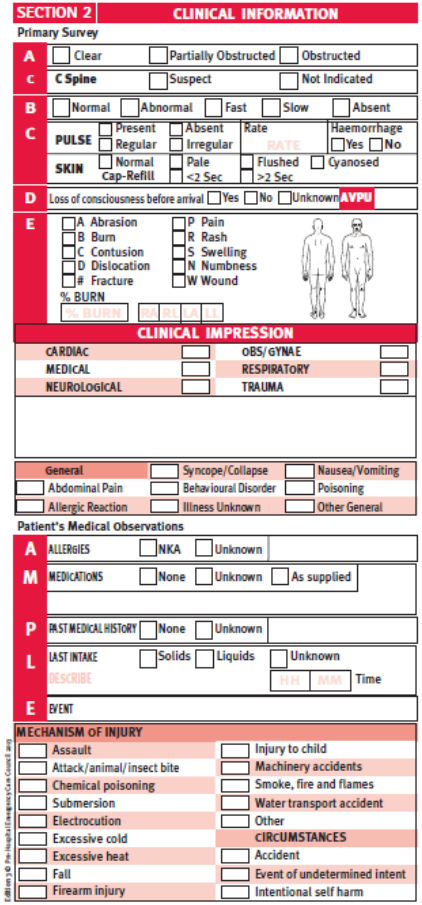
PATIENT DISPOSITION

☐ Discharged ☐ Transferred to ED ☐ Referred to GP ☐ Refused further care *

HH MM Time

* DECLINED TREATMENT TO BE COMPLETED IN SECTION 3

ADDITIONAL INFORMATION



SECTION 2 CLINICAL INFORMATION

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)

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

Patient's Medical Observations

A ALLERGIES ☐ NKA ☐ Unknown

M MEDICATIONS ☐ None ☐ Unknown ☐ As supplied

P PAST MEDICAL HISTORY ☐ None ☐ Unknown

L LAST INTAKE ☐ Solids ☐ Liquids ☐ Unknown DESCRIBE HH MM Time

E EVENT

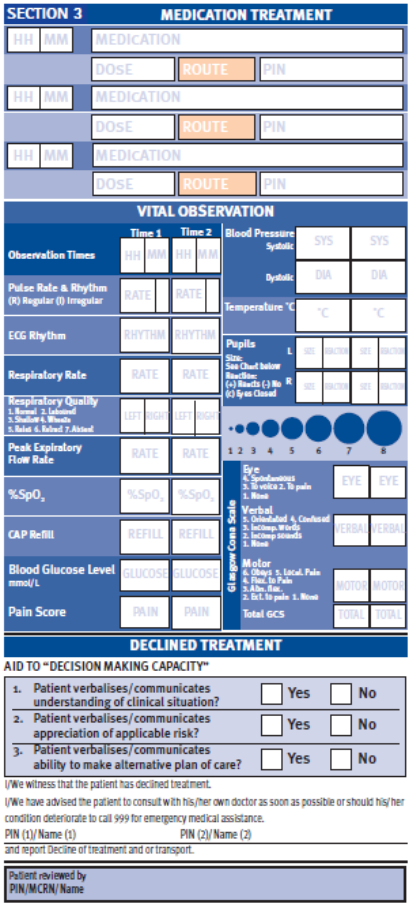
MECHANISM OF INJURY

☐ Assault ☐ Attack/animal/insect bite ☐ Chemical poisoning ☐ Submersion ☐ Electrocution ☐ Excessive cold ☐ Excessive heat ☐ Fall ☐ Firearm injury

☐ Injury to child ☐ Machinery accidents ☐ Smoke, fire and flames ☐ Water transport accident ☐ Other

