Ambulatory Care Report Information Standard 2016

Pre-Hospital Emergency Care Council

ACR Information Standard

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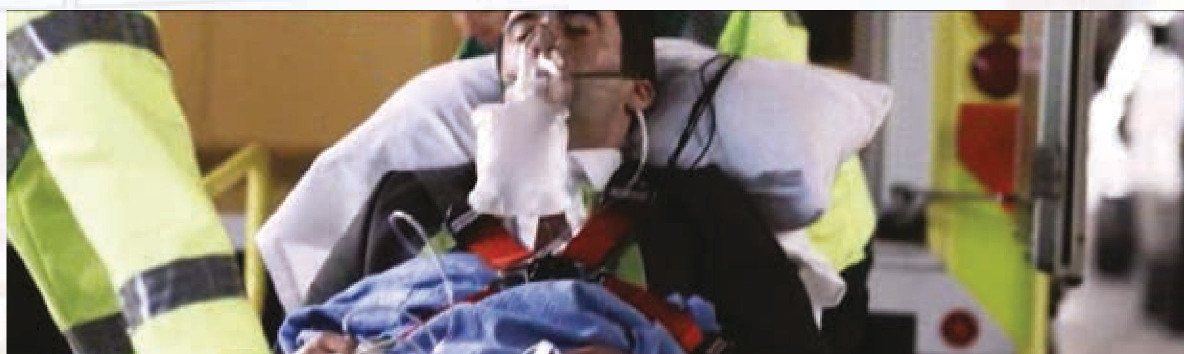

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Pre-Hospital Emergency Care Council

Introduction

The Pre-Hospital Emergency Care Council protects the public by independently specifying, reviewing, maintaining and monitoring standards of excellence for the delivery of quality pre-hospital emergency care for people in Ireland.

PHECC is charged under our Establishment Order (Statutory Instrument No. 109 of 2000).

> *(f) advise the Minister of the standards which should inform the education and training of emergency medical technicians in the State;*

To fulfil this commitment PHECC develops and supports the national implementation of EMS information standards, associated patient reports and data completion standards across all PHECC recognised licenced providers; statutory, private, auxiliary and voluntary. The standards provide definitions for all of the data elements, data types and data domains in the patient reports completed nationally by all licenced providers.

The benefits of good quality data include providing:

- Accurate information to enable informed decision making in the delivery of safe quality care (1).
- Documentary evidence to assist the practitioner meet his/her CPC requirements.
- Data for quality, robust clinical audit.
- Data to support the legal requirements under the Data Protection Acts (2).
- Data for research into pre-hospital skills, equipment and services (3).
- Data to support the development of Strategic Plans.

The Ambulatory Care Report (ACR) Information Standard consists of the set of data elements about the patient which include but are not exclusive to: name and address, date of birth, venue, location, care management, chief complaint and patient disposition.

Safe reliable care depends on access to and use of accurate reliable information. Here is a summary of data quality dimensions (4).

Completion Standard	Description
Accuracy and Factualness	Accurate data is an essential requirement of documentation. Pre-hospital emergency care practitioners and responders must capture data accurately and distinguish between what they observe and what the patient states.
Completeness	Complete data will have all of the information recorded of the interaction which occurred between the practitioner/responder and the patient.
Legibility	The data must be recorded legibly to enable a correct interpretation of the data.
Objectivity	Data must be recorded objectively and not include value judgements.
Timeliness	Data should be recorded real-time or as close to real-time as possible.
Validity	The data is collected in accordance with the data definitions recorded in the current information standard which applies to the patient report which is being completed.

SECTION 1

1. Incident data

ID No.	Data Element	Data Domain	Definition	Data Type
1. Incident data				
1.1	Venue	Name of venue	Name of place where event is taking place	Free text Alphabetic
1.2	Post number	Number of post	Number assigned to post in venue	Free text Alphanumeric
1.3	Location of incident	Location	Location of incident at venue	Free text Alphanumeric
1.4	Event type	Event	Type of event Classified as place of occurrence of incident under International Classification of Diseases Australian Modification, Tenth Revision (ICD-10-AM Codes) external causes of morbidity and mortality. Coded in combination with Event and Mechanism of Injury	Free text Alphanumeric
1.5	Time at patient	Hour Minute Second	The time of arrival of the first emergency response at the patient	Numeric HH:MM:SS
1.6	Date at patient	Day Month Year	The date of arrival of the first emergency response at the patient	Numeric DD/MM/YYYY
1.7	Reason at event	Participant Spectator Official Other	Purpose at event	Tick box

