ADMINISTRATIVE AND GENERAL MANAGEMENT

QUALITY ASSURANCE / QUALITY IMPROVEMENT

QUALITY ASSURANCE GUIDELINES

The _____Emergency Medical Services District is dedicated to providing public safety services to our citizens that result in improved quality of life and peace of mind. Medical Quality Assurance and Quality Improvement is the first step in achieving this goal.

As a cooperative effort between ABC staff, EMS personnel, and Medical Control, the following guidelines were developed.

QAULITY ASSURANCE - OPERATIONS MANAGER

The following guidelines will be used as criteria for specific Advanced Life Support calls to be reviewed by the Operations Manager:

- **ALL PRIORITY ONE TRANSPORTS**

CARDIAC ARREST

- Scene time
- Intubation
- Defibrillation
- Proper drug usage and administration

INTUBATIONS (ALL)

- Patient condition
- Scene Time
- Number of Attempts
- Any other concerns

MULTI-STSTEMS TRAUMA

- Multi-Systems Trauma
- Scene Time
- Treatment during and after extrication (if applicable)
- Patient Condition (If flown)

Upon completion of the ambulance report, the ALS personnel responsible for patient care will leave the report in the secure completed report file located at their station. This should be done as soon as possible to avoid any paperwork being held over to the next shift. Unless Patient Care Record is generated using the EPCR. On Monday, Wednesday, and Friday the paperwork will be collected by the Operations Manager or designee who will process it using the above guidelines.

If there is a concern regarding patient care or protocols, the Operations Manager will attach a "_____Emergency Medical Services District Quality Assurance Report" form to the ambulance report and deliver it to the Medical Director. The Medical Director will be asked to provide comments and recommendations based on his assessment of the report. The Operations Manager may assign responsibility to EMS Instructors or ALS personnel, as appropriate, training related issues.

"_____Emergency Medical Services District Quality Assurance Report" forms will be filed at the _____Emergency Medical Services District.

QAULITY ASSURANCE - IN-HOUSE

All ambulance reports will be reviewed by the responding ambulance crew for completion. One Hundred Percent (100%) of all EMS runs will be reviewed by the Operations Manager or designee. The Operations Manager will use the "_____Emergency Medical Services District Monthly In-House Quality Assurance Summary" to log all reports that he / she reviews. Comments or suggestions for each ambulance run will be documented on the "_____Emergency Medical Services District Monthly In-House Quality Assurance Summary" form; If correction or further action is needed to complete the report, the items will be listed on the "_____Emergency Medical Services District Patient Care Form Q.A. Check Sheet" and returned to the Medic responsible for the report. Monthly Quality Assurance meetings will be scheduled with the Medical Director and on duty crews will participate in the process. All other employees will be encouraged to attend.

"_____Emergency Medical Services District Quality Assurance Report" and "_____Emergency Medical Services District Monthly In-House Quality Assurance Summary" forms will be filed at the _____ Emergency Medical Services District.

NOTE: Ambulance reports contain confidential information; All copies of ambulance reports used for review must be returned after review, along with the "_____Emergency Medical Services District Monthly In-House Quality Assurance Summary" form and "_____ Emergency Medical Services District Quality Assurance Report/s" (if applicable).

ABC will select one ambulance report for each shift per month; a "_____ Emergency Medical Services District Survey" will be mailed to the customer for feedback, along with a Self-addressed Stamped Envelope for return. The surveys will be forwarded to the Director of Operations and the ABC Board for review..
"_____ Emergency Medical Services District Survey" forms will be filed at the _____ Emergency Medical Services District.

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_____ EMS District

Quality Assurance Report

Ambulance Report # (if available): _____ Ambulance Report Date: ___/_____/_____

Incident Location: _____

Patient Name: _____

Action Needed: ☐ None ☐ Documentation ☐Completion

☐ Other: _____

Comments:

Recommendations:

Date: _____/_____/_____ Signature/s: _____

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_____ EMS District

Monthly In-House Quality Assurance Summary

MONTH:_____ , _____

Report #	**Action Needed**	**Comments**
	☐ None ☐ Documentation ☐Completion ☐ Other	
	☐ None ☐ Documentation ☐Completion ☐ Other	
	☐ None ☐ Documentation ☐Completion ☐ Other	
	☐ None ☐ Documentation ☐Completion ☐ Other	
	☐ None ☐ Documentation ☐Completion ☐ Other	
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Date: _____/_____/_____ Signature/s: _____ Page _____ of _____