CIRCUMSTANCES

☐ Accident ☐ Event of undetermined intent ☐ Intentional self harm



SECTION 3 MEDICATION TREATMENT

HH MM MEDICATION

DOSE | ROUTE | PIN

HH MM MEDICATION

DOSE | ROUTE | PIN

HH MM MEDICATION

DOSE | ROUTE | PIN

VITAL OBSERVATION

	Time 1	Time 2
Observation Times	HH MM	HH MM
Pulse Rate & Rhythm (R) Regular (I) Irregular	RATE	RATE
ECG Rhythm	RHYTHM	RHYTHM
Respiratory Rate	RATE	RATE
Respiratory Quality 1. Normal 2. Laboured 3. Shallow 4. Wheeze 5. Rales 6. Rehtd 7. Absent	LEFT RIGHT	LEFT RIGHT
Peak Expiratory Flow Rate	RATE	RATE
%SpO2	%SpO2	%SpO2
CAP Refill	REFILL	REFILL
Blood Glucose Level mmol/L	GLUCOSE	GLUCOSE
Pain Score	PAIN	PAIN

Blood Pressure Systolic SYS SYS; Diastolic DIA DIA

Temperature °C °C °C

Pupils L SIZE REACTION SIZE REACTION; Size: See Chart below; Reaction: (+) Reacts (-) No (0) Eyes Closed R SIZE REACTION SIZE REACTION

1 2 3 4 5 6 7 8

Glasgow Coma Scale: Eye 4. Spontaneous 3. To voice 2. To pain 1. None EYE EYE; Verbal 5. Oriented 4. Confused 3. Inc/comp. words 2. Inc/comp sounds 1. None VERBAL VERBAL; Motor 6. Obeys 5. Local. Pain 4. Flex. to Pain 3. Abn. flex. 2. Ext. to pain 1. None MOTOR MOTOR; Total GCS TOTAL TOTAL

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.

Patient reviewed by PIN/MCRN/Name

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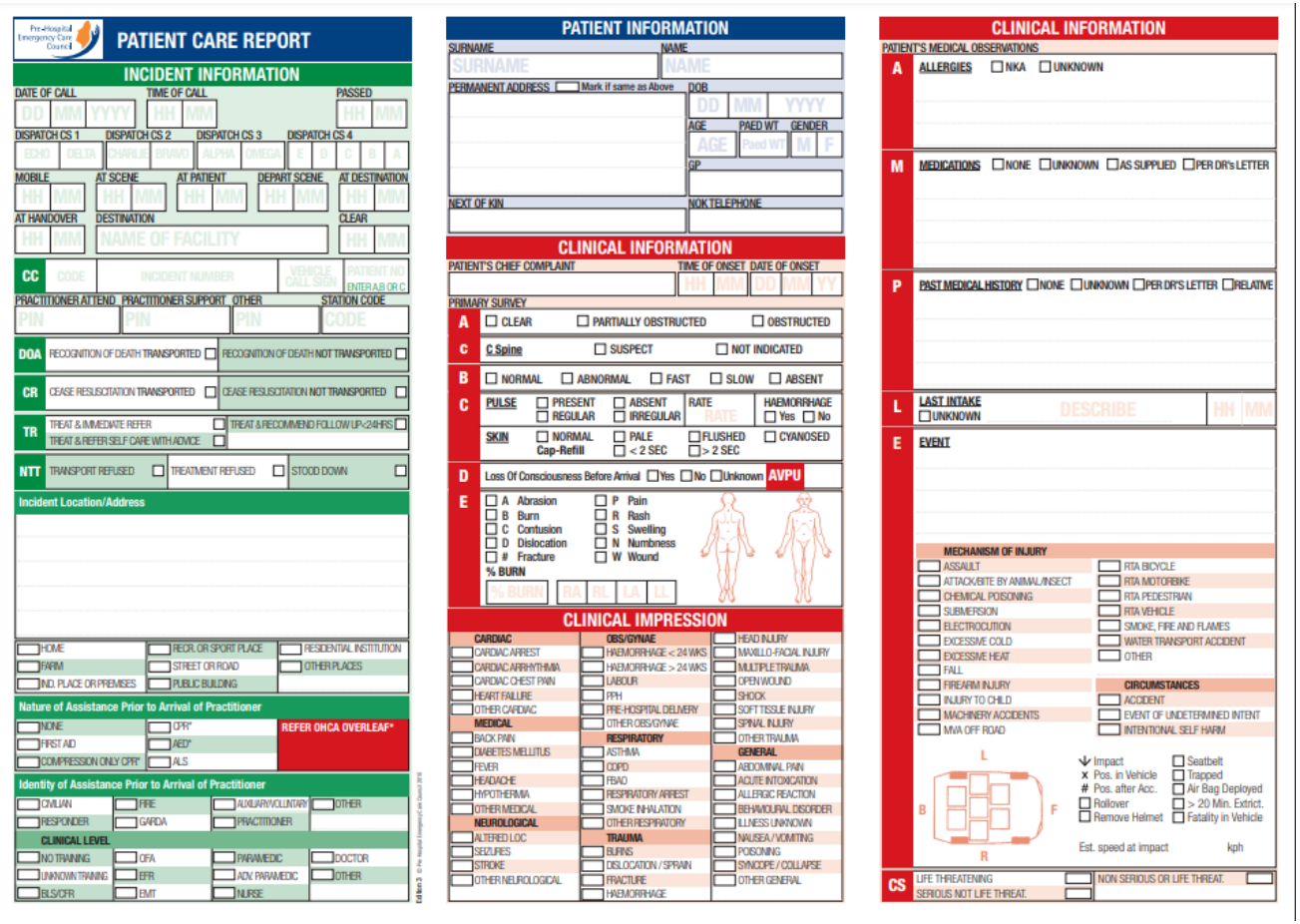
PCR



