Rogers Fire Department Standard Operating Procedures

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PURPOSE

The purpose of this policy is to provide information on the Rogers Fire Department Medical Quality Improvement Program.

POLICY

The Rogers Fire Department establishes a quality improvement program to ensure that emergency medical care is rendered in a professional and systematic format. It shall be the responsibility of the Fire Chief, with coordinated efforts from the Captain assigned to EMS, Medical Director, and Master Paramedics to provide a thorough review of emergency medical incidents.

Company officers shall be responsible for ensuring patient care reports are completed by personnel assigned to them. Company officers shall ensure the following items are entered correctly:

- Paperwork
  - Hospital face sheet submitted with patient information (address, phone number, social security number, insurance)
  - Signed HIPPA form
  - Copy of Hospital PCR
  - Release form, if no transport occurred
- EPCR
  - Patient care narrative using the chronological patient care narrative rubric. (See below)
  - Appropriate interventions included in the report (completed drop down boxes in the computer system)
  - A set of vital signs documented for each patient

- At least two sets of vital signs are required if patient care is ≥ 15 minutes in duration
- Mileage for transport
- NFIRS errors completed
- NEMSIS errors completed

Chronological Patient Care Narrative Rubric

The patient care narrative will follow the chronological format and include, at a minimum, the necessary pertinent information described below.

- Dispatched To: A brief description of the initial dispatch
- Upon Arrival: Describe the incident scene
- Chief Complaint: Quote the patients chief complaint.
- Primary Assessment: Your first impression, patient's level of consciousness, airway, breathing, circulation, history of present illness, past medical history, and life threatening conditions.
- Secondary/ Focused Assessment: Information that pertains to a detailed physical exam, or a focused assessment, pertinent negatives, cardiac rhythm interpretation, 12 lead interpretation, lung sounds, and CBG
- Interventions: All interventions that were provided to the patient. (This section is required only if the intervention is not documented in the 'Interventions' section of the EPCR or further documentation of a intervention is needed.)
- Ongoing Assessment: The patient's response to the interventions or additional assessments that were performed.
- Transport: Mode of transport, destination, and the individual that patient care was transferred to.
- Notes: Any additional information that needs to be documented.

A template for the chronological format will be available in the EPCR system to help prompt the narrative writer of the needed information and organization of the narrative.

Some patient chief complaints require mandatory benchmarks.

- Chest pain or discomfort requires:

    - Patient must be placed on the monitor within 5 minutes and 12-lead obtained within 10 minutes. These times must be documented. All 12-leads that are of suspect etiology must be transmitted to receiving facility
- Intubation with endotracheal tube or esophageal airway requires:
    - Confirmation of placement by at least three approved methods
        - One of which must be capnography
- If the patient complains of pain, documentation with use of 1-10 pain scale should be used.

Formal Quality Improvement

The Rogers Fire Department will utilize a process involving three levels of review in its Quality Improvement Program.

Level 1: This level of review will be performed on reports where protocol deviation(s), without documentation of valid justification, discrepancies in reporting that do not follow SOP 203, and medication errors. Cardiac arrest, CVA, STEMI, and Trauma alerts will receive a Level 1 review. This level of review will be conducted by the EMS Program Manager. Reviews will be documented utilizing RFD Form 62.

Level 2: Reviews will elevate to Level 2 when the EMS Program Manager determines infractions or protocol deviations exist beyond documentation and/or clerical errors. This level of review will be conducted by three Master Paramedics. These reviewers will be randomly selected by the EMS Program Manager and shall not be assigned to the same platoon on which the EMS incident occurred. Anonymity of the care provider, reviewers, and patient will be maintained by all involved personnel.

Level 3: Reviews will elevate to Level 3 when two or more Level 2 reviewers recommend further action. A Level 3 review may also be initiated upon recommendation of Command Staff. This level of review, and any subsequent action, will be conducted by Command Staff personnel. This review may include the Medical Director.

The EMS Program Manager will prepare an Utstein style template report each month. This report will provide specific details on cardiac arrest events. This report will be completed and submitted to the Fire Chief no later then the 10th day of the following month. Additionally, a report outlining chest pain and cardiac rhythm disturbance incidents will be created and submitted to the Fire chief no later then the 20th day of month.
It shall be the responsibility of the EMS Program Manager to initiate a Form 62 (EMS Quality Improvement Form), on incidents that mandate review. The following incidents may also be reviewed:

1. PAI and Intubations outside of cardiac arrest incidents

2. Invasive procedures and emergency transports to the hospital, as necessary
3. Citizen complaints
4. Other circumstances, as determined by the EMS Program Manager or Fire Chief

The Medical director shall review all PAI procedures and any other call types or procedures deemed necessary.

Clinical Indicators

The following information will be attained each month to measure department-wide performance on EMS calls. Performance for all clinical skills shall be reported to the EMS Advisory Committee and Medical Director each month. It is the responsibility of the EMS Advisory Committee, EMS Program Manager, and Medical Director to determine the cause of clinical performance that falls below the levels indicated below.

Clinical Skill	Performance Threshold	Measurement Frequency	Reporting Method
Intubation Attempts and Success	70% Success Rate	Monthly	Monthly Activity Report
Intravenous Attempts and Success (Extremity)	80% Success Rate (First Attempt)	Monthly	Monthly Activity Report
Advanced Airway (Overall Success – All Methods)	100% Success Rate within three attempts (all devices, totaled)	Monthly	Monthly Activity Report
Interosseous Access	85% Success Rate (First Attempt)	Monthly	Monthly Activity Report
Blood Glucose Analysis (Unconscious, Altered LOC, and Diabetic Patients)	100% Completion on Appropriate Patients	Monthly	Monthly Activity Report
12-Lead Administration	100% Completion on Appropriate Patients	Monthly	STEMI Monthly Report

Patient Care Report – Documentation Quality Review

The Administrative Assistant to Emergency Medical Services shall complete a Form 119, CQI PCR Initial Review Form, on all patient encounters in which a patient is treated. The form shall serve as a rubric to ensure patient care reports are completed in the proper format with necessary data. PCRs found deficient in any area will require the Administrative Assistant to Emergency Medical Services to notify the EMS Program Manager.