CGP148

Clinical Audit Policy and Procedure

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1. POLICY INTRODUCTION

This Policy and Procedure specifies the National Ambulance (NA) requirements for Clinical audit, the process for carrying out the clinical audit and the methods of feeding back outcomes to ensure continuous improvement. Clinical audit is an integral part of the services ongoing commitment to strive to encourage a culture of accountability, transparency, collaboration and excellence in providing the paramount pre-hospital service in the Middle East and to ensure continuous improvement in quality and safety of patient care and outcomes.

This Policy and Procedure must be read and understood in the context of QHP 202 Audit, Inspection and non-conformance Policy and Procedure. This policy directly supports the 'Continuous Improvement' and Implementation, Monitoring and Reporting management system components.

2. SCOPE

This policy applies to all activities, e.g. clinical care, documentation and communication that are carried out by a NA clinical employee.

This policy applies to all NA clinical employees as well as those employees named below in the Roles and Responsibilities section.

3. ROLES AND RESPONSIBILITIES

In addition to the relevant roles and responsibilities detailed in "QHP202 - Audit Inspection and Non Conformance Policy and Procedure" the following roles and responsibilities apply:

Chief Administrative Medical Officer (CAMO)/Delegate: Will set the audit requirements, have general oversight of the process and will review any Sentinel Events or clinical incidents that require investigation found or bought to NA.

Director of Operation (DOO): Will ensure that necessary operational mechanisms are in place and operational staff are compliant with any agreed audit requirements and any recommendations for improvement in the quality.

Clinical Education Manager (CEM): Will oversee the training adaptation required in order to reach the required standards of the clinical practice expected from clinicians. The Clinical Audit programme will be linked to the Mentorship scheme in order to have seamless vision on the staff compentacies.

Operational Managers: Will ensure that all PCRs are completed and available for audit at the Head Quarters. Will ensure all operational staff work to the required levels of patient care outlined in the CGP's and relevant guidelines and requirements of the contract. Will also ensure that they are aware of the policies and procedures in place and are adequately trained, qualified and experienced to perform in their allocated responsibilities of patient care.

Clinical Governance and Audit Officer / Delegated Clinical Auditor: Will lead on the design and development of Clinical Audit Programme, utilising the reported data to impliment changes to clinical policy and procedures. All audit reports will be collated to support and demonstrate Clinical Governance quality improvement in line with regulatory requirements.

Auditors: Will conduct the audit to a high level ensuring that all audit findings are recorded in a timely manner and bought to the attention of relevant managers, staff and CAMO/ Medical designate as required.

Clinical staff: Will ensure that they follow best practice delivering high standards of care and that they follow the policies, procedures and protocols relevant to their contract.

4. POLICY STATEMENT

4.1. Definition:

Clinical audit involves improving the quality of patient care by looking at current practice and modifying it where necessary.

4.2. Objectives

National Ambulance conducts informal and formal audits, reviews and investigations of the current operations, contracts and clinical care in order to:

- Identify potential improvements to processes, programs, functions, decision making and clinical care using an agreed annual audit plan;
- Ensure that the clinical audit and quality improvement initiatives are integrated into the wider strategic vision and business plans of NA;
- Provide information that supports development or revision of performance indicators and metrics;
- Identify real or potential misuse of NA resources; and
- Identify potential areas for research and development activities
- Educate, reward, and improve excellence in clinical care.

4.3. Scope of Audit

National Ambulance conducts audits on all elements of clinical care and transport to ensure that we are meeting the needs of our customers, governing board, and employees. Our target of Clinical Audit is 10% of paper PCR/ePCR.

4.4. Audit tools

All clinical activity is measured against the approved and published clinical policies and procedures, Legal and Regulatory requirements set by DOH/MOH and other governmental bodies. Accrediting organisations also influence the audit tools used.

Best clinical practice is taken into account while ensuring the quality of patient care is maintained. CGP 134 Patient Care Protocols must be adhered to whilst practising at NA.

Areas where risks are identified should be taken into account including but not limited to QHSE Incidents.

In some cases formal audit tools will be developed to ensure audit activity is robust and consistent.