PATIENT CARE REPORT

INCIDENT INFORMATION

DATE OF CALL | TIME OF CALL | PASSED

DISPATCH CS 1 | DISPATCH CS 2 | DISPATCH CS 3 | DISPATCH CS 4

MOBILE | AT SCENE | AT PATIENT | DEPART SCENE | AT DESTINATION

AT HANDOVER | DESTINATION | CLEAR

CC | CODE | INCIDENT NUMBER | VEHICLE CALL SIGN | PATIENT NO. ENTER A,B OR C

PRACTITIONER ATTEND | PRACTITIONER SUPPORT | OTHER | STATION CODE

DOA | RECOGNITION OF DEATH TRANSPORTED | RECOGNITION OF DEATH NOT TRANSPORTED

CR | CEASE RESUSCITATION TRANSPORTED | CEASE RESUSCITATION NOT TRANSPORTED

TR | TREAT & IMMEDIATE REFER | TREAT & RECOMMEND FOLLOW UP <24HRS | TREAT & REFER SELF CARE WITH ADVICE

NTT | TRANSPORT REFUSED | TREATMENT REFUSED | STOOD DOWN

Incident Location/Address

HOME | RECR. OR SPORT PLACE | RESIDENTIAL INSTITUTION
FARM | STREET OR ROAD | OTHER PLACES
IND. PLACE OR PREMISES | PUBLIC BUILDING