2. Patient demographics

ID No.	Data Element	Data Domain	Definition	Data Type
2. Patient demographics				
2.1	Title	Dr / Mr / Mrs / Ms / Prof	A prefix added to a name	Tick box
2.2	Surname	Surname	Their family name, surname, last name or marital name	Free text Alphabetic
2.3	Forename	First name	The given name, first name or forename	
2.4	Individual Health Identifier (IHI)	Code	A unique, non-transferable number assigned to all individuals using health and social care services	Alphanumeric
2.5	Date of birth	Day Month Year	Specific day, month and year patient was born	Numeric DD/MM/YYYY
2.6	Age	Age	Age of patient recorded in days, weeks, months or years as appropriate	Numeric
2.7	Gender	Male Female Intersex or Indetermined Not stated/Inadequately described	Classification of sex of patient	Tick box M / F / I / U
2.8	Permanent address	Permanent address	Location of patient's permanent address	Alphanumeric
2.9	Eircode	Code	Location code comprising of routing key and unique identifier	Alphanumeric
2.10	Next of kin	Surname First name	Name of patient's next of kin	Alphabetic
2.11	Telephone number of next of kin	Telephone number	Telephone number of patient's next of kin	Numeric

3. Clinical information

ID No.	Data Element	Data Domain	Definition	Data Type
3. Clinical				
3.1	Patient chief complaint	Chief complaint	The presenting complaint which is the reason pre-hospital emergency care is being sought	Alphabetic
3.2	Time of onset	Hour Minute	Time of onset of presenting complaint	24 hour HH:MM
3.3	Date of onset	Day Month Year	Date of onset of presenting complaint	Numeric DD/MM/YYYY
3.4	Presentation type	Injury Illness Environmental Mental or behavioural disorders	Illness presenting category	Tick box

4. Care management

ID No.	Data Element	Data Domain	Definition	Data Type
4. Care management				
4.1	Observe and supportive care	Observe and supportive care	Any observation and or supportive care deemed necessary	Tick box
4.2	RICE	Rest Ice Compression Elevation	Rest, Ice, Compression and Elevation as required	Tick box
4.3	Wound management	Wound care	Any wound care including closure deemed necessary	Tick box
4.4	Other	Other care management	Care management required which is not listed	Tick box Record free text in details section

5. Treated by

ID No.	Data Element	Data Domain	Definition	Data Type
5. Treated by				
5.1	PIN	PIN/HSPI	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	Numeric Alphanumeric
5.2	Further observation or care required	Yes No	If the patient requires further observation and/or care tick the 'Yes' and follow instructions to record additional information	Tick box

6. Patient disposition

ID No.	Data Element	Data Domain	Definition	Data Type
6. Patient disposition				
6.1	Discharged	Discharged	Select discharge if appropriate care pathway for the patient	Tick box
6.2	Transferred to ED	Transferred	Select transfer to ED if appropriate pathway for the patient	Tick box
6.3	Destination	Code/HSPI	Hospital destination code: (Ref: PHECC Hospital/Destination facility codes for pre-hospital patient reports/Health Service Provider Identifier (HSPI) assigned to the health care service provider	Alphanumeric
6.4	Referred to GP	Referred to GP	Select refer to GP if appropriate pathway for the patient	Tick box
6.5	Refused further care	Refused further care	Select refused further care in the event of patient refusing care and completed 'Declined Treatment' section	Tick box
6.6	Time	Hour Minute Second	Enter time patient disposition was completed	Numeric 24 hr clock HH:MM:SS

SECTION 2

7. Patient clinical assessment

ID No.	Data Element	Data Domain	Definition	Data Type
7.1 Primary survey				
	Airway clear	Yes No	Initial rapid assessment of airway to determine if any life threatening condition exists	Tick box
	Airway partially obstructed	Yes No		
	Airway obstructed	Yes No		
	C Spine suspect	Yes No	Initial rapid assessment of C Spine to determine if life threatening condition exists	Tick box
	C Spine not indicated	Yes No		
	Breathing normal	Yes No	Initial rapid assessment of breathing to determine if life threatening condition exists	Tick box
	Breathing abnormal	Yes No		
	Breathing fast	Yes No		
	Breathing slow	Yes No		
	Breathing absent	Yes No		
	Pulse present	Yes No	Initial rapid assessment of circulation to determine if life threatening condition exists	Tick box Numeric
	Pulse regular	Yes No		
	Pulse absent	Yes No		
	Pulse irregular	Yes No		
	Pulse rate	Measurement		
	Skin normal	Yes No		
	Skin pale	Yes No		
	Skin flushed	Yes No		
	Skin cyanosed	Yes No		
	Cap-refill <2sec	Yes No		
	Cap-refill >2sec	Yes No		
	Loss of consciousness before arrival	Yes No Unknown	Initial rapid assessment of level of consciousness to determine if life threatening condition exists	Tick box
	AVPU	Alert, Verbal, Painful or Unresponsive	Determination of responsiveness of patient	A, V, P, U