4.5. Paper PCR and ePCR Audit

All paper PCR's and ePCR's are eligible for audit of clinical practice, medication use and legal compliance. Completed PCRs are retrieved from the bases and brought to Head Quarters by process detailed below (Also refer Appendix 2 – Paper PCR/ePCR Retrieval Process) and the completed ePCRs will be saved in the ePCR server as a PDF:

- Completed paper PCRs are placed in a secured envelope with restricted sticker placed on it by a designated staff from all bases at the end of each shift in the order of one envelope per day.
- Logistics will collect the envelopes on designated days as agreed with the Operations and stored in warehouse until they are delivered to the Head Quarters for further processing.
- The received paper PCRs are scanned and renamed according to the approved format.
- The scanned paper PCRs are then allocated for audits.
- ePCR's undergo an automated filtering for the Clinical Audit Selection Criteria and self-populate into Clinical Audit Tool allocation for audit by the Clinical Auditors/Auditors. This is done manually for paper PCR's. Refer to Appendix 4 - Clinical Audit Selection Criteria. Allocated paper PCRs for manual audit is logged in CGF168 - Data Allocation for Paper PCR Clinical Audit Registry. In the event of missing PCR, investigation will be carried out with the departments involved until the PCRs are located and delivered to the HQ.
- Audit will be conducted by the Clinical Auditor, Physicians or designated paramedic/s (if needed after CAMO approval). (refer Appendix 3 – Clinical Audit Process).

The Chief Administrative & Medical Officer/Medical delegate may, however request that structured and scheduled paper PCR /ePCR audits are carried out to ensure they meet the current and relevant clinical requirements. Examples would include, but are not limited to:

Table 1 – Clinical Audit Selection Criteria

100%	NE HEMS (Helicopter Emergency Services)/MOPA Acute Coronary syndrome Cardiac arrest Sepsis Burns Cerebrovascular accident Hypoglycemia
10%	Paediatric Pain Non-conveyance of patient episodes Multi trauma
1%	Other (if needed to reach the target of 10%)

Auditors will be auditing based on the clinical parameters but they will also ensure that all pertinent aspects of Patient Care Documentation as specified in Appendix 5 – Clinical Audit Checklist for Clinical Auditors. The Auditors are in turn audited by Clinical Governance & Audit Officer on random basis to add value to the process.

All patient information data will be managed in a confidential manner and stored appropriately as per the policies referenced below:

- CGP 119 Patient Care Documentation and Patient Care Record Policy and Procedure
- COP 401 Information Management Policy
- COP 402 Document Retention Policy and Procedure
- QHP 202 Audit, Inspection and non-conformance Policy and Procedure

The CAMO / Medical delegate may request further assessment of PCR's as required for a review of clinical practice or study purposes. This is an essential part of critical incident review and should be concluded expeditiously.
Any supplementary documentation relating to the PCR should also be considered, e.g. QHSE Report form.
The process for audit of PCRs is at Appendix 3 – Clinical Audit Process.

The PCR audit Report and Findings will be discussed with the Chief Administrative & Medical Officer/Medical delegate, and Director of Operation monthly (or whenever needed).

4.6. Feedback from audit activity

Positive feedback is the main goal of audit, in order to encourage growth and learning; to improve care and patient outcomes.

The expected outcomes of each audit are to identify areas of good clinical practice/success, and areas for improvement. Clinical Governance and Audit Officer / Delegated Clinical Auditor will be directly contacting

the clinicians by email if there are any questions related to their PCR/ePCR and copy the direct manager of the staff, DOO and CAMO on the email. This email will be send from the clinical audit email: "**clinicalaudit@national ambulance**".

On a monthly basis the CAMO/delegate will review the clinical audit Report including the the charts highlighted as not being compliant to CGP134 or any other area and interviene as required. A daily automated email will be send to each clinician shows the ePCR score based on the completion of the selected automated cell as mentioned in "Table 2 – ePCR Score"

Table 2 – ePCR Score

Question	Score
Is the triage category marked?	1
Is the CAD number documented clearly and correctly?	1
Are two patient identifiers documented? (Name, DOB, ID)	1
Is the Gender - Male or Female specified?	1
Patient Age Documented?	1
Nationality Documented?	1
If Paediatric - are details of next of Kin, Relationship and phone number documented?	1
Are all Call details including date and times documented appropriately as needed?	1
Allergy documented or tick box for "No Known Drug Allergy" (NKDA) marked?	1
Past Medical History documented?	1
Regular medications documented?	2
Last Oral Intake documented?	1
Chief complaint/presenting complaint documented?	2
Time of incident/onset/injury documented?	1
Falls Assessment documented?	1
Minimum of 2 sets of observations including pain scores documented?	2
BGL tested and documented?	1
Was there consent to treat recorded?	1
Non transport waiver complete - Was patient transport box marked?	2
Clinician Signature on PCR?	1

Feedback will be communicated by a number of methods, e.g. Revision of policies and procedures circulated and published for staff and in some cases individual employee feedback from managers.