Nature of Assistance Prior to Arrival of Practitioner

NONE | CPR* | REFER OHCA OVERLEAF*
FIRST AID | AED*
COMPRESSION ONLY CPR* | ALS

Identity of Assistance Prior to Arrival of Practitioner

CIVILIAN | FIRE | AUXILIARY/VOLUNTARY | OTHER
RESPONDER | GARDA | PRACTITIONER

CLINICAL LEVEL

NO TRAINING | OFA | PARAMEDIC | DOCTOR
UNKNOWN TRAINING | EFR | ADV. PARAMEDIC | OTHER
BLS/CFR | EMT | NURSE

PATIENT INFORMATION

SURNAME | NAME

PERMANENT ADDRESS | Mark if same as Above | DOB

AGE | PAED WT | GENDER

GP

NEXT OF KIN | NOK TELEPHONE

CLINICAL INFORMATION

PATIENT'S CHIEF COMPLAINT | TIME OF ONSET | DATE OF ONSET

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 | HAEMORRHAGE | Yes | No

SKIN | NORMAL | PALE | FLUSHED | CYANOSED | Cap-Refill | < 2 SEC | > 2 SEC

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

CLINICAL IMPRESSION

CARDIAC: CARDIAC ARREST | CARDIAC ARRHYTHMIA | CARDIAC CHEST PAIN | HEART FAILURE | OTHER CARDIAC

MEDICAL: BACK PAIN | DIABETES MELLITUS | FEVER | HEADACHE | HYPOTHERMIA | OTHER MEDICAL

NEUROLOGICAL: ALTERED LOC | SEIZURES | STROKE | OTHER NEUROLOGICAL

OBS/GYNAE: HAEMORRHAGE < 24 WKS | HAEMORRHAGE > 24 WKS | LABOUR | PPH | PRE-HOSPITAL DELIVERY | OTHER OBS/GYNAE

RESPIRATORY: ASTHMA | COPD | FBAO | RESPIRATORY ARREST | SMOKE INHALATION | OTHER RESPIRATORY

TRAUMA: BURNS | DISLOCATION / SPRAIN | FRACTURE | HAEMORRHAGE

HEAD INJURY | MAXILLO-FACIAL INJURY | MULTIPLE TRAUMA | OPEN WOUND | SHOCK | SOFT TISSUE INJURY | SPINAL INJURY | OTHER TRAUMA

GENERAL: ABDOMINAL PAIN | ACUTE INTOXICATION | ALLERGIC REACTION | BEHAVIOURAL DISORDER | ILLNESS UNKNOWN | NAUSEA / VOMITING | POISONING | SYNCOPE / COLLAPSE | OTHER GENERAL

CLINICAL INFORMATION

PATIENT'S MEDICAL OBSERVATIONS

A | ALLERGIES | NKA | UNKNOWN

M | MEDICATIONS | NONE | UNKNOWN | AS SUPPLIED | PER DR's LETTER

P | PAST MEDICAL HISTORY | NONE | UNKNOWN | PER DR'S LETTER | RELATIVE

L | LAST INTAKE | UNKNOWN | DESCRIBE

E | EVENT

MECHANISM OF INJURY: ASSAULT | ATTACK/BITE BY ANIMAL/INSECT | CHEMICAL POISONING | SUBMERSION | ELECTROCUTION | EXCESSIVE COLD | EXCESSIVE HEAT | FALL | FIREARM INJURY | INJURY TO CHILD | MACHINERY ACCIDENTS | MVA OFF ROAD | RTA BICYCLE | RTA MOTORBIKE | RTA PEDESTRIAN | RTA VEHICLE | SMOKE, FIRE AND FLAMES | WATER TRANSPORT ACCIDENT | OTHER

CIRCUMSTANCES: ACCIDENT | EVENT OF UNDETERMINED INTENT | INTENTIONAL SELF HARM

L | B | F | R

Impact | Pos. in Vehicle | Pos. after Acc. | Rollover | Remove Helmet | Seatbelt | Trapped | Air Bag Deployed | > 20 Min. Extrict. | Fatality in Vehicle

Est. speed at impact kph

CS | LIFE THREATENING | SERIOUS NOT LIFE THREAT. | NON SERIOUS OR LIFE THREAT.

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Information required

ACR/PCR should not distract from your care giving or communication with the patient!

- Sections
  - Incident Information
    - Details of incident
    - Patient Information
  - Clinical Information
    - Primary Survey
    - Secondary Survey
  - Medication Treatment
    - Vitals
    - Declined Treatment

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Copies

- Top Copy
  - Travels with the patient
    - given to arriving EMS
- Bottom Copy
  - Stored locally by CDO
  - Hand delivered to Civil Defence College for storage at a later point

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Handover…

- Important to let EMS take control once they arrive
- Vital to hand over all information you have gathered
- Recording the timing of events or medications is very important
- Do not leave scene until told you can go
  - Duty of care
  - Abandonment!

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Handover…

- What to do;
  - Introduce the casualty to the EMS
  - Give a summary of their condition, what you found when you arrived and what treatment you provided
  - Ensure that your hand over is comprehensive, but concise

