PROCEDURE EVALUATION FORM

Date: _____ Time: _____ Prehospital Care Report #: _____

EMT/AEMT/PM Name(s): _____ Accreditation #(s): _____

ADVANCED AIRWAY PLACEMENT

Orotracheal Intubation Size _____

Attempts: _____ Depth: _____ Successful? □ Yes □ No

□ King Airway

Size _____Attempts _____ Successful? □ Yes □ No

Final depth: _____cm Final volume of air: _____ mL

Check pertinent: □ Excessive vomitus □ Excessive Blood

□ Trismus □ Unable to visualize cords □ Airway obstruction

□ Unable to position for intubation □ Facial trauma

□ Unable to obtain good mask seal

□ Other _____

_____

Introducer Stylet (Bougie) used? □ Yes □ No

Cricoid pressure? □ Yes □ No Suctioning? □ Yes □ No

□ Orotracheal Intubation for Peds greater than 8 years

Size _____Attempts:_____Successful? □ Yes □ No

WAVEFORM CAPNOGRAPHY READINGS

Required in all airway procedures:

@1 min_____mmHg @ 5 min_____mmHg

@ 10 min_____ mmHg Upon arrival to ED _____mmHg

Printed ETCO2 strip with PCR (1min & at Turnover)? □ Yes □ No

_____

BVM (PEDIATRIC PATIENTS LESS THAN 9 YEARS OF AGE)

PT age _____ Mask Size _____ BLS Airway size _____

Cricoid Pressure used with BVM? □ Yes □No

Suctioning? □ Yes □ No Comments: _____

_____

NEEDLE THORACOSTOMY

Subcutaneous Air noted? □ Yes □ No

Tracheal Deviation noted? □ Yes □ No

Needle Placement? □ Right □ Left □ Bilateral

Open chest wound? □ Yes □ No

If yes, occlusive dressing applied? □ Yes □ No

Dressing lifted if patient condition worsened? □ Yes □ No

Base Hospital contact? □ Yes □ No

Where was procedure performed? □ On scene □ En route to hospital

Did the PT condition improve? □ Yes □ No

As evidenced by:_____

_____

Pt vital signs prior to procedure: BP: _____/_____ Pulse _____

Respiratory rate _____ Pulse oximetry _____%

_____

TRANSCUTANEOUS PACING

Age of patient: _____ Presenting rhythm: _____

TCP started because: □ Atropine ineffective □ IV not established

Capture? □ Yes □ No Did the PT condition improve? □ Yes □ No

Final Pacer Settings: mA _____ ppm _____

Pacing performed □ Before □ After Base Hospital Contact

Versed given? □ Yes □ No Dose: _____ mg □ IV □ IM

If no, why not?

_____

_____

_____

_____

INTRAOSSEOUS (IO) VASCULAR ACCESS

Age of patient: _____ Number of attempts: _____

Base Contact made prior to placement? □ Yes □ No

IO placement successfully performed? □ Yes □ No (explain below)

Placement from tuberosity : Medial □ .5" □ 1:

Distally □.5" □ 1" proximally: □ .5" □ 1"

Device used: □ B.I.G. □ EZ-IO □ Manual Device

□ Other

Peds age setting dialed to (if applicable):

□ 0-3 □ 3-6 □ 6-12

Comments: _____

_____

_____

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

Age of patient: _____ Oxygen prior to CPAP? □ Yes □ No

_____ LPM via: □ mask □ nasal cannula

Lung sounds prior to CPAP: _____

Nitroglycerine TM/SL prior to CPAP: □ yes □ No _____ # of doses

Nitroglycerine paste applied: □ prior to CPAP □ after CPAP □ n/a

Blood pressure prior to CPAP? _____ / _____

CPAP started at _____cm H2O Ended at _____ cm H20

Relief obtained by patient? □ Yes □ No

As evidenced by: _____

_____

_____

Versed given? □ Yes □ No Dose: _____mg □ IV □ IM

Comments: _____

_____

_____

Signature of EMT/AEMT/PM: _____

Physician Section:

Intubation (ET or King Airway) successful? □ Yes □ No

Physician Signature: _____ Date _____

Print Physician Name: _____ Receiving Hospital: _____ Base Hospital _____

EMTs, AEMTs, and Paramedics*: Please submit this completed form along with the completed Patient Care Report to your organization's QI Coordinator.*

Provider QI Coordinators*: Please review this Procedure Evaluation Form along with its associated Patient Care Report.*

□ *Patient care complies with Performance Standards/Policies*

□ *Patient care does not comply with Performance Standards/Policies (QI review and remediation attached)*

Please forward all documents to:

Fax: Riverside County EMS Agency
Attention: Laura Wallin, EMS Specialist/QI Coordinator
(951) 358-5160

Or you may mail it to: Riverside County EMS Agency
Attention: Laura Wallin, RN
EMS Specialist/QI Coordinator
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