4.7. Making Improvements

Clinical audit reports should identify any sub optimal practice; an action plan must be developed and implemented to resolve the practical issues. If the sub optimal practice appears to concern individual healthcare professionals the CGP 203 Fitness to Practice Policy and Procedure should be used.

Minor non-conformances and positive feedback can be managed through use of the normal NA communication channels such as Hazard Alerts.

Minor individual non-conformances should be communicated to the Mentorship Operation Manager, NA Education Manager and CAMO/Medical delegate to ensure that any need for remedial education or revision of face to face training or elearning is managed.

All reports and action plans must have oversight and approval from the CAMO/Medical delegate.

Ownership and timeframes for action plans and recommendations for improvement must be clearly identified.

Any necessary changes to policies, procedures and guidelines must be planned, carried out and implemented and the outcome of any revisions monitored.

4.8. Sustaining Improvements

The audit cycle is a continuous cycle. Any improvements that are made must be fully monitored to ensure the aim of the planned improvement is achieved.

Re audit activity must take place to ensure that the improvements are maintained.

5. RELEVANT LEGISLATION / STANDARD

Code, Name of Legislation	Jurisdiction
JCI Accreditation Standards for Medical Transport Organisation,– (MOI.4, MOI.4.2,)	2nd Edition, July 2015

6. CGW109 CLINICAL AUDIT PROCESS

7. RELATED POLICIES AND FORMS

List related policies and procedures to the created/updated policy.

Policy & Procedure /Form
CGP103 – Patient Rights and Responsibilities Policy and Charter
CGP105 – Consent Policy and Procedures
CGP134 – Patient Care Protocol
CGP116 - Policy and Procedure for Transport of High Risk Patients
CGP113 – Pain Management Policy & Procedure
CGP212 – Clinical Glossary Terms

8. FEEDBACK

Any feedback or suggestions for improvement to this Policy, Processes or Procedures can be submitted to qhse@nationalambulance.ae

9. DOCUMENT CONFIGURATIONS CONTROL DATE

A review and update of this document will take place as necessary, when changes occur that identify the need to revise this Policy such as changes in roles and responsibilities, release of new legislative or technical guidance, or identification of a new policy area.

This document ownership for editing is identified as:

- Chief Administrative & Medical Officer / Medical Delegate

This controlled document is managed / overseen by Poilcy Review Committee

Change Brief

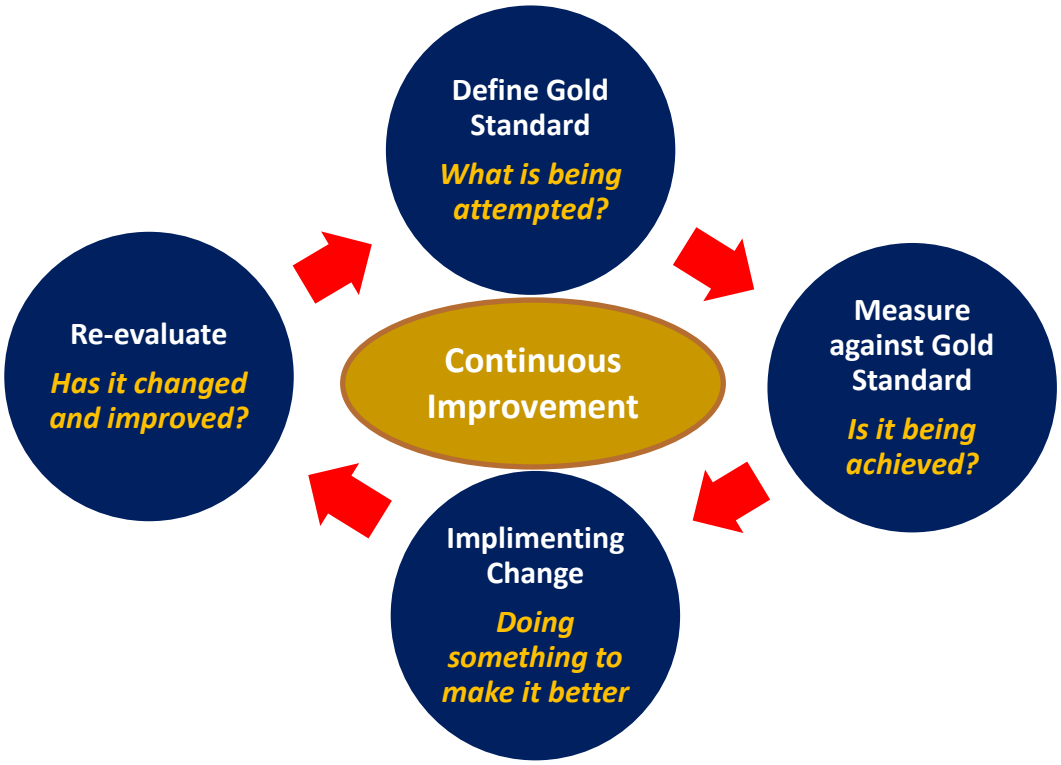
Version No.	Date	Changes
1	November 2014	New Policy
2	January 2016	Patient confidentiality incorporated, data retention reference, flow chart updated to reflect adapted process and updated audit cycle. Corporate colours adopted
3	September 2016	Audit Criteria revision Removal of PHECC reference Inclusion of PCR Retrieval and Audit Process Inclusion of Audit Checklist Appendix
4	September 2018	Clinical Audit process updated Missing ePCR is logged in CGF 168 – Missing ePCR/PCR Register Clinical Audit flow chart updated Clinical Audit Criteria Clinical Audit Checklist updated Change “Chief Medical Advisor” to “Medical Director” Add the Appendix title in the policy Update PCR Audit (5.4)
5	February 2020	Update the policy in the new template Move definition in the policy statement Rename “Section “Clinical Audit Policy” to “Policy Statements” Update “Clinical Audit Criteria” Appendix 4” Add Working Diagnosis to Appendix 4 Change BSL to BGL in Appendix 4 Change clinical Audit Definition