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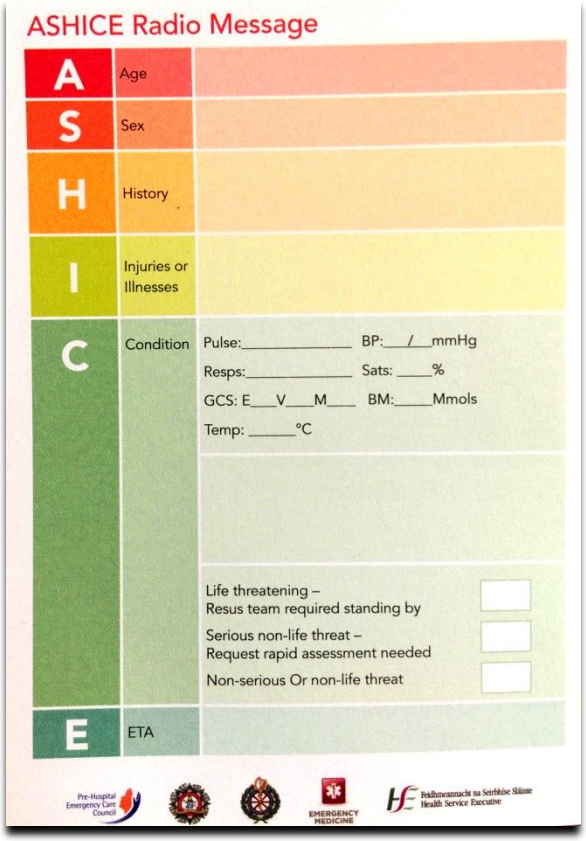
Handover…

- ASHICE!
  - **A** Age of patient
  - **S** Sex of patient
  - **H** History (what happened)
  - **I** Injuries
  - **C** Condition of patient
  - **E** ETA



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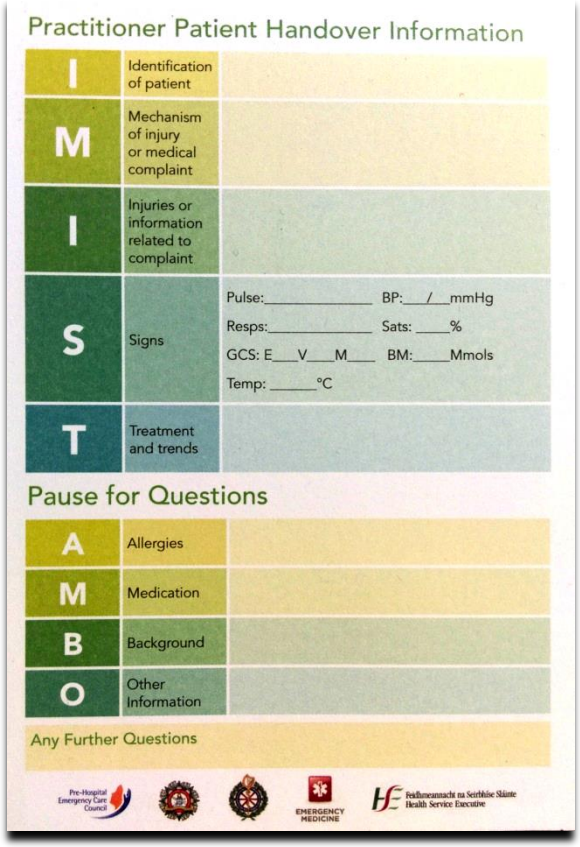
Handover…

- IMISTAMBO!
  - **I** Identification of patient
  - **M** Mechanism of injury
  - **I** Injuries
  - **S** Signs
  - **T** Treatment
  - **A** Allergies
  - **M** Medication
  - **B** Background
  - **O** Other Information


Practitioner Patient Handover Information

I	Identification of patient	
M	Mechanism of injury or medical complaint	
I	Injuries or information related to complaint	
S	Signs	Pulse:_____ BP:___/___mmHg Resps:_____ Sats: ____% GCS: E___V___M___ BM:____Mmols Temp: _____°C
T	Treatment and trends	

Pause for Questions

A	Allergies	
M	Medication	
B	Background	
O	Other Information	

Any Further Questions

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Assessment

- Give 3 reasons why do we record patient information
- State 5 pieces of information that are recorded on an ACR
- Why is this important not to be distracted by filling out an ACR when treating a patient?
- Explain the essential elements of a verbal handover report to arriving EMS

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Summary

- Why record patient information
- Key information to record
- Completing an ACR for a patient scenario
- Handover to EMS and what to do/say
- Demonstration of effective handover

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