ID No.	Data Element	Data Domain	Definition	Data Type
	Abrasion	Yes No	Brief account of findings for time critical/potentially time critical features including circulation, sensation, motion, Wallace Rule of Nines Burns calculation	Tick box Alphabetic on body image Numeric %
	Burn	Yes No		
	% burn	Yes No		
	Contusion	Yes No		
	Dislocation	Yes No		
	Fracture	Yes No		
	Pain	Yes No		
	Rash	Yes No		
	Swelling	Yes No		
	Numbness	Yes No		
	Wound	Yes No		
	CSM RA / RL / LA / LL	Yes No		
7.2 Clinical impression				
	Specific			
	Cardiac	Yes No	An early clinical impression of the presenting illness/injury. (ref: ICD 10 AM)	Tick box Free text Alphabetic
	Medical	Yes No		
	Neurological	Yes No		
	Obs/Gynae	Yes No		
	Respiratory	Yes No		
	Trauma	Yes No		
	General			
	Abdominal pain	Yes No	An early clinical impression of the presenting illness/injury. (ref: ICD 10 AM)	Tick box Free text Alphabetic
	Allergic reaction	Yes No		
	Syncope and or collapse	Yes No		
	Behavioural disorder	Yes No		
	Illness unknown	Yes No		
	Nausea and or vomiting	Yes No		
	Poisoning	Yes No		
	Other general	Yes No		

ID No.	Data Element	Data Domain	Definition	Data Type
7.3 AMPLE survey				
	No known allergies	Yes No	Reported known drug and agent allergies if known	Tick box Free text Alphabetic
	Allergies unknown	Yes No		
	Free text	Text		
	Medications known	Yes No	Record of medications taken regularly if known or as recorded	Tick box Free text Alphabetic
	Medications unknown	Yes No		
	Medications as supplied	Yes No		
	Medications per doctor's letter	Yes No		
	Free text	Text		
	Past medical history known	Yes No	Past medical history reported by patient or relative if present or known	Tick box Alphabetic
	Past medical history unknown	Yes No		
	Past medical history per doctor's letter	Yes No		
	Past medical history per relative	Yes No		
	Last intake unknown	Yes No	Description of last food or drink consumed Time last food or drink consumed	Tick box Free text Alphanumeric 24 hour HH:MM
	Last intake description	Description		
	Last intake time	Hour Minute		
	Event	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 occurence and mechanism of injury	Free text Alphabetic

ID No.	Data Element	Data Domain	Definition	Data Type
7.4 Mechanism of injury				
	Assault	Yes No	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	Tick box
	Attack/Bite by Animal/Insect	Yes No		
	Chemical poisoning	Yes No		
	Electrocution	Yes No		
	Excessive cold	Yes No		
	Excessive heat	Yes No		
	Fall	Yes No		
	Firearm injury	Yes No		
	Injury to child	Yes No		
	Machinery accidents	Yes No		
	Smoke, Fire Flames	Yes No		
	Submersion	Yes No		
	Stabbing	Yes No		
	Water transport accident	Yes No		
	Other	Yes No		
	Other	Text		
	Circumstances			
	Accident	Yes No	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	Tick box
	Event of undetermined intent	Yes No		
	Intentional self harm	Yes No		

8. Medication treatment

ID No.	Data Element	Data Domain	Definition	Data Type
8.1 Medications, route, dose and time				
	Time	Hour Minute	Time medication administered	24 hour HH:MM
	Medications	Medication name	Medications available to pre-hospital practitioners as per current edition of PHECC CPGs	Alphanumeric
	Dose	Measurement in addition to the following: Short code - g (grams) Short code - L (litres) Short code - mcg (micrograms) Short code - Mg (milligrams) Short code - mL (millilitres) Short code - mEq/L (milliEquivalent per litre) Short code - % (percent)	Unit of measurement of administered medication	Numeric Alphabetic
	Route	Route	Route of administered medication	Alphabetic
	PIN	Practitioner PIN/HSPI	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	Numeric

9. Vital observations

ID No.	Data Element	Data Domain	Definition	Data Type
9.1 Vital observations - elements				
	Vital observation time 1 Vital observation time 2	Hour Minute	The times 1st and 2nd set of vital observations recorded	24 hour HH:MM
	Pulse rate	Measurement	Clinical indicators of current health status	Numeric Alphabetic Tick box
	Pulse rhythm	Short code - R (regular) Short code - 1 (irregular)		
	Electrocardiograph (ECG) rhythm	Rate		
		Short code - NSR (Normal sinus rhythm)		
		Short code - SB (Sinus bradycardia)		
		Short code - ST (Sinus tachycardia)		
		Short code - PAC (Premature atrial contraction)		
		Short code - PVC (Premature ventricular contraction)		
		Short code - VT (Ventricular tachycardia)		
		Short code - JR (Junctional rhythm)		

ID No.	Data Element	Data Domain	Definition	Data Type
		Short code - SVT (Superventricular tachycardia)		
		Short code - AF (Atrial fibrillation) Short code - AFL (Atrial flutter)		
		Short code - FHB (First degree heart block)		
		Short code - SHBT1 (Second degree heart block type 1)		
		Short code - SHBT2 (Second degree heart block type 2)		
		Short code - THB (Third degree heart block)		
		Short code - ASY (Asystole)		
		Short code - IDO (Idioventricular)		
		Short code - PEA (Pulseless electrical activity)		
		Short code - VF (Ventricular fibrillation)		
	Respiratory rate	Respiratory rate		
	Respiratory quality	Short code - 1 (Normal respiration quality)		
		Short code - 2 (Laboured quality)		
		Short code - 3 (Shallow quality) Short code - 4 (Wheeze)		
		Short code - 5 (Creps)		
		Short code - 6 (Retract)		
		Short code - 7 (Absent)		
	Peak expiratory flow rate	Measurement		
	% SpO_2	Percentage oxygen saturation		
	Capillary refill	Measurement		
	Blood glucose level	Measurement	Numeric value in mmol/L as recorded by glucometer	Numeric Alphanumeric + / -
	Pain score	Measurement	Pain score of patient's pain intensity as reported by them	
	Blood pressure	Systolic blood pressure Diastolic blood pressure	Clinical indicators of current health status	
	Temperature	Measurement		
	Pupil size	Measurement		
	Pupil reaction	Short code - + (Pupil reacts) Short code - - (Pupil does not react) Short code - C (Eyes closed)		

ID No.	Data Element	Data Domain	Definition	Data Type
	Glasgow Coma Scale			
	Eyes	Short code - 4 (Spontaneous eye response)	Clinical indicators of patient current health status	Numeric
		Short code - 3 (Response to voice)		
		Short code - 2 (Response to pain)		
		Short code - 1 (No response)		
	Verbal	Short code - 5 (Orientated verbal response)		
		Short code - 4 (Confused verbal response)		
		Short code - 3 (Inappropriate words)		
		Short code - 2 (Incomprehensible sounds)		
		Short code - 1 (None)		
	Motor	Short code - 6 (Obeys)		
		Short code - 5 (Local pain)		
		Short code - 4 (Flexion to pain)		
		Short code - 3 (Abnormal flexion)		
		Short code - 2 (Extension to pain)		
		Short code - 1 (None)		

10. Declined treatment

10.1 Declined treatment - elements

ID No.	Data Element	Data Domain	Definition	Data Type
	Aid to decision making capacity	Understanding of clinical situation Yes No	Determination of patient decision making capacity to reject treatment and to make an alternative care plan	Tick box
	Appreciation of applicable risk	Yes No		
	Ability to make alternative care plan	Yes No		
	PIN/HSPI	Name	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	Alphabetic Free text

11. Patient reviewed

11.1 Patient reviewed - elements

ID No.	Data Element	Data Domain	Definition	Data Type
	Patient reviewed by	PIN HSPI MCR Name	Personal Identification Number (PIN) of the person with responsibility for reviewing the patient at the end of their episode of care. This can be the PHECC PIN, the organisation PIN, the PIN of the registration body of the care giver or the Health Service Practitioner Identifier (HSPI).	Alphabetic

12. References

(1, 3) Pre-Hospital Emergency Care Council. (2007) *Patient Care Report Guidebook: For Pre-Hospital Emergency Care*, 2nd ed., Kildare: Pre-Hospital Emergency Care Council.

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