6	March 2022	• *Add policy name to QHP202* • *Update the position (CAMO & DOO)* • *Add Paper PCR* • *Add secured envelop with restricted sticker placed on it in point 4.5* • *Delete 4th sentence in point 4.5* • *Add Allocated paper PCRs for manual audit is logged in CGF168 - Data Allocation for Paper PCR Clinical Audit Registry in point 4.5* • *Add if needed after CAMO approval to last point in 4.5* • *Add MOPA to table 1* • *Delete supervisors and add Clinical Governance & Audit Office* • *Update table 2 (ePCR Score)* • *Delete Routine Information Bulletin (RIB) from the policy* • *Update Clinical Audit Flow Chart (point 6)* • *Update Appendix 2 – PCR retrieval process* • *Update Appendix 3 - Clinical Audit Selection Criteria and Working Diagnosis Codes* • *Update Appendix 4 – Clinical Audit Checklist*

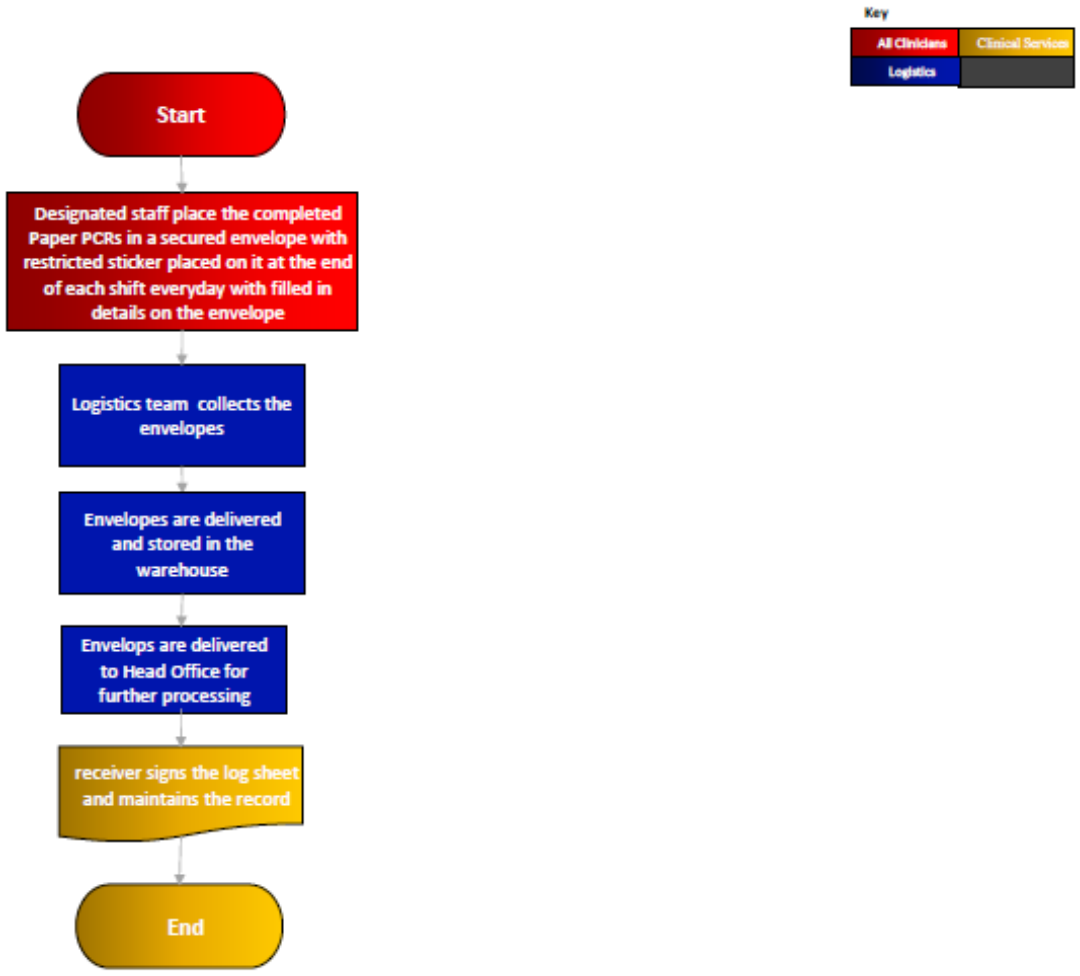
CEO Approval

Board Member Verification

Appendix 1 – Clinical Audit Cycle Process



Appendix 2 – PCR / ePCR Retrieval Process



Appendix 3 – Clinical Audit Selection Criteria

CLINICAL AUDIT CRITERIA (24 March 2022)					
CODE	CATEGORIES (WORKING DIAGNOSIS)	ALLOCATION MARKERS	CLINICAL AUDIT MEASURABLE ELEMENT	EXPECTED OUTCOME	PERCENTAGE (%)

	Sepsis	Review all patients with all the below:
		• Adult Shock Index ≥ 0.9
		• SIPA (Shock Index Paediatric adjusted)
		  • SIPA 4-6 years ≥ 1.2
		  • SIPA 6-12 years ≥ 1.0
		  • SIPA ≥ 12 years ≥ 0.9
		• Under 4 years:
		  • Tachycardia > 130bpm
		  • Hypotensive - systolic <85 mmHg
		
		AND Temperature >38.5^{0}C
			• Was an antipyretic medication (Paracetamol, Ibuprofen, diclofenac) given Y/N
			• Was IV/IO fluid required for this patient Y/N
			• Was IV/IO fluid given? Y/N
				• Compliance to CGP 134
				• Compliance to CGP 110
				• Compliance to CGP 119
					100

6	Cardiac Arrest	Select all code 6 patients for audit	• Did they follow the BLS/ALS algorithm? - Y/N • Was CPR/AED administered timely? - Y/N • Was ECG done and analysed? - Y/N • Was ECG attached with the PCR? - Y/N	• Compliance to CGP 110 • Compliance to CGP 119 • Compliance to CGP 134	100
7	Acute Coronary Syndrome	Select all code 7 patients OR • 300mg Aspirin given OR • GTN given	• Was 12 lead ECG done and attached to the PCR? - Y/N • Was adequate pain management achieved? - Y/N • Was appropriate care provided - Y/N	• Compliance to CGP 113 • Compliance to CGP 119 • Compliance to CGP 134	100
	Hypoglycaemic	Review all patients with: • BGL below <72 mg/dl (<4 mmol/l)	• Did the Blood Glucose Leve (BGL) improve after management? - Y/N • Was the appropriate type of treatment given? (oral carbs, glucose, glucagon, etc.) - Y/N	• Compliance to CGP 119 • Compliance to CGP 134	100
18	Cerebrovascular Accident (Stroke)	Select all code 18 patients for audit	• Were 2 GCS documented? - Y/N • Was BE FAST score documented? - Y/N • Was BGL assessed and documented? - Y/N	• Compliance to CGP 119 • Compliance to CGP 134	100
22	Burns	Select all code 22 patients for audit	• Was the burn percentage assessed and documented? - Y/N • Was wound care appropriately done? - Y/N • Was IV/IO fluid initiated if the burn percentage was more than 10%? - Y/N • Was adequate pain management initiated? - Y/N	• Compliance to CGP 113 • Compliance to CGP 119 • Compliance to CGP 134	100

21, 24, 25	Multi - Trauma	Select red/yellow categories from the codes 21, 24 & 25 AND
		Early Warning Score (EWS) of ≥3 OR
		• Adult Shock Index ≥ 0.9
		• SIPA (Shock Index Paediatric adjusted)
		  • SIPA 4-6 years ≥ 1.2
		  • SIPA 6-12 years ≥ 1.0
		  • SIPA ≥ 12 years ≥ 0.9
		• Under 4 years:
		  • Tachycardia > 130bpm
		  • Hypotensive - systolic <85 mmHg
			• Was the hypotension managed? - Y/N
			• Was primary (ABCDEAVPU) and secondary (PQRST) survey completed and documented? - Y/N
			• Was IV/IO fluids required for this patient Y/N
			• Was IV/IO fluids given? Y/N
			• Was the patient packaged appropriately? - Y/N
			• Was adequate pain management initiated? - Y/N
				• Compliance to CGP 113
				• Compliance to CGP 119
				• Compliance to CGP 134
					10

	DOH requirements for quality audits	• Narcotics & Controlled Drugs (Morphine, Haloperidol, Ketamine, Midazolam, Fentanyl) • Interfacility Transport	• Was the verbal authorisation documented? - Y/N • If the patient was escorted by non-NA clinical staff, was the licence number documented? - Y/N	• Compliance to CGP 119 • Compliance to CGP 134 • Compliance to CGP 113	
	JCIA requirements for quality audits	• All cases with Sodium Chloride 0.9%	• Was IV/IO fluids given according to patient need and documented? - Y/N	• Compliance to CGP 119 • Compliance to CGP 134 • Compliance to QHP 105	100
	Paediatric Pain Scores	Select 10% of all cases under 12 years of age	• Were 2 pain scores documented? - Y/N • Was adequate pain management initiated? - Y/N • Was NOK / guardian information completed correctly Y/N • If Paediatric patient transport occurred, did escort happen with parent, guardian, appropriate non-NA escort? Y/N	• Compliance to CGP 113 • Compliance to CGP 119 • Compliance to CGP 134	10
	Non-conveyed patients	Select 10% of all non-transported patients	• Was patient capacity box marked? - Y/N • Was patient transport box marked? - Y/N • Was further advice given and documented? - Y/N • If signature was required, was it present? Y/N • Was language barrier documented? Y/N	• Compliance to CGP 105 • Compliance to CGP 115 • Compliance to CGP 119 • Compliance to CGP 134 • Compliance to CGP 152	10
	Mentorship (not from ePCR database)	PCRs that are audited by mentors and Clinical Educators during "ride along"	• Compliance to CGP 119 • Compliance to CGP134	• Compliance to CGP 119 • Compliance to CGP 134	100
	Clinical Incident (not from ePCR database)	PCRs arising from the below category: • QHSE • Clinical investigation	• Compliance to CGP 134	• Compliance to relevant policies and protocol	100
	Project specific	Allocation as and when required	• Compliance to required policies and protocol	• Compliance to specific project	Up to 10% of total PCR's

Working Diagnosis Codes and Definitions

Working Diagnosis Codes and Definitions Code No.	Code Name	DEFINITION	Exclusions (below is a non-exhaustive list of exclusions)
1	**Abdominal / Back Pain**	Abdominal / lower back pain of medical origin (non-trauma) that cannot be categorized to a more specific code	- Epigastric pain of possible cardiac origin - code 7 - Trauma related pain - code 21 - Obs and Gynae pain - code 15 - AAA or GI Bleeds - code 4
2	**Allergic Reaction**	Allergic or anaphylactic reaction	- Surgical emphysema - code 21
3	**Infectious Disease**	Significant Infection/sepsis eg. Meningococcal, Chicken Pox, Mumps, Measles, MERs	- Mild flu/cold symptoms, coughs, minor eye/ear infections - code 17
4	**Bleeding (Non-trauma)**	Internal or external bleeding of a non-traumatic origin e.g. AAA, GI bleeds, epistaxis, varicose veins	- Traumatic bleeding - code 21 - Obs and Gynae- code 15 - Brain bleeds - code 18
5	**Breathing Difficulty**	Acute or chronic breathing problem of a medical origin (non-Trauma) e.g. PE, COPD, Asthma	- Trauma related SOB e.g. Tension Pneumothorax, Pulmonary contusion - code 21 - Cardiac chest pain with SOB – code 7 - Smoke inhalation – code 22 - Anaphylaxis – 2 - Foreign body airway obstruction - 8
6	**Cardiac arrest**	Cardiac arrest where resuscitation is attempted	- Deceased and no resuscitation attempt made - code 28
7	**Chest Discomfort / Heart Probs.**	Symptoms that indicate Acute Coronary Syndrome. Other heart problems/arrhythmias etc. Non-traumatic muscular/Skeletal pain Pulmonary chest pain	- Abdo/back pain of non-cardiac origin - code 1 - Traumatic chest pain - code 21

8	**Choking**	Total airway obstruction from a foreign body	- Airway swelling e.g. Epiglottitis - code 3 - Smoke inhalation - code 22 - Anaphylaxis - code 2
9	**Diabetic**	Hypoglycaemia or Hyperglycemia as primary complaint	- Minor Hypo/Hyperglycemia but primary complaint is something else e.g. patient with a chest pain and a slightly raised BSL - code 7
10	**Environmental / Toxic Exposure**	Chief complaint is as a result of exposure to excessive heat or cold or a hazardous material or gas e.g. H2S or CO. Poisonous plants	- Smoke inhalation - code 22 - Medication overdose – code 14
11	**Medical Knowledge (Inter Facility Transport)**	Only for Interfacility Transport	**DO NOT USE**
12	**Head / Neck**	Chief complaint is a nonspecific Headache or Neck Pain of medical origin	- Head pain as a result of Trauma - code 21 - Head pain or neck pain as a result of significant infection e.g. Meningococcal Disease, use code 3 - Non traumatic brain bleeds, use code 18
13	**Mental / Emotional / Psych**	Chief complaint is psychological e.g. combative patients, suicidal tendencies, etc. (May have minor self-harm injuries)	- Significant trauma resulting from a psychological episode e.g. arterial bleed from self-harm -code 21 - Significant injury from hanging - 21
14	**Overdose / Poison**	A medication or a poison or a toxin entering the body by any route. Includes alcohol intoxication, medication, organophosphate, household cleaners	- Smoke inhalation - code 22 - HS2 exposure - code 22 - envenomation via animal bite/sting - code 26 - Allergic reaction to a medication - 2
15	**Pregnancy / Obs / Gyn**	Any grouping of symptoms suspected to be of an Obs or Gynae origin e.g. Labour contractions, menstrual cramps, ectopic pregnancy	- None
16	**Seizures**	Seizure activity as a chief complaint - Non-trauma. Includes pseudo seizures	- Seizures related solely to hypoglycaemia - code 9 - Trauma related seizures - code 21

			-
17	**Sick (Unknown) / Other**	Any patient whose symptoms do not fall within one of the other categories. Minor illness with normal vital signs	- If a specific code can be found on this list
18	**Stroke (CVA)**	FAST + All non-trauma related brain injuries	- Trauma related Brain Injuries - code 21 - Not FAST +
19	**Uncons / Sync / Unresp /**	Partial or complete LOC that cannot be categorized into a more specific code. Collapse of a medical origin	- Trauma related LOC - code 21 - Dizziness from Cardiac origin - code 7 - Unresponsiveness from drugs or toxins - code 14 - LOC due to a seizure – 16 - General weakness – code 17
20	Paediatrics		Do not use
21	**Assault / Trauma**	Acute injury arising from external forces e.g. sporting injuries, falls, assault including injuries to the head and neck, fractures, dislocations. Falls from greater than 2 meters	- Water related incidents - code 23 - MVA - code 25 - Falls from standing – code 24
22	**Burns / Therm / Elec / Chem**	All burns due to thermal, electrical, chemical, nuclear or solar exposure. Includes associated smoke/inhalation.	- Where injury more serious than burn - code 21 - H2S or CO inhalation - 10
23	**Drowning / Water Injury**	Drowning/near drowning, diving accidents, water sporting injuries (motorized or non-motorized)	- Scolds from hot water - code 22 - If resuscitation attempted for cardiac arrest – code 6
24	**Falls / Accidents / Pain**	**Chronic/non-acute pain** (arthritis, spondylosis, surgery scarring etc). Pain from historical injuries/surgeries. Falls from standing	- Falls from height - code 21 - Minor falls secondary to a significant medical event - use specific medical code
25	**Motor Vehicle Accident (MVA)**	Trauma or injury from a motor vehicle accident, or road going vehicle such as a bicycle or motor scooter	- Skateboards, scooters, non-road worthy rideable devices - code 21
26	**Animal Bites**	Animal, insect or reptile bites/ stings, with or without venom	- Allergic reaction as a result of a bite or sting - code 2

27	**Standby**	Being present at a designated location to provide medical cover	- If while on standby a patient is assessed (even visually) use appropriate code for their condition
28	**Deceased**	Deceased on arrival; confirmed by NA Guidelines where no CPR is started	- CPR started for any length of time – code 6
29	**No inj / Illness**	Vitals normal, no injuries, asymptomatic e.g. Request for vitals sign check	- None

Approved by:

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Dr. Ayman Ahmad
CAMO

Appendix 4 Clinical Audit Checklist for Clinical Auditors

PCR / ePCR Audit			
No.	**Item**	**Option**	
1	ePCR#		
2	CAD No-Patient		
3	Contract		
4	Incident Date		
5	CAD Ticket Status		
6	Is/are staff IDs documented?	1/0	
7	Patient Category	1-Red/ 2-Yellow/ 3-Green/ 0-Black	
8	Is the triage category marked correctly?	1	0
9	Is the CAD number documented clearly and correctly?	1	0
10	Are **two** patient Identifiers, name and date of birth documented?	1	0
11	Is the Gender - Male or Female specified?		
12	Patient Age (Paediatric Cases Only)		
13	If Paediatric - are details of next of Kin, Relationship and phone number documented?	1	0
14	Paed Actual Weight or estimated weight documented?	1	0
15	Is Nationality documented?	1	0
16	Are all Call details including date and times documented appropriately as needed?		
17	Was allergies documented? or tick box for "No Known Drug Allergy" (NKDA) marked?	1	0
18	Has patient past medical history been documented?	1	0
- 19	Has patient regular medications been documented?	1	0
20	Narcotics/CD's - Was the verbal authorisation documented?	9/1	0
21	Last Oral Intake documented?	1	0
22	Is the Chief Complaint / presenting complaint appropriately documented?	1	0
23	Time of incident/onset/injury documented?	1	0
24	Was FAST +/- documented? For CVA (Stroke) cases only	1	0
25	Was the burn assessed and managed correctly? For burn cases only	1	0
26	Was IV/IO fluid initiated if the burn percentage was more than 10%?	1	0
27	Was the hypotension managed?		
28	Was an appropriate patient examination and management documented to be compliant to CGP134 (Clinical Care Protocols)	1	0
29	Was a fall assessment documented?	1	0
30	OBS HR, RR, BP, SPo2, AVPU/GCS, temp, (6 items must be there)	1	0
31	Minimum of 2 sets of observations including pain scores documented?	1	0
32	All observation recording times documented correctly (5mins critical cases and 15mins stable cases)?	1	0

33	Was BGL Tested and documented?	1	0
34	Is the medications administered correctly written?	1	0
35	Has the appropriate medication been given?	1	0
36	Is the signature and staff ID no. responsible for drug administration documented?	1	0
37	Was IV/IO fluid required for this patient	9/1	0
38	Was IV/IO fluid given?	9/1	0
39	Circulation: has IV/IO line been inserted?	9/1	0
40	Airway and ventilation documented?	9/1	0
41	Circulation: ECG and findings documented, if required?	9/1	0
42	Was ECG attached with the PCR?	9/1	0
43	Was CPR/AED administered timely?	9/1	0
44	Was ROSC achieved?	9/1	0
45	Immobilisation including, collar, spinal board, splints documented?	9/1	0
46	Was the patient packaged appropriately?	9/1	0
47	Name, designation and signature of receiving clinician documented?	9/1	0
48	What is the Primary final working diagnosis?		
49	Diagnosis Free text documented?	1	0
50	Was there consent to treat recorded?	1	0
51	Non transport waiver complete - Was patient capacity box marked?	1	0
52	Non transport waiver complete - Was patient transport box marked?	1	0
53	Patient/guardian signature documented?	1	0
54	Was further advice given and documented?	9/1	0
55	Where there any language barriers?	1	0
56	Was the PCR signed off by the clinician?	1	0
57	Are the appropriate abbreviations used and in compliance to QHP105?	1	0
58	Was there compliance to CGP 119? (Ptn Care Documentation and PCR Policy and Procedure)	1	0
59	If the patient was escorted by non-NA clinical staff, was the licence number documented?	1	0
60	If Paediatric patient transport occurred, did escort happen with parent, guardian, appropriate non-NA escort?	1	0
61	Was there compliance to CGP 116 (Policy and Procedures for Transport of Specialty Patient Population)	1	0
62	Was there compliance to CGP113 (Pain Management)	1	0
63	Was there compliance to CGP 103 (Patient Rights and Responsibilities)	1	0