



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director
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DATE: October 26, 2010

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Reza Vaezazizi, M.D.
ICEMA Medical Director

Virginia Hastings
ICEMA Executive Director

SUBJECT: PROTOCOLS & QI PLAN FOR 45 DAY COMMENT

The following nine (9) protocols and QI Plan have been reviewