

Privileged and Confidential Peer Review Information

Minutes of the QI/SCTP Meeting 10/25/06 @ 08:00 hrs (A-Shift)

408 E. Marion St., Shelby, NC

Members Present:

Silver, Donna	Wacaster, Alan	Childers, Kenneth
Simonetti, Heidi	Newport, Shelia	Haskins, Andy
Parker, Melissa	Blanton, Darin	Jenkins, Louis

Meeting called to order:

Chairman Ken Childers called the meeting to order.

Review of Minutes from the previous meeting:

The minutes from the previous Sept. meeting were reviewed and approved with the following changes:

Alan Wacaster was present at that meeting, and Altered Mental Status and Overdose was to read "Narcan 0.4 – 2 mg IV."

Old Business:

BCLS updates were held for October's inservice. Course report rosters have been forwarded to CRMC Ed. Dept. for pocket cards. When BCLS cards are received copies should be made for the training file and the cards distributed to the employee.

November's inservice will cover Trauma Patient Assessment and Medical Patient Assessment. The corresponding skills sheets will be checked off during that inservice.

The FTOs and training officer are targeting Jan. 2007 as ACLS update month.

Ms. Rachael Wood, at Crawley has been contacted once again with dates for Crawley Hsp. ventilator training. Ms. Wood was asked to hold training after inservice dates, or at least one class after the QI/SCTP meeting.

Mr. Blanton noted that Crawley may be expanding its ventilator bed facility to 10 beds.

On approximately Oct. 10th, an SCTP discovered that the SCTP ambulance did not contain any Impact Ventilator circuits when a critical care transport was pending. The SCTP gave this information to the supervisor. The committee has asked that additional ventilator circuits be placed on that unit.

The DOA policy is at a stand still until Law Enforcement Agencies can agree on a county wide policy.

Punctuation, spelling and “grammer” continues to be a systemic problem in PCR documentation. The committee agreed that attention to this problem is a “lost cause.” All shifts have had documentation classes, but overall there has been little improvement.

EmsCharts.Com was discussed. Will routine deletion of redundant images that are attached to PCRs cause problems if an attorney reviews a call? While the committee was unable to adequately answer the question, it was noted that when a mistake is made in a written narration, a single line drawn through the mistake with initials is sufficient.

New Business:

CRMC and KMH are going to new vacutainer tubes. Information sheets on these new blood tubes are attached. Start date for this is not know at this time.

An ITLS class will be held at CCC Nov. 17th, 18th, and 19th. David Clary at CCC should be contacted to register at 704-484-6658.

IV performance was reviewed. CCEMS had a 68.2% success rate for 09/20/06 thru 10/24/06. This was down 1% from the last time period. ETT success rates were also reviewed. According to the EmsCharts query there were 17 attempts at intubation for the time period 09/20/06-10/24/06. The success rate was 47.1%. This figure was scrutinized using another query.

The second intubation query showed ten PCRs were intubation attempts were made. The following results were hand counted from those PCRs:

Two Combitubes were successful after intubation failed.

Six patients were successfully intubated.

One patient bit down on the tube after a successful intubation and the tube was removed in the field.

One patient was not intubated because of airway complications from blood, trauma, etc., however, other invasive airway attempts were not documented to have been used.

When precepting orientees SCTPs are asked to remain with the orientee at all times. Orientees should not be turned over to the second crew member during patient transports at any time.

The following draft protocols were reviewed:

Bradycardia

Wide QRS Unstable Tachycardia With a Pulse

Wide QRS Stable Tachycardia With a Pulse

Narrow QRS Stable Tachycardia With a Pulse

Fibrinolytic Checklist
Capnography Waveform

Five of the protocols were re-written to conform to the new AHA ACLS standards. These protocols, and three previously re-written cardiac protocols, are attached as one document.

Next meeting date:

The next QI/SCTP meeting will be held on Nov. 29th, 2006, at 08:00 hrs, at 408 E. Marion St. The committee will not meet in Dec. It will reconvene in Jan., 2007.

Executive Session:

The committee went into executive session and reviewed PCRs.

Case # 102506-3 18 y/o male w/ GSW to abdomen and right forearm.
Comments: Two IVs were initiated, one was to right forearm. HR was documentd at 80 but rhythm strip showed 110 rate. Oxygen was not administered. O2 sat was 91%.

Case # 102506-4 30 y/o male transported to CMC, post MVA, with multiple skeletal fractures. Pt. was on ventilator. *Comments:* Versed and Norcuron were administered, but times of administration were not listed. Tube placement was not verified in narrative prior to transport.

Case # 102506-5 43 y/o male transported to CMC with cranial bleeding. Was on vent. *Comments:* Incorrect listing of primary care giver. Mis-spellings. Norcuron administration was listed as being given by "Layperson" in Medications/Infusions Prior to Assessment box.

Case # 102506-7 61 y/o male involved in MVA auto vs tree. *Comments:* When airway was opened via Modified Jaw Thrust, narrative states patient was not breathing. Efforts to ventilate patient or treat this problem were not documented. Intubation attempts were unsuccessful but Combitube or LMA was not used as back-up airway. OPA was used instead. Patient was initially in Sinus Bradycardia prior to asystole. Could pacing have been considered? There was no secondary survey to verify chest/thoracic injuries that may have been caused by steering wheel. Not documented if medical control was contacted early.

Case # 102506-9 67 y/o female, interfacility transport of STEMI patient. Patient went into cardiac arrest near county line. *Comments:* Did a good job considering circumstances. Transport was diverted to GMH. Recommend this call to be considered as a "Save".

Case # 102506-14 46 y/o male with GI bleeding. *Comments:* Pt. w/ GI Bleed, decreased BP, tachycardia, and no IV? Should have been attended by an EMT-P and not the lesser certified person on the unit.

Case # 102506-18 71 y/o female in cardiac arrest. *Comments:* Waveform capnography line was occluded. Why not change line?

Case # 102506-19 61 y/o male in cardiac arrest. *Comments:* Documentation makes it impossible to determine when rhythm changes occurred, or the appropriateness of medications.

Case # 102506-20 67 y/o male in cardiac arrest. *Comments:* CO2 waveforms ranged from 20-60? But was not a perfusing rhythm? “Attempts at intubation unsuccessful due to large amounts of vomitus, large airway obstruction with chewing tobacco and anterior airway.” Was suctioning used? ‘Initial Physical Findings’ box states that abdominal palpation was “hollow”?