Patient Care Report Guidebook 2018

For Pre-Hospital Emergency Care

Pre-Hospital
Emergency Care
Council

CONTENT

Introduction

PHECC Mission Statement:

"The Pre-Hospital Emergency Care Council protects the public by independently specifying, reviewing, maintaining and monitoring standards of excellence for the safe provision of quality pre-hospital emergency care"

PHECC has produced this Patient Care Report Guidebook 2018 to assist practitioners, Licensed CPG Providers, Recognised Institutions and all PCR users with completion of the PCR in accordance with best practice guidance on PCR data entry requirements.

The PCR was first implemented in 2005 following many stakeholder engagement events, and revisions followed in 2007, 2011 and again in 2014.

In line with the launch of Clinical Practice Guidelines 2017 Edition (updated 2018), an extensive and thorough review of the PCR and PCR Information Standard was carried out by Quality and Safety Committee, Medical Advisory Committee and approved by Council in 2018.

Delivery of healthcare is information intensive, generating huge volumes of data continuously[1]. Every day, practitioners spend a significant amount of their time recording patient data which includes data received from EMS Control Centre, data received from the patient at scene and data entered by the practitioner relating to the assessment, medications and interventions delivered.

Safe, reliable healthcare depends on access to and the use of information that is accurate, relevant, legible and valid[2]. High quality information should be the basis on which all decisions regarding healthcare are made, from individual patient care to strategic planning[3]. It is therefore crucial that all pre-hospital emergency care practitioners take particular care in ensuring that information is accurate. Poor quality data could impact patient safety, training/upskilling requirements, strategic management of the Licensed CPG Provider and many other aspects of pre-hospital emergency care delivery.

Information and communication technology have a critical role to play in ensuring that patient information is available when and where it is required across healthcare facilities[4]. The implementation of Individual Health Identifiers (IHI) will ensure that the integration of all patient records, regardless of the source of the data, will occur seamlessly and PHECC has incorporated the capture of this information into the PCR, to meet requirements when IHI national roll-out occurs.

The PHECC Governance Validation Framework (GVF) requires Licensed CPG Providers to submit annual evidence of audit activities[5]. Audit is a proven vehicle in driving change within a provider to improve quality by enabling a process to study the activities within the organisation and assess clinical practice against standards. A PCR completed according to the Standards for Documentation will provide the reliable source for the data required to meet the requirements of the GVF.

Shane Mooney

Mr. Shane Mooney
Council member & Chair, Quality and Safety Committee.

**Patient Documentation
Principles and Standards**

SECTION A

Patient Documentation, Principles and Standards

1. Aim

The aim of this guidebook is to provide clear directions for the accurate completion of Patient Care Reports. Accurate, reliable, legible and complete documentation for every patient is fundamental to delivering safe, reliable pre-hospital care to the highest standard.

2. Authority

Licensed CPG Providers are required, under compliance with the standards of the Governance Validation Framework, to have made certain that accurate, clear patient data is recorded on Patient Care Reports.

3. Purpose

Why is it important to fill out Patient Care Reports?

3.1 Clinical

Recording pre-hospital care, interventions and medications administered to patients is an essential clinical responsibility of all pre-hospital emergency care practitioners and any health care practitioner who administers care to the patient pre-hospital. In cases of major trauma or immediate critical care, patient care will take precedence over full completion of the Patient Care Report.

The data recorded on the Patient Care Reports are an important part of the patient handover at the destination facility. Lack of up-to-date information can lead to unnecessary duplication of patient assessment and delay in the administration of appropriate, timely treatment.

3.2 Legal Protection

Patient Care Reports are legal documents and may be required as evidence to aid a legal process. Practitioners are accountable for their practice and the recording of interventions and medications administered to patients pre-hospital is an essential clinical responsibility for all pre-hospital emergency care practitioners. Patient Care Reports identify the care that has been provided by the practitioner.

3.3   Organisation Information

Quality health information is essential for patient care, clinical governance, policy and research. To provide high quality, safe care to the patient, the data recorded on the Patient Care Report will provide information on the quality of the healthcare and this in turn will inform and support decision making by Licensed CPG Providers, policy makers and patients alike.

4.   When to fill out a Patient Care Report

4.1   General

Patient Care Reports must be completed in all circumstances where a practitioner assesses, delivers an intervention and/or administers a medication to a patient. This includes incidents where a patient refuses treatment and/or transport contrary to the advice given by the practitioner.

In cases of major trauma or immediate critical care, patient care will take precedence over full completion of the Patient Care Report during transportation. However, it should be completed as soon as is practicably possible.

4.2   Clinical Record Management

Recording pre-hospital care, medications and interventions administered to patients is an essential clinical responsibility for all pre-hospital emergency care practitioners and responders. It is vital that each patient report provides accurate information as it related to the health of the patient and activity of the organisation.

The management of personal health information is about having regard and respect for the person to whom the information relates. The principles of good information management ensure that the personal information is handled securely, efficiently and effectively, the information is available for health professionals at receiving destinations in order to make certain the best possible care and support is provided for the people for whom the PHECC Licensed CPG Providers collect health data.

Ensure that patient health information is managed in accordance with the key legislative frameworks of General Data Protection Regulation (EU) 2016/679[6] (GDPR), Data Protection Act 1988 Revised[7], Data Protection (Amendment) Act 2003[8] and Data Protection Act 2018[9].

The Principles of Data Protection [10]

Here is a brief overview of the Principles of Data Protection [10] as found in Article 5 GDPR [6] and set out on the website of the Data Protection Commission [10].

1. **Lawfulness, fairness, and transparency:** Any processing of personal data should be lawful and fair. It should be transparent to individuals that personal data concerning them are collected, used, consulted, or otherwise processed and to what extent the personal data are or will be processed.

2. **Purpose Limitation:** Personal data should only be collected for specified, explicit, and legitimate purposes and not further processed in a manner that is incompatible with those purposes. In particular, the specific purposes for which personal data are processed should be explicit and legitimate and determined at the time of the collection of the personal data.

3. **Data Minimisation:** Processing of personal data must be adequate, relevant, and limited to what is necessary in relation to the purposes for which they are processed. This requires, in particular, ensuring that the period for which the personal data are stored is limited to a strict minimum (see also the principle of "Storage Limitation" below).

4. **Accuracy:** Controllers must ensure that personal data are accurate and, where necessary, kept up to date; taking every reasonable step to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay.

5. **Storage Limitation:** Personal data should only be kept in a form which permits identification of data subjects for as long as is necessary for the purposes for which the personal data are processed. In order to ensure that the personal data are not kept longer than necessary, time limits should be established by the controller for removal or for a periodic review.

6. **Integrity and Confidentiality:** Personal data should be processed in a manner that ensures appropriate security and confidentiality of the personal data, including protection against unauthorised or unlawful access.

7. **Accountability:** The controller is responsible for, and must be able to demonstrate, their compliance with all of the above Principles of Data Protection. Controllers must take responsibility for their processing of personal data and how they comply with the GDPR, and be able to demonstrate their compliance, in particular to the Data Protection Commission (DPC).

SECTION B

Standards for Documentation

Section B

Standards for Documentation

5. General Standards for Documentation

There are a number of data quality dimensions which should be adhered to when completing the Patient Care Report:

5.1   Accuracy, Factualness and Objectivity

5.2   Reliability

5.3   Legibility

5.4   Completeness

5.5   Relevance

5.6   Timeliness

5.7   Validity

5.8   Numerical Accuracy

5.9   Use of Abbreviations and Symbols

5.10 Errors

5.11 Signing (PIN/HSPI) the Patient Care Report

5.12 Tick box and Coding Entry

5.13 Completion Overview

5.1   Accuracy, Factualness and Objectivity

Accurate data is an essential requirement of documentation. The accuracy of data refers to how closely the data describes what it was designed to record and measure.

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

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

5.2 Reliability

Reliable data refers to whether the data consistently measures over time the patient assessment, and patient management it was designed to represent.

5.3 Legibility

The data must be recorded legibly to enable a correct interpretation of the data.

5.4 Completeness

Complete data refers to the information recorded of the interactions which occurred between the practitioner/responder and the patient.

5.5 Relevance

Relevant data meets the current and future needs of the users of the data. Managing relevance requires that pre-hospital emergency care providers are aware of the information needs of data users and the uses of the data in terms of national audits i.e. national trauma audit.

5.6 Timeliness

Timely data is collected within a reasonable agreed time period. Data should be completed in real-time or as close to the event as possible as it may lack accuracy due to difficulties in recall. However, the Patient Care Report may be completed after handover if circumstances prevented it being completed prior to patient handover at the destination facility.

5.7 Validity

The data is collected in accordance with the data definitions in the current information standard referring to the patient report which is being completed.

5.8 Numerical Accuracy

Numerical accuracy is essential when recording numbers on Patient Care Reports and is essential for the integrity of the data used, e.g. to verify blood pressure, pulse and respiration measurements.

5.9 Use of Abbreviations and Symbols

Only accepted pre-hospital abbreviations and symbols should be used in filling out the Patient Care Report.

5.10 Errors

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

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

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

5.11 Signing (PIN/HSPI) the Patient Care Report

In answer to concern raised by practitioners in relation to the use of signatures on Patient Care Reports, PHECC introduced the concept of using the unique 4 digit Personal Identification Number (PIN) instead of a signature. A Health Service Provider Identifier (HSPI) is a unique number that is assigned to a health service provider such as a registered healthcare professional, hospital or clinic.

- The practitioner attending i.e. the main caregiver to the patient for the duration of the call should enter their PIN/HSPI in the designated 'practitioner attend' box
- The practitioner supporting should enter their PIN/HSPI into the designated 'practitioner support' box
- Other: The practitioner assisting in the care of the patient (e.g. undergrad/ post grad intern/other) should enter their PIN/HSPI into the designated 'Other' box
- Station PIN: The designated PIN of the station from where the vehicle was dispatched should be entered in the designated 'Station PIN' box

5.12 Tick Box and Coding Entry

The tick box and code entry can be rapidly and accurately recorded. It should be noted that where medication is recorded using codes that are only understood by the practitioner, the relevant information should also be clearly written to ensure that the receiving health care professionals understand the care delivered pre-hospital.

Only use those codes designated on the form.

Where a tick (✔) is required keep inside the box.

5.13 Completion Overview

A logical and sequential check of the Patient Care Report prior to completion by each practitioner will enable the identification of missing or incorrect information and confirmation that the record of the patient care is accurate and complete.

The need for legibility and correctness is paramount. Illegible reports can easily be misinterpreted. All entries must be made using a ballpoint pen pressing firmly to ensure all copies of the Patient Care Report are legible.

SECTION C

**Guide for Completion
Incident Information**

6.1 INCIDENT INFORMATION

Incident Information

Date Of Call	Time Of Call	Passed
DD MM YYYY ①	HH MM ②	HH MM ③

Dispatch Classification Reference

④			

Priority Response ⑬ ECHO · DELTA · CHARLIE · BRAVO · ALPHA · OMEGA

Inter Facility Patient Transfer	Clinical Escort	Non-Clinical Escort
YES NO ⑭	YES NO	YES NO
If selected ▼	If selected ▼	If selected ▼
Vehicle Crew Clinical Level	**Clinical Level**	**Non-Clinical Escort Identity**
☐ AP ☐ P	☐ MP/RN/M	☐ Healthcare assistant
☐ EMT ☐ FAR		☐ Family member
		☐ Other
		☐ Free Text

Mobile	At Scene	At Patient	Depart Scene	At Destination
HH MM ⑤	HH MM ⑥	HH MM ⑦	HH MM ⑧	HH MM ⑨

At Handover	Destination	Clear
HH MM ⑩	NAME OF FACILITY/EIRCODE ⑪	HH MM ⑫

CC	CODE 27a	INCIDENT NUMBER 27b	VEHICLE CALL SIGN 27c	PATIENT NO 27d ENTER A,B OR C

Practitioner Attend	Practitioner Support	Other	Station Code
PIN/HSPI ⑮	PIN/HSPI	PIN/HSPI	CODE ⑯

DOA ㉒
Recognition of Death ☐	Cease Resuscitation ☐
Transported ☐	

VOD ㉓
Verification of Death ☐	Time of Death Verified HH MM
Expected Death ☐	Sudden/Unexpected Death ☐
Obvious Dead Body ☐	Verification of Death Record Completed ☐
Control Contacted ☐	

PC ㉔
PC Services At Home ☐	Known advanced progressive and life limiting illness ☐
Medication Directive in place ☐	Specialist PC Team/GP Contacted ☐
Completed PCR Copy left on scene ☐	DNR Order in place ☐

TR ㉕
Treat & Immediate Refer ☐	Treat & Recommend Follow Up<24Hrs ☐
Treat & Refer Self Care With Advice ☐	

NTT ㉖
Transport Declined ☐	Treatment Declined ☐
Stood Down ☐	

Incident Location/Address ⑰   ■ Mark if same as Permanent Address

E I R C O D E

Home ⑱ ☐	Rec. Or Sports Place ☐	Residential Institution ☐
Farm ☐	Street Or Road ☐	Healthcare Facility ☐
Ind. Place Or Premises ☐	Public Building ☐	Other Places ☐

Nature of Assistance Prior to Arrival of Practitioner ⑲

None ☐	CPR* ☐	**REFER OHCA OVERLEAF***
First Aid Response (FAR) ☐	AED* ☐	
Compression Only CPR* ☐	ALS ☐	

Identity of Assistance Prior to Arrival of Practitioner ⑳

Citizen ☐	Fire ☐	Auxiliary/Voluntary ☐	Other ☐
Responder ☐	Garda ☐	Practitioner ☐	

Clinical level ㉑

No Training ☐	FAR/OFA ☐	Paramedic ☐	Doctor ☐
Unknown training ☐	EFR ☐	Adv. Paramedic ☐	Other ☐
BLS/CFR ☐	EMT ☐	Nurse ☐	

Background

All incident information must be entered using both alphabetical and numerical entries as appropriate. Some of the data will be captured by the EMS Control Centre and communicated to the practitioner.

Key Performance Indicators (KPIs) are used to monitor and evaluate critical areas of clinical and support functions that influence patient outcome. The collection and collation of patient data enables the measurement of PHECC KPIs.

1. **DATE OF CALL**

2. **TIME OF CALL**

3. **PASSED**

4. **DISPATCH CLASSIFICATION REFERENCE (DCR)**

5. **MOBILE**

6. **AT SCENE**

7. **AT PATIENT**

8. **DEPART SCENE**

9. **AT DESTINATION**

10. **AT HANDOVER**

11. **DESTINATION**

12. **CLEAR**

13. **PRIORITY RESPONSE**

14. **INTER FACILITY PATIENT TRANSFER**

15. **PRACTITIONER PIN**

16. **STATION**

17. **INCIDENT ADDRESS**

18. **INCIDENT LOCATION**

19. **NATURE OF ASSISTANCE PRIOR TO ARRIVAL OF PRACTITIONER**

20. **IDENTITY OF ASSISTANCE PRIOR TO ARRIVAL OF PRACTITIONER**

21. **CLINICAL LEVEL**

22. **DEAD ON ARRIVAL**

23. **VERIFICATION OF DEATH (VOD)**

24. **PALLIATIVE CARE (PC)**

25. **TREAT & REFER (TR)**

26. **NOT TREATED/NOT TRANSPORTED (NTT)**

27. **PATIENT CARE REPORT UNIQUE IDENTIFIER**
    (a) **Control Centre (CC):**
    (b) **Incident number:**
    (c) **Vehicle call sign:**
    (d) **Patient number:**
    (e) **Barcode number:**

① DATE OF CALL

Specific day, month and year the call is received at EMS Control Centre. (ref: Definitions to support PHECC EMS.
Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

Date Of Call

DD	MM	YYYY

How to enter:

Enter date of day followed by month and year.
For example: 23rd January 2018 as: 23 01 2018.
If numeric is singular it must be preceded by a zero.

② TIME OF CALL

Time recorded at the precise moment the call is received at EMS Control Centre. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

Time Of Call

HH	MM

How to enter:

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

③ PASSED

Time the dispatch details of the call are passed to the first appropriate emergency response. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

Passed

HH	MM

How to enter:

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

4 ## DISPATCH CLASSIFICATION REFERENCE (DCR)

Dispatch Classification advised (ref: Medical Priority Dispatch System).

Dispatch Classification Reference

How to enter:

Enter as number range 1-37 Echo, Delta, Charlie, Bravo, Alpha or Omega; number range 1-9 suffix code.

5 ## MOBILE

Time the first appropriate emergency response is mobile and on way to the scene. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Interfacility Transfer Standard).

Mobile

HH	MM

How to enter:

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

6 ## AT SCENE

Time of arrival of the first appropriate emergency response at scene. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

At Scene

HH	MM

How to enter:

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

7 **AT PATIENT**

Time of arrival of the first appropriate emergency response at the patient. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

At Patient

HH	MM

How to enter:

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

8 **DEPART SCENE**

Time the patient departs the scene to travel to the hospital/destination facility. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

Depart Scene

HH	MM

How to enter:

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

9 **AT DESTINATION**

Time patient arrives at hospital/destination facility. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

At Destination

HH	MM

How to enter:

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

10 AT HANDOVER

Time of completed handover of patient at hospital/destination facility. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

At Handover
HH | MM

How to enter:

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

11 DESTINATION

Hospital destination code. (ref: PHECC hospital/destination facility codes for pre- hospital patient reports/Health Service Provider Identifier (HSPI) assigned to the healthcare organisation.

Destination
NAME OF FACILITY/EIRCODE

How to enter:

Enter name of facility/eircode.

12 CLEAR

Time ambulance/vehicle, crew and equipment available to respond to another incident. (ref: Definitions to support PHECC EMS Priority Dispatch Standard and PHECC Inter Facility Transfer Standard).

Clear
HH | MM

How to enter:

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

* Add SS for electronic records only.

13 PRIORITY RESPONSE

Priority response code advised (ref: Definitions to support PHECC Priority Dispatch Standard).

Priority Response	ECHO	DELTA	CHARLIE	BRAVO	ALPHA	OMEGA

How to enter:

Tick appropriate box - Echo, Delta, Charlie, Bravo, Alpha, Omega.

14 INTER FACILITY PATIENT TRANSFER

Transfer of a patient between facilities (hospitals or local injury units), must be carried out with due regard to patient clinical needs. (ref: current PHECC Inter Facility Patient Transfer Standard).

Inter Facility Patient Transfer		Clinical Escort		Non-Clinical Escort	
YES	NO	YES	NO	YES	NO
If selected		If selected		If selected	
Vehicle Crew Clinical Level		**Clinical Level**		**Non-Clinical Escort Identity**	
☐ AP	☐ P	☐ MP/RN/M		☐ Healthcare assistant	
☐ EMT	☐ FAR			☐ Family member	
				☐ Other	
				☐ Free Text	

How to enter:

Inter facility patient transfer and clinical level - tick box as appropriate.
Hospital Clinical Escort and clinical level - tick box as appropriate.
Non-Clinical Escort - tick box as appropriate.

15 PRACTITIONER PIN

PHECC Personal Identification Number (PIN)/Health Service Provider Identifier (HSPI) assigned to the PHECC practitioner or health professional engaged in the care of the patient.

Practitioner Attend	Practitioner Support	Other
PIN/HSPI	PIN/HSPI	PIN/HSPI

How to enter:

Enter PIN/HSPI of the practitioner who is attending to the care of the patient and the supporting/driving practitioner or other.

16 STATION

Station code allocated by PHECC to the individual pre-hospital emergency care service provider station locations. (Ref: PHECC Station Codes or Eircode as appropriate).

Station Code

CODE

How to enter:

Enter the station code from where the ambulance was dispatched.

17 INCIDENT ADDRESS

Address to where the first appropriate response is dispatched in response to a phone call to EMS Control Centre.

Incident Location/Address	☐ Mark if same as Permanent Address
	E I R C O D E

How to enter:

Tick box if address is same as permanent address as it is recorded in patient information or enter incident address free text.

18 TYPE OF INCIDENT LOCATION

Place of occurrence of incident is classified under International Classification of Diseases, Australian Modification, Tenth Revision (ICD-10-AM Codes), External causes of morbidity and mortality. (u50-y98). Coded in combination with event and mechanism of injury.

☐ Home	☐ Rec. Or Sports Place	☐ Residential Institution
☐ Farm	☐ Street Or Road	☐ Healthcare Facility
☐ Ind. Place Or Premises	☐ Public Building	☐ Other Places

How to enter:

Tick box as appropriate.

19 NATURE OF ASSISTANCE PRIOR TO ARRIVAL OF PRACTITIONER

Type of assistance given prior to arrival of EMS practitioner.

Nature of Assistance Prior to Arrival of Practitioner		
☐ None	☐ CPR*	**REFER OHCA OVERLEAF***
☐ First Aid Response (FAR)	☐ AED*	
☐ Compression Only CPR*	☐ ALS	

How to enter:

Tick box as appropriate.

20 IDENTITY OF ASSISTANCE PRIOR TO ARRIVAL OF PRACTITIONER

Identity of individual providing assistance prior to arrival of EMS practitioner.

Identity of Assistance Prior to Arrival of Practitioner			
☐ Citizen	☐ Fire	☐ Auxiliary/Voluntary	☐ Other
☐ Responder	☐ Garda	☐ Practitioner	

How to enter:

Tick box as appropriate.

21 CLINICAL LEVEL

Clinical level of individual providing assistance prior to arrival of EMS practitioner.

Clinical level			
☐ No Training	☐ FAR/OFA	☐ Paramedic	☐ Doctor
☐ Unknown training	☐ EFR	☐ Adv. Paramedic	☐ Other
☐ BLS/CFR	☐ EMT	☐ Nurse	

How to enter:

Tick box as appropriate.

22 DEAD ON ARRIVAL (DOA)

Ref: Current edition CPGs.
Recognition of death - practitioner recognises death.
Cease resuscitation - practitioner ceases resuscitation.
Transported - patient is transported.

DOA	Recognition of Death	☐	Cease Resuscitation	☐
	Transported	☐		

How to enter:

Tick box as appropriate.

23 VERIFICATION OF DEATH (VOD)

The decision taken by a PHECC registered Paramedic or Advanced Paramedic, in the pre-hospital environment, that a person has died, and life is extinct and the documentation of this decision.

VOD	Verification of Death	☐	Time of Death Verified	HH	MM
	Expected Death	☐	Sudden/Unexpected Death		☐
	Obvious Dead Body	☐	Verification of Death Record Completed		☐
	Control Contacted	☐			

How to enter:

Tick box as appropriate.

Enter time of death verified as 24 hour time entry HH:MM:SS*

24 PALLIATIVE CARE (PC)

Palliative care services for patients with a known advanced and life-limiting illness who are currently receiving palliative care services at home.

PC	PC Services At Home	☐	Known advanced progressive and life limiting illness	☐
	Medication Directive in place	☐	Specialist PC Team/GP Contacted	☐
	Completed PCR Copy left on scene	☐	DNR Order in place	☐

How to enter:

Tick box as appropriate.

25 · TREAT & REFER (TR)

Treat and immediate referral for follow up care.

Treat and recommend for follow up care within 24 hours.

Treat and refer for self-care with advice (ref: Current edition CPGs).

TR	Treat & Immediate Refer ☐	Treat & Recommend Follow Up<24Hrs ☐
	Treat & Refer Self Care With Advice ☐	

How to enter:

Tick box as appropriate.

26 · NOT TREATED/NOT TRANSPORTED (NTT)

Transport declined by patient.

Treatment declined by patient.

Crew stood down by Licensed CPG Provider.

NTT	Transport Declined ☐	Treatment Declined ☐
	Stood Down ☐	

How to enter:

Tick box as appropriate.

27 · PATIENT CARE REPORT UNIQUE IDENTIFIER

This is the current unique identifier for the patient and the report.

Unique identifier comprises of 4 separate elements which creates one unique number.

(a)   Control Centre (CC):

Licensed CPG Provider Control Centre Code (ref: PHECC Control Centre and Station Codes for pre-hospital reports).

CC CODE

How to enter:

Enter Control Centre code.

(b)   Incident number:

Sequential number generated for the incident by the Licensed CPG Provider (ref: PHECC Control Centre and station codes for pre-hospital reports).

INCIDENT NUMBER

How to enter:

Enter incident number generated by CC.

(c)   Vehicle call sign:

This is the call sign or number allocated to specific vehicles within the Licensed CPG Providers. (ref: PHECC Control Centre and Station codes for pre-hospital reports).

VEHICLE CALL SIGN

How to enter:

Enter the call sign number allocated to specific vehicle/unit.

(d)   Patient number:

The patient number indicates first, second or third patient, A, B or C in a possible multiple person incident travelling in the same ambulance. (ref: PHECC Control Centre and Station codes for pre-hospital reports).

PATIENT NO
ENTER A,B OR C

How to enter:

Enter A, B or C.

(e)   Barcode number:

Specific pre-printed barcode. Barcode number may be used in the absence of the Incident number.

ZZ1234567

How to enter:

Enter Barcode number in the absence of the incident number.

SECTION C

**Guide for Completion
Patient Information**

6.2 PATIENT INFORMATION

Health professionals spend a significant amount of time handling patient information from a variety of sources.

Therefore it is important that the patient is identified correctly encouraging efficient communication between healthcare professionals, particularly on handover of the patient record to the destination hospital.

1. **TITLE**
2. **INDIVIDUAL HEALTH IDENTIFIER**
3. **SURNAME**
4. **FORENAME**
5. **PERMANENT ADDRESS**
6. **EIRCODE**
7. **DATE OF BIRTH**
8. **AGE**
9. **PAEDIATRIC WEIGHT**
10. **GENDER**
11. **GENERAL PRACTITIONER (GP)**
12. **NEXT OF KIN**
13. **TELEPHONE NUMBER OF NEXT OF KIN**

Background

All patient demographic details should be entered as both alphabetical and numerical as required.

This information enables the healthcare team address the patient by name and ensures that the details of care and treatment provided are recorded on the correct record.

1   TITLE

Title

Mr | Mrs | Ms | Other

How to enter:

A prefix added to a name.

Tick Mr/Mrs/Ms/Other as appropriate.

2   INDIVIDUAL HEALTH IDENTIFIER (IHI)

Individual Health Identifier

How to enter:

Enter unique, non-transferable number assigned to all individuals using health and social care services.

3   SURNAME

Surname

SURNAME

How to enter:

Enter the family name, surname, last name or marital name.

4   FORENAME

Forename

FORENAME

How to enter:

Enter the given name, first name or forename.

5   PERMANENT ADDRESS

Permanent Address

How to enter:

Enter location of patient's permanent residence.

6 EIRCODE

```
E  I  R  C  O  D  E
```

How to enter:

Enter location code comprising of routing key and unique identifier.

7 DATE OF BIRTH

DOB

```
DD  MM  YYYY
```

How to enter:

Enter specific day, month and year the patient was born.

For example: 23rd January 2018 as: 23 01 2018.

If numeric is singular it must be preceded by a zero.

8 AGE

Age

```
AGE
```

How to enter:

Enter age of patient recorded in days, weeks, months or years as appropriate.

For example: 2/52 for a 2 week old infant, or 8/12 for an 8 month old or 22 for a 22 year old.

If entering an estimated age indicate by the addition of (approx.).

If unknown record 'U'.

9 PAEDIATRIC WEIGHT

Paed WT

```
Paed WT
```

How to enter:

Enter paediatric weight expressed in kilograms.

⑩ GENDER

Gender

| M | F |

How to enter:

Enter classification of sex of patient. Tick M/F as appropriate.

⑪ GENERAL PRACTITIONER (GP)

GP

NAME/MCRN

How to enter:

Enter name of patient's general practitioner who can be contacted if necessary.

If unknown record 'U'.

⑫ NEXT OF KIN

Next Of Kin

NAME

How to enter:

Enter name of patient's next of kin/nearest relative/guardian who can be contacted if necessary.

If unknown record 'U'.

⑬ TELEPHONE NUMBER OF NEXT OF KIN

NOK Telephone

TELEPHONE

How to enter:

Enter phone number of patient's next of kin.

If unknown record 'U'.

SECTION C

Guide for Completion
Clinical Information

6.3   CLINICAL INFORMATION

All clinical data must be captured and recorded accurately and as close to real time as possible. However in cases of major trauma or immediate clinical care, information may be entered as soon as is practically possible.

Clinical Information

Patient's Chief Complaint	Time Of Onset	Date Of Onset
1	HH MM	DD MM YY

Primary Survey **2**

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 ☐ P Pain
	☐ B Burn ☐ R Rash
	☐ C Contusion ☐ S Swelling
	☐ D Dislocation ☐ N Numbness
	☐ # Fracture ☐ W Wound
	%BURN **CSM**
	% BURN RA RL LA LL

Clinical Impression **3**

Cardiac	Seizures	Smoke Inhalation	Spinal Injury
☐Cardiac Arrest	☐Stroke	☐Other Respiratory	☐Other Trauma
☐Cardiac Arrhythmia	☐Other Neurological	**Sepsis**	**General**
☐Cardiac Chest Pain	**Obs/Gynae**	☐Sepsis	☐Abdominal Pain
☐Heart Failure	☐Haemorrhage<24 Wks	☐Severe/Septic Shock	☐Acute Intoxication
☐STEMI	☐Haemorrhage>24 Wks	**Trauma**	☐Allergic Reaction
☐Other Cardiac	☐Labour	☐Burns	☐Behavioural Disorder
Medical	☐PPH	☐Dislocation / Sprain	☐Illness Unknown
☐Back Pain	☐Pre-hospital Delivery	☐Fracture	☐Nausea / Vomiting
☐Diabetes Mellitus	☐Other Obs/Gynae	☐Haemorrhage	☐Poisoning
☐Fever	**Respiratory**	☐Head Injury	☐Syncope/Collapse
☐Headache	☐Asthma	☐Maxillo-facial injury	☐Other General
☐Hypothermia	☐COPD	☐Multiple Trauma	
☐Other Medical	☐FBAO	☐Open Wound	
Neurological	☐Respiratory Arrest	☐Shock	
☐Altered LOC	☐Respiratory Distress	☐Soft Tissue Injury	

Clinical Information

Patient's Medical Observations

A	**ALLERGIES** ☐ NKA ☐ Unknown
	4

M	**MEDICATIONS** ☐ None ☐ Unknown ☐ As Supplied ☐ Per Dr's Letter
	5

P	**PAST MEDICAL HISTORY** ☐ None ☐ Unknown ☐ Per Dr's Letter ☐ Per Relative
	6

The critial elements which need to be recorded are:

Patient's Chief Complaint, Time of Onset, Primary Survey, Clinical Impression, AMPLE Survey, Mechanism of Injury and Circumstances.

L	**LAST INTAKE** ❼	DESCRIBE	HH	MM
	☐ Unknown			

E	**EVENT** ❽

Mechanism Of Injury

☐ Assault		☐ RTA Motorbike	
☐ Attack/Bite By Animal/Insect		☐ RTA Pedestrian	
☐ Chemical Poisoning		☐ RTA Vehicle	
☐ Electrocution		☐ Smoke, Fire And Flames	
☐ Excessive Cold		☐ Submersion	
☐ Excessive Heat		☐ Stabbing	
☐ Fall		☐ Water Transport Accident	
☐ Firearm Injury		☐ Other	
☐ Injury To Child		**Circumstances** ❾	
☐ Machinery Accidents		☐ Accident	
☐ MVA Off Road		☐ Event Of Undetermined Intent	
☐ RTA Bicycle		☐ Intentional Self Harm	

L ❿

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

⓫ **CS**	Life Threatening	☐	Non Serious Or Non Life Threat.	☐
	Serious Not Life Threatening	☐		

1. **PATIENT'S CHIEF COMPLAINT**

2. **PRIMARY SURVEY**

3. **CLINICAL IMPRESSION**

4. **ALLERGIES**

5. **MEDICATIONS**

6. **PAST MEDICAL HISTORY**

7. **LAST INTAKE**

8. **EVENT AND MECHANISM OF INJURY**

9. **CIRCUMSTANCES OF INJURY**

10. **VEHICLE DETAILS**

11. **CLINICAL STATUS**

① PATIENT'S CHIEF COMPLAINT

The patient's presenting complaint which is the reason pre-hospital emergency care is being sought.

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

Patient's Chief Complaint	Time Of Onset	Date Of Onset
	HH MM	DD MM YY

How to enter:

Enter patient's complaint, time and date of onset/occurrence.

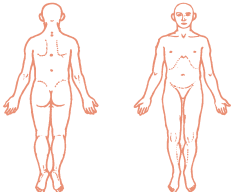Enter time as 24 hour time entry HH:MM.

Enter date of day followed by month and year.

If numeric is singular it must be preceded by a zero.

If unknown record 'U'.

② PRIMARY SURVEY

Initial rapid assessment of airway, C Spine, breathing, circulation and level of consciousness to determine if any life-threatening condition exists. This information should be entered in real time.

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 ☐ P Pain
	☐ B Burn ☐ R Rash
	☐ C Contusion ☐ S Swelling
	☐ D Dislocation ☐ N Numbness
	☐ # Fracture ☐ W Wound
	%BURN CSM
	% BURN RA RL LA LL

How to enter:

Tick appropriate box as outlined below:

A	**Airway**	Tick box as appropriate
C	**C spine**	Tick box as appropriate
B	**Breathing**	Tick box as appropriate
C	**Circulation**	Tick box as appropriate
	Pulse:	Tick box as appropriate and indicate Rate
	Haemorrhage	Tick box as appropriate
	Skin	Tick box as appropriate
	Cap-Refill	Tick box as appropriate
D	**Disability**	Loss of consciousness before arrival and tick as appropriate
	AVPU	Indicate an AVPU level to determine responsiveness of patient
E	**Expose**	Tick box as appropriate
		Include % Burns based on Wallace Rule of Nines if appropriate
	CSM	Tick box as appropriate RA/RL/LA/LL
		Shade or mark the diagram and place the appropriate letter beside the site of injuries, e.g. **P Pain**

3 CLINICAL IMPRESSION

An early clinical impression of what is the presenting illness/injury based on the combination of information available following primary survey (ref: ICD 10 AM).

Clinical Impression			
Cardiac	☐ Seizures	☐ Smoke Inhalation	☐ Spinal Injury
☐ Cardiac Arrest	☐ Stroke	☐ Other Respiratory	☐ Other Trauma
☐ Cardiac Arrhythmia	☐ Other Neurological	**Sepsis**	**General**
☐ Cardiac Chest Pain	**Obs/Gynae**	☐ Sepsis	☐ Abdominal Pain
☐ Heart Failure	☐ Haemorrhage<24 Wks	☐ Severe/Septic Shock	☐ Acute Intoxication
☐ STEMI	☐ Haemorrhage>24 Wks	**Trauma**	☐ Allergic Reaction
☐ Other Cardiac	☐ Labour	☐ Burns	☐ Behavioural Disorder
Medical	☐ PPH	☐ Dislocation / Sprain	☐ Illness Unknown
☐ Back Pain	☐ Pre-hospital Delivery	☐ Fracture	☐ Nausea / Vomiting
☐ Diabetes Mellitus	☐ Other Obs/Gynae	☐ Haemorrhage	☐ Poisoning
☐ Fever	**Respiratory**	☐ Head Injury	☐ Syncope / Collapse
☐ Headache	☐ Asthma	☐ Maxillo-facial injury	☐ Other General
☐ Hypothermia	☐ COPD	☐ Multiple Trauma	
☐ Other Medical	☐ FBAO	☐ Open Wound	
Neurological	☐ Respiratory Arrest	☐ Shock	
☐ Altered LOC	☐ Respiratory Distress	☐ Soft Tissue Injury	

How to enter:

Enter your clinical impression by ticking appropriate box in appropriate section and expand Clinical Impression in free text if appropriate. It is imperative that a clinical impression based on the history taken from the patient and your best clinical judgement is recorded.

Additional information:

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

4   ALLERGIES

Reported known drug and agent allergies if known.

Patient's Medical Observations	
A	**ALLERGIES** ☐ NKA ☐ Unknown

How to enter:

Tick box as appropriate and list allergies if known.

Additional information:

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

5   MEDICATIONS

Record of medications taken regularly if known or as recorded.

M	**MEDICATIONS** ☐ None ☐ Unknown ☐ As Supplied ☐ Per Dr's Letter

How to enter:

Tick box as appropriate or list drugs as seen or recounted by patient.

Record "As Supplied" for medications collected and brought to the hospital/ destination facility.

Record as "Per Dr's Letter" if one is available.

Additional information:

Compliance with medication should be ascertained. It could have an impact on chief complaint if the routine tablets have not been taken e.g. daily warfarin, or

insulin dependent diabetics who have skipped a meal etc.

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

6 PAST MEDICAL HISTORY

Past medical history reported by patient or relative if present or known.

P	**PAST MEDICAL HISTORY** ☐None ☐Unknown ☐Per Dr's Letter ☐ Per Relative

How to enter:

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

Additional information:

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

7 LAST INTAKE

Description and time of last food or drink consumed.

L	**LAST INTAKE** ☐ Unknown	DESCRIBE	HH MM

How to enter:

Enter time as 24 hr clock entry HH:MM.
Free text description of food or drink.
Tick Unknown if information not available.

Additional information:

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

8 EVENT AND MECHANISM OF INJURY

Description of Event:

Identify the activity of the patient at the time the incident occurred. (ref: ICD 10 AM, External causes of morbidity and mortality (u50-y98)). Event is coded in combination with place of occurrence and mechanism of injury.

E	**EVENT**

How to enter:

Enter free text description of event which occurred, as assessed by practitioner, or recounted by patient or observer.

Additional information:

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

Description of Mechanism of Injury:

Mechanism by which injury occurred. (ref: ICD 10 AM, External causes of morbidity and mortality (u50-y98)). Coded in combination with place of occurrence and event.

Mechanism Of Injury		
☐ Assault	☐ RTA Motorbike	
☐ Attack/Bite By Animal/Insect	☐ RTA Pedestrian	
☐ Chemical Poisoning	☐ RTA Vehicle	
☐ Electrocution	☐ Smoke, Fire And Flames	
☐ Excessive Cold	☐ Submersion	
☐ Excessive Heat	☐ Stabbing	
☐ Fall	☐ Water Transport Accident	
☐ Firearm Injury	☐ Other	
☐ Injury To Child		
☐ Machinery Accidents		
☐ MVA Off Road		
☐ RTA Bicycle		

ZZ1234567

How to enter:

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

If RTA has occurred, use the diagram to describe the impact on the vehicle and the occupant(s).

Additional information:

Recording the external causes of trauma permits an audit of factors that precipitate trauma. This may contribute to accident prevention and in accident kinematics.

* See Incident Information

9 CIRCUMSTANCES OF INJURY

Assessment of circumstances of incident. (ref: ICD 10 AM, External causes of morbidity and mortality (u50-y98)). Coded in combination with place of occurrence and activity.

Circumstances
☐ Accident
☐ Event Of Undetermined Intent
☐ Intentional Self Harm

How to enter:

Tick appropriate box as outlined below:
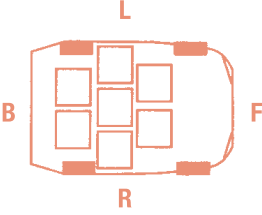
•   If following assessment of scene and patient it appears that the event was accidental, tick 'Accident'

•   If following assessment of scene and patient the intent of the event cannot be determined, tick 'Event of Undetermined Intent'

•   If following assessment of scene and patient it appears that the patient intended to self harm, tick 'Intentional Self Harm'

Additional information:

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

10 VEHICLE DETAILS

Vehicle details following car crash.

How to enter:

Tick appropriate box and record as appropriate on diagram.

11 CLINICAL STATUS

A clinical status decision following assessment by the practitioner where life is at risk in the immediate timeframe or a critical timeframe, or where there is a serious but not life threatening risk to patient, or where the risk to life is not serious or not life threatening.

CS	Life Threatening		Non Serious Or Non Life Threat.	
	Serious Not Life Threatening			

How to enter:

Tick appropriate box.

SECTION C

Guide for Completion
Vital Observations

6.4 VITAL OBSERVATIONS

Vital Observation

Observation Times [1]	TIME 1	TIME 2	TIME 3	TIME 4
	HH MM	HH MM	HH MM	HH MM
Pulse Rate & Rhythm [2] (R) Regular (I) Irregular	RATE	RATE	RATE	RATE
ECG Rate [3]	RATE	RATE	RATE	RATE
ECG Rhythm [4]	RHYTHM	RHYTHM	RHYTHM	RHYTHM
Respiratory Rate [5]	RATE	RATE	RATE	RATE
Respiratory Quality [6] ❶ Normal ❷ Laboured ❸ Shallow ❹ Wheeze ❺ Rales ❻ Retract ❼ Absent	LEFT RIGHT	LEFT RIGHT	LEFT RIGHT	LEFT RIGHT
Peak Expiratory Flow Rate [7]	RATE	RATE	RATE	RATE
% SpO_2 [8]	% SpO_2	% SpO_2	% SpO_2	% SpO_2
% $ETCO_2$ [9]	% $ETCO_2$	% $ETCO_2$	% $ETCO_2$	% $ETCO_2$
CAP Refill [10]	REFILL	REFILL	REFILL	REFILL
Blood Pressure [11] — Systolic	SYS	SYS	SYS	SYS
Diastolic	DIA	DIA	DIA	DIA
Temperature ºC [12]	ºC	ºC	ºC	ºC
National Early Warning Score [13]	SCORE	SCORE	SCORE	SCORE
PUPILS [14] Size: See Chart Overleaf Reaction: (+) Reacts (-) No (c) Eyes Closed — L	SIZE REACTION	SIZE REACTION	SIZE REACTION	SIZE REACTION
R	SIZE REACTION	SIZE REACTION	SIZE REACTION	SIZE REACTION
Glasgow Coma Scale (GCS) — Eye Opening ❹ Spontaneous ❸ To sound ❷ To pressure ❶ None Non testable NT	EYE OPENING	EYE OPENING	EYE OPENING	EYE OPENING
Verbal Reponse ❺ Orientated ❹ Confused ❸ Words ❷ Sounds ❶ None Not Testable NT [15]	VERBAL	VERBAL	VERBAL	VERBAL
Motor Response ❻ Obey commands ❺ Localising ❹ Normal flexion ❸ Abnormal flexion ❷ Extension ❶ None Not Testable NT	MOTOR	MOTOR	MOTOR	MOTOR
Total GCS [16]	TOTAL	TOTAL	TOTAL	TOTAL
Revised Trauma Score (RTS) [17]	SCORE	SCORE	SCORE	SCORE
Pain Score 0 to 10 [18]	PAIN	PAIN	PAIN	PAIN
Blood Glucose Level mmol/L [19]	GLUCOSE	GLUCOSE	GLUCOSE	GLUCOSE

FAST Assessment

F	Yes ☐ No ☐	A	Yes ☐ No ☐	S	Yes ☐ No ☐	T	HH MM

Background

A record of the vital signs and physical assessment of the patient gives the practitioner a baseline evaluation of the condition of the patient and will highlight deterioration and or improvement in response to care delivered.

How to enter:

Record observations numerically as they are carried out on patient.

Additional information:

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

1. OBSERVATION TIMES

2. PULSE RATE AND RHYTHM

3. ECG RATE

4. ECG RHYTHM

5. RESPIRATORY RATE

6. RESPIRATORY QUALITY

7. PEAK EXPIRATORY FLOW RATE

8. % SpO$_2$

9. % ETCO$_2$

10. CAP REFILL

11. BLOOD PRESSURE

12. TEMPERATURE °C

13. NATIONAL EARLY WARNING SCORE

14. PUPILS

15. GLASGOW COMA SCALE (GCS)

16. REVISED TRAUMA SCORE (RTS)

17. PAIN SCORE (0-10)

18. BLOOD GLUCOSE LEVEL mmol/L

19. FAST Assessment

① OBSERVATION TIMES

Observation Times	TIME 1		TIME 2		TIME 3		TIME 4	
	HH	MM	HH	MM	HH	MM	HH	MM

How to enter

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

② PULSE RATE AND RHYTHM

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

How to enter

Enter the pulse rate per minute and comment on whether the pulse is regular-R or irregular-I.
If unable to palpate, record '0'.

③ ECG RATE

ECG Rate	RATE	RATE	RATE	RATE

How to enter

Enter the ECG rate as displayed on the cardiac monitor.

④ ECG RHYTHM

ECG Rhythm	RHYTHM	RHYTHM	RHYTHM	RHYTHM

How to enter

Enter the heart rhythm as interpreted.

5 RESPIRATORY RATE

Respiratory Rate	RATE	RATE	RATE	RATE

How to enter

Enter the respiratory rate per minute.

6 RESPIRATORY QUALITY

Respiratory Quality ❶ Normal ❷ Laboured ❸ Shallow ❹ Wheeze ❺ Rales ❻ Retract ❼ Absent	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

How to enter

Indicate the respiratory quality in both lungs by inserting the appropriate numeral.

7 PEAK EXPIRATORY FLOW RATE

Peak Expiratory Flow Rate	RATE	RATE	RATE	RATE

How to enter

Enter rate as appropriate.

8 % SpO$_2$

% SpO$_2$	% SpO$_2$	% SpO$_2$	% SpO$_2$	% SpO$_2$

How to enter

Where available enter figure displayed on monitor.

9 % ETCO$_2$

% ETCO$_2$	% ETCO$_2$	% ETCO$_2$	% ETCO$_2$	% ETCO$_2$

How to enter

Where available enter figure displayed on monitor.

🔟 CAP REFILL

CAP Refill	REFILL	REFILL	REFILL	REFILL

How to enter

Enter as appropriate < 2 sec or > 2 sec.

1️⃣1️⃣ BLOOD PRESSURE

Blood Pressure	Systolic	SYS	SYS	SYS	SYS
	Diastolic	DIA	DIA	DIA	DIA

How to enter

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

1️⃣2️⃣ TEMPERATURE °C

Temperature ºC	ºC	ºC	ºC	ºC

How to enter

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

1️⃣3️⃣ NATIONAL EARLY WARNING SCORE

National Early Warning Score	SCORE	SCORE	SCORE	SCORE

How to enter

Enter early warning scoring using defined parameters which indicate deterioration in acute patients (ref: current PHECC CPGs).

14 PUPILS

Clinical indicators of patient current health status.

PUPILS									
Size: See Chart Overleaf	**L**	SIZE	REACTION	SIZE	REACTION	SIZE	REACTION	SIZE	REACTION
Reaction: (+) Reacts (-) No (c) Eyes Closed	**R**	SIZE	REACTION	SIZE	REACTION	SIZE	REACTION	SIZE	REACTION

How to enter

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

Pupil Size Chart

1 • 2 • 3 ● 4 ● 5 ● 6 ● 7 ● 8 ●

15 GLASGOW COMA SCALE (GCS)

Clinical indicators of patient current health status.

Glasgow Coma Scale (GCS)				
Eye Opening ❹ Spontaneous ❸ To sound ❷ To pressure ❶ None Non testable NT	EYE OPENING	EYE OPENING	EYE OPENING	EYE OPENING
Verbal Reponse ❺ Orientated ❹ Confused ❸ Words ❷ Sounds ❶ None Not Testable NT	VERBAL	VERBAL	VERBAL	VERBAL
Motor Response ❻ Obey commands ❺ Localising ❹ Normal flexion ❸ Abnormal flexion ❷ Extension ❶ None Not Testable NT	MOTOR	MOTOR	MOTOR	MOTOR
Total GCS	TOTAL	TOTAL	TOTAL	TOTAL

How to enter

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

16 REVISED TRAUMA SCORE (RTS)

Revised Trauma Score (RTS)	SCORE	SCORE	SCORE	SCORE

How to enter

Enter injury severity score estimating the degree of injury and prognosis of a trauma patient (ref: current PHECC CPGs).

17 PAIN SCORE (0-10)

Pain Score 0 to 10	PAIN	PAIN	PAIN	PAIN

How to enter

Enter the pain score of the patient's pain intensity as reported by them, where 0 = no pain and 10 = the worst pain ever experienced by the patient.

18 BLOOD GLUCOSE LEVEL mmol/L

Blood Glucose Level mmol/L	GLUCOSE	GLUCOSE	GLUCOSE	GLUCOSE

How to enter

Enter the numeric value in mmol/L as recorded by glucometer.

N.B. Any other relevant observations not captured here should be recorded in the **Additional Information** section of the Report.

19 FAST Assessment

Rapid assessment tool to assist in the early recognition of stroke (CVA).

F	Yes ☐ No ☐	A	Yes ☐ No ☐	S	Yes ☐ No ☐	T	HH	MM

How to enter

Tick box as appropriate.

Enter time as 24 hour time entry HH:MM. Time is time of assessment carried out. If numeric is singular it must be preceded by a zero.

SECTION C

**Guide for Completion
Care Management**

6.5 CARE MANAGEMENT

Care Management

Airway / Breathing					
☐ Basic Airway Management	PIN		☐ Haemostatic Dressing	PIN	
☐ BVM	PIN		☐ Wound Closure	PIN	
☐ CPAP Therapy	PIN		☐ Other	PIN	
☐ Cricothyroidotomy	PIN		**Motion Restriction**		
☐ FB Clearance Magill Forceps	PIN		☐ Canvas Sheet	PIN	
☐ Intubation	PIN		☐ Cervical Collar	PIN	
☐ Needle Thoracocentesis	PIN		☐ Vacuum Mattress	PIN	
☐ O₂ Therapy	PIN		☐ Long Board	PIN	
☐ Pocket Mask	PIN		☐ Split Stretcher	PIN	
☐ Supraglottic Airway	PIN		☐ Rapid Extrication	PIN	
Cardiac Support			☐ Splint	PIN	
☐ 12 Lead ECG	PIN		☐ Spinal Injury Decision	PIN	
☐ REFER OHCA OVERLEAF	PIN		☐ Sepsis Bundle	PIN	
PCI Centre Contacted	YES	NO	**Miscellaneous**		
	PIN		☐ Active Rewarming	PIN	
Cardiologist	MCRN		☐ Burns Dressing	PIN	
Accepted YES Declined YES			☐ Other Dressing	PIN	
Circulation Support			☐ Positioning	PIN	
☐ Intravenous Cannula	PIN		☐ Taser Gun Barb	PIN	
☐ Intraosseous Cannula	PIN		☐ Urinary Catheterisation	PIN	
Haemorrhage Control			☐ Other	PIN/MCRN	
☐ Direct Pressure	PIN				
☐ Pressure Points	PIN				
☐ Tourniquet Use	PIN				

How to enter:

Tick as appropriate each item of care management intervention and record PIN of administering practitioner.

Additional information:

Accurate clinical record keeping of care provided has a positive influence on the continuum of care for patients. This facilitates assessment of care management, the use of equipment and PHECC Clinical Practice Guidelines appropriate to presenting condition (Chief Complaint) and Clinical Impression. It will also provide evidence for upskilling requirements.

SECTION C

**Guide for Completion
Medication Treatment**

6.6 MEDICATION TREATMENT

Medication Treatment		
Time (24H)	**Medication Treatment**	
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI
HH MM	MEDICATION	
	DOSE	ROUTE	PIN/HSPI

Background:

All medications administered must be recorded and signed for by the practitioner. This reflects best practice and is also a legal requirement. It permits assessment of medication treatment provided, appropriate to presenting condition.

Time medication administered, medication name, dose of medication administered, route of administered medication, and PIN/HSPI of practitioner who administered the medication.

How to enter:

- Record time medication administered; HH:MM.

- Record name of medication administered; medications available to pre-hospital practitioners as per current edition of PHECC CPGs.

- Enter dose of medication administered; unit of measurement of administered medication.

- Enter route of administered medication.

- Enter PIN/HSPI of the practitioner who administered the medication; PHECC Personal Identification Number (PIN)/Health Service Provider Identifier (HSPI) assigned to the PHECC practitioner or health professional engaged in the care of the patient.

SECTION C

**Guide for Completion
Continuity Of Care**

6.7 CONTINUITY OF CARE

Continuity Of Care				
Assuming clinical lead	❶ ☐	PIN/MCRN	HH	MM
Reliquinshing clinical lead	❷ ☐	PIN/MCRN	HH	MM
Medical support received	❸ ☐	PIN/MCRN	HH	MM
Pre-alert to destination facility	❹ ☐	PIN/MCRN	HH	MM
Practitioner	PIN/HSPI	HH	MM ❺	☐ Receiving Handover
Practitioner	PIN/HSPI	HH	MM ❻	☐ Intervention

1. **ASSUMING CLINICAL LEAD**

2. **RELINQUISHING CLINICAL LEAD**

3. **MEDICAL SUPPORT RECEIVED**

4. **PRE-ALERT TO DESTINATION FACILITY**

5. **HANDOVER**

6. **INTERVENTION**

❶ **ASSUMING CLINICAL LEAD**

Record if clinical lead handed over/not handed over to a person of a higher clinical level.

Assuming clinical lead	☐	PIN/MCRN	HH	MM

How to enter:

Tick box as appropriate.

Enter PHECC Personal Identification Number (PIN)/Medical Council Registered Number (MCRN).

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

② RELINQUISHING CLINICAL LEAD

Record if clinical lead handed over/not handed over to a person of a higher clinical level.

| Reliquinshing clinical lead | ☐ | PIN/MCRN | HH | MM |

How to enter:

Tick box as appropriate.
Enter PHECC Personal Identification Number (PIN)/Medical Council Registered Number (MCRN).
Enter the time using the 24-hour clock entry HH:MM.

③ MEDICAL SUPPORT RECEIVED

Record of medical support received.

| Medical support received | ☐ | PIN/MCRN | HH | MM |

How to enter:

Tick box as appropriate.

Enter PHECC Personal Identification Number (PIN)/Medical Council Registered Number (MCRN).

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

④ PRE-ALERT TO DESTINATION FACILITY

Record of destination facility pre-alerted.

| Pre-alert to destination facility | ☐ | PIN/MCRN | HH | MM |

How to enter:

Tick box as appropriate.

Enter PHECC Personal Identification Number (PIN)/Medical Council Registered Number (MCRN).

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

5 HANDOVER

The top copy of the completed Patient Care Report must be handed over, with the patient, to the healthcare professional at the destination facility in order to facilitate a continuum of patient care by communicating clear accurate data to the receiving healthcare team.

Record if patient handover received by a practitioner who is not the principal care giver, time and PIN. Record care administered in care management and PIN.

Practitioner PIN/HSPI HH MM ☐ Receiving Handover

How to enter:

Tick box as appropriate

Enter PHECC Personal Identification Number (PIN)/Health Service Provider Identifier (HSPI).

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

6 INTERVENTION

Record if care administered by a practitioner who is not the principal care giver, time and PIN. Record care administered in care management and PIN.

Practitioner PIN/HSPI HH MM ☐ Intervention

How to enter:

Tick box as appropriate.

Enter PHECC Personal Identification Number (PIN)/Health Service Provider Identifier (HSPI).

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

ADDITIONAL INFORMATION

Clinical
Other
Record free text as required.

Additional Information
CLINICAL
OTHER

CLINICAL AUDIT

1. Clinical audit

Tick box if the patient incident requires systematic review.

2. Receiving staff signature/HSPI

Enter receiving staff signature/Health Service Provider Identifier (HSPI) of person receiving patient.

CA		RECEIVING STAFF SIGNATURE/HSPI

Guide for Completion
Declined Treatment and/or Transport

6.8 DECLINED TREATMENT AND/OR TRANSPORT

Declined Treatment and/or Transport

Practitioner aid to determine patient "decision making capacity"

A person lacks of capacity to make a decision if he or she is unable to:

- Understand the information relevant to the decision ☐ YES ☐ NO
- Retain the information long enough to make a voluntary choice ☐ YES ☐ NO
- Use or weigh that information as part of the process of making the decision, or ☐ YES ☐ NO
- Communicate decision by any means (including sign language/assistive technology) or if the implementation of the decision requires the act of a third party ☐ YES ☐ NO

I/We witness that the patient has declined treatment/transport to the Emergency Department.

I/We have advised the patient to consult with his/her own doctor as soon as possible or should his/her condition deterioate to call 999/112 for emergency medical assistance.

PIN/HSPI (1) [   ]

PIN/HSPI (2) [   ]

Report to the EMS Control Centre ☐ YES ☐ NO

Additional Information

Background:

In the event of the emergency vehicle being called to a scene and the injured party refusing treatment and/or transport this section must be completed by two practitioners where possible. It is also possible to report the event to the Communications Centre in the absence of a second PIN/HSPI.

How to enter:

Tick appropriate box.

Enter the PIN/HSPI of the practitioner who attended the patient.

Practitioner aid to determine patient decision making capacity to reject treatment and/or transport and to make an alternative care plan.

Additional information:

It is important the practitioner is aware of the number of calls the service receives in which treatment or transport was refused by the patient.

When assessing a patient's capacity to refuse, the practitioner must consider factors which may reduce capacity including shock or severe pain.

SECTION C

Guide for Completion
Out-Of-Hospital Cardiac Arrest

6.9 OUT-OF-HOSPITAL CARDIAC ARREST

Out-of-Hospital Cardiac Arrest

Chest Pain ①

Yes ☐ No ☐ Unknown ☐ **Time of Chest Pain** HH MM

Collapse ②

Yes ☐ No ☐ **Time of Collapse** HH MM

Category of person who witnessed collapse ③

Citizen	Not dispatched by ambulance control
Responder on duty	Dispatched by ambulance control
Responder other	Not dispatched by ambulance control
Responder auxiliary/voluntary service	On duty at or near the scene
Practitioner	Dispatched by ambulance control
Doctor or off-duty practitioner	Not dispatched by ambulance control
Doctor or off-duty practitioner	Dispatched by ambulance control
Nurse	
Fire	
Garda	

Chest Compressions ④

Yes ☐ No ☐— IF NO ADD REASON NOT COMMENCED

Time chest compressions commenced   HH MM   Dispatcher aided Yes ☐ No ☐

Total duration of chest compressions   HH MM

Mechanical cardiopulmonary device was used   Yes ☐   No ☐   PIN/HSPI

Category of person who commenced chest compressions ⑤

Citizen	Not dispatched by ambulance control
Responder on duty	Dispatched by ambulance control
Responder other	Not dispatched by ambulance control
Responder auxiliary/voluntary service	On duty at or near the scene
Practitioner	Dispatched by ambulance control
Doctor or off-duty practitioner	Not dispatched by ambulance control
Doctor or off-duty practitioner	Dispatched by ambulance control
Nurse	
Fire	
Garda	

Defibrillator ⑥   Yes ☐   No ☐   PIN/HSPI

Category of person who first applied defibrillator pads ⑦

Citizen	Not dispatched by ambulance control
Responder on duty	Dispatched by ambulance control
Responder other	Not dispatched by ambulance control
Responder auxiliary/voluntary service	On duty at or near the scene
Practitioner	Dispatched by ambulance control
Doctor or off-duty practitioner	Not dispatched by ambulance control
Doctor or off-duty practitioner	Dispatched by ambulance control
Nurse	
Fire	
Garda	

Initial Arrest Rhythm ⑧   Shockable ☐   Unshockable ☐

Specify: (if known)

Specify rhythm What was first cardiac rhythm recorded prior to defibrillation

☐ Ventricular fibrillation	☐ Ventricular tachycardia
☐ Unknown rhythm - shock advised	☐ Asystole
☐ Unknown rhythm - no shock advised	☐ Pulseless electrical activity

Time First Arrest Rhythm Analysis   HH MM

Shock ⑨

Was shock advised   ☐ Yes ☐ No ☐ N/A   PIN/HSPI

Was shock delivered   ☐ Yes ☐ No   Defibrillator malfunction ☐

Total shocks delivered NUMBER   Time of first shock delivered HH MM

Background:

In the event of an out-of-hospital cardiac arrest it is imperative that cardiac arrest details are collected here. The practitioner is in the unique position to record this information which is extremely important in the collection of out-of-hospital cardiac arrest data nationally, and contributes to the out-of-hospital cardiac arrest (OHCA) data collected on the OHCA Register (OHCAR).

Category of person who delivered first shock (10)	
Citizen	Not dispatched by ambulance control
Responder on duty	Dispatched by ambulance control
Responder other	Not dispatched by ambulance control
Responder auxiliary/voluntary service	On duty at or near the scene
Practitioner	Dispatched by ambulance control
Doctor or off-duty practitioner	Not dispatched by ambulance control
Doctor or off-duty practitioner	Dispatched by ambulance control
Nurse	
Fire	
Garda	

Return of spontaneous circulation (ROSC) at any stage (11)   Yes ☐   No ☐

Did rearrest occur   Yes ☐   No ☐   no. of times ▭

Category of person who first achieved return of spontaneous circulation (ROSC) (12)	
Citizen	Not dispatched by ambulance control
Responder on duty	Dispatched by ambulance control
Responder other	Not dispatched by ambulance control
Responder auxiliary/voluntary service	On duty at or near the scene
Practitioner	Dispatched by ambulance control
Doctor or off-duty practitioner	Not dispatched by ambulance control
Doctor or off-duty practitioner	Dispatched by ambulance control
Nurse	
Fire	
Garda	

CPR in progress when transporting (13)   Yes ☐   No ☐

Spontaneous circulation on arrival to hospital (14)   Yes ☐   No ☐

Doctor in attendance (15)   MCRN ▭   Yes ☐   No ☐

Cardiac First Response (CFR) Report handover (16)   Yes ☐   No ☐

SIGNATURE/PIN/HSPI

NOTES

1. **CHEST PAIN**

2. **COLLAPSE**

3. **CATEGORY OF PERSON WHO WITNESSED COLLAPSE**

4. **CHEST COMPRESSIONS**

5. **CATEGORY OF PERSON WHO COMMENCED CHEST COMPRESSIONS**

6. **DEFIBRILLATOR PADS**

7. **CATEGORY OF PERSON WHO FIRST APPLIED DEFRIBRILLATOR PADS**

8. **INITIAL ARREST RHYTHM**

9. **SHOCK**

10. **CATEGORY OF PERSON WHO DELIVERED FIRST SHOCK**

11. **RETURN OF SPONTANEOUS CIRCULATION (ROSC)**

12. **CATEGORY OF PERSON WHO FIRST ACHIEVED ROSC**

13. **CPR IN PROGRESS WHEN TRANSPORTING**

14. **SPONTANEOUS CIRCULATION ON ARRIVAL TO HOSPITAL**

15. **DOCTOR IN ATTENDANCE**

16. **CARDIAC FIRST RESPONSE (CFR) REPORT HANDOVER**

① CHEST PAIN

Record of chest pain, time or best estimate of time of chest pain.

Chest Pain				
Yes ☐	No ☐	Unknown ☐	Time of Chest Pain	HH MM

How to enter:

Tick appropriate box – Yes, No or Unknown.
Enter the time using the 24-hour clock entry HH:MM.

② COLLAPSE

Record and time of collapse seen or heard.

Collapse			
Yes ☐	No ☐	Time of Collapse	HH MM

How to enter:

Tick appropriate box – Yes or No.
Enter the time using the 24-hour clock entry HH:MM.

③ CATEGORY OF PERSON WHO WITNESSED COLLAPSE

Category of person who witnessed collapse	
☐ Citizen	Not dispatched by ambulance control
☐ Responder on duty	Dispatched by ambulance control
☐ Responder other	Not dispatched by ambulance control
☐ Responder auxiliary/voluntary service	On duty at or near the scene
☐ Practitioner	Dispatched by ambulance control
☐ Doctor or off-duty practitioner	Not dispatched by ambulance control
☐ Doctor or off-duty practitioner	Dispatched by ambulance control
☐ Nurse	
☐ Fire	
☐ Garda	

How to enter:

Tick appropriate box for category of person who witnessed collapse.

4 **CHEST COMPRESSIONS**

Record of commencement of chest compressions.

Chest Compressions				
Yes ☐ No ☐	IF NO ADD REASON NOT COMMENCED			
Time chest compressions commenced	HH MM	Dispatcher aided Yes ☐ No ☐		
Total duration of chest compressions	HH MM			
Mechanical cardiopulmonary device was used Yes ☐ No ☐		PIN/HSPI		

How to enter:

Tick appropriate box – Yes or No; If No add reason not commenced.

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

Enter Personal Identification Number (PIN)/Health Service Provider Identifier (HSPI) assigned to the PHECC practitioner or health professional engaged in the care of the patient.

5 **CATEGORY OF PERSON WHO COMMENCED CHEST COMPRESSIONS**

Category of person who commenced chest compressions	
☐ Citizen	Not dispatched by ambulance control
☐ Responder on duty	Dispatched by ambulance control
☐ Responder other	Not dispatched by ambulance control
☐ Responder auxiliary/voluntary service	On duty at or near the scene
☐ Practitioner	Dispatched by ambulance control
☐ Doctor or off-duty practitioner	Not dispatched by ambulance control
☐ Doctor or off-duty practitioner	Dispatched by ambulance control
☐ Nurse	
☐ Fire	
☐ Garda	

How to enter:

Tick appropriate box for category of person who commenced chest compressions.

6 **DEFIBRILLATOR PADS**

Record of application of defibrillator pads.

Defibrillator	Yes ☐ No ☐	PIN/HSPI

How to enter:

Tick appropriate box - Yes or No.

Enter Personal Identification Number (PIN)/Health Service Provider Identifier (HSPI) assigned to the PHECC practitioner or health professional engaged in the care of the patient.

7 **CATEGORY OF PERSON WHO FIRST APPLIED DEFIBRILLATOR PADS**

Category of person who first applied defibrillator pads	
☐ Citizen	Not dispatched by ambulance control
☐ Responder on duty	Dispatched by ambulance control
☐ Responder other	Not dispatched by ambulance control
☐ Responder auxiliary/voluntary service	On duty at or near the scene
☐ Practitioner	Dispatched by ambulance control
☐ Doctor or off-duty practitioner	Not dispatched by ambulance control
☐ Doctor or off-duty practitioner	Dispatched by ambulance control
☐ Nurse	
☐ Fire	
☐ Garda	

How to enter:

Tick appropriate box for category of person who first applied defibrillator pads.

8 INITIAL ARREST RHYTHM

Initial arrest rhythm.

Initial Arrest Rhythm	Shockable ☐	Unshockable ☐
Specify: (if known)		

Specify rhythm What was first cardiac rhythm recorded prior to defibrillation	
☐ Ventricular fibrillation	☐ Ventricular tachycardia
☐ Unknown rhythm - shock advised	☐ Asystole
☐ Unknown rhythm - no shock advised	☐ Pulseless electrical activity
Time First Arrest Rhythm Analysis	HH MM

How to enter:

Tick appropriate box for shockable or unshockable and specify if known.
Specify first cardiac rhythm recorded prior to defibrillation – tick appropriate box.

Enter time or best estimated first cardiac rhythm recorded prior to defibrillation using the 24-hour clock entry HH:MM.

9 SHOCK

Shock				
Was shock advised	☐ Yes ☐ No ☐ N/A			PIN/HSPI
Was shock delivered	☐ Yes ☐ No	Defibrillator malfunction ☐		
Total shocks delivered NUMBER		Time of first shock delivered HH MM		

How to enter:

When defibrillator pads applied was shock advised by defibrillator - tick appropriate box Yes, No or N/A.

Enter Personal Identification Number (PIN)/Health Service Provider Identifier (HSPI) assigned to the PHECC practitioner or health professional engaged in the care of the patient.

When defibrillator advised shock, was shock delivered - tick appropriate box Yes or No.

Record of malfunction of defibrillator – tick if appropriate.

Enter number of total shocks delivered.

Enter time of first shock delivered using the 24-hour clock entry HH:MM.

10 ## CATEGORY OF PERSON WHO DELIVERED FIRST SHOCK

Category of person who delivered first shock		
	Citizen	Not dispatched by ambulance control
	Responder on duty	Dispatched by ambulance control
	Responder other	Not dispatched by ambulance control
	Responder auxiliary/voluntary service	On duty at or near the scene
	Practitioner	Dispatched by ambulance control
	Doctor or off-duty practitioner	Not dispatched by ambulance control
	Doctor or off-duty practitioner	Dispatched by ambulance control
	Nurse	
	Fire	
	Garda	

How to enter:

Tick appropriate box for category of person who delivered first shock.

11 ## RETURN OF SPONTANEOUS CIRCULATION (ROSC)

Return of spontaneous circulation (ROSC) at any stage	Yes ☐ No ☐
Did rearrest occur	Yes ☐ No ☐ no. of times

How to enter:

ROSC returned at any stage during cardiac incident - tick appropriate box Yes or No.

Did a rearrest occur at any stage post ROSC? If so, number of rearrests - tick appropriate box Yes or No - enter number of times.

12 ## CATEGORY OF PERSON WHO FIRST ACHIEVED ROSC

Category of person who first achieved return of spontaneous circulation (ROSC)		
	Citizen	Not dispatched by ambulance control
	Responder on duty	Dispatched by ambulance control
	Responder other	Not dispatched by ambulance control
	Responder auxiliary/voluntary service	On duty at or near the scene
	Practitioner	Dispatched by ambulance control
	Doctor or off-duty practitioner	Not dispatched by ambulance control
	Doctor or off-duty practitioner	Dispatched by ambulance control
	Nurse	
	Fire	
	Garda	

How to enter:

Tick appropriate box of category of person who first achieved ROSC.

13 **CPR IN PROGRESS WHEN TRANSPORTING**

Patient transferred to hospital while CPR in progress.

CPR in progress when transporting	Yes ☐ No ☐

How to enter:

Tick appropriate box – Yes or No.

14 **SPONTANEOUS CIRCULATION ON ARRIVAL TO HOSPITAL**

Spontaneous circulation on arrival to hospital	Yes ☐ No ☐

How to enter:

Tick appropriate box – Yes or No.

15 **DOCTOR IN ATTENDANCE**

Doctor in attendance	MCRN	Yes ☐ No ☐

How to enter:

Tick appropriate box – Yes or No.

Enter Medical Council Registered Number (MCRN).

16 **CARDIAC FIRST RESPONSE (CFR) REPORT HANDOVER**

CFR Report completed and handed over to the ambulance service.

Cardiac First Response (CFR) Report handover	Yes ☐ No ☐
SIGNATURE/PIN/HSPI	

How to enter:

Tick appropriate box – Yes or No.

Enter signature, Personal Identification Number (PIN)/Health Service Provider Identifier (HSPI) assigned to the PHECC practitioner or health professional engaged in the care of the patient.

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Pre-Hospital Emergency Care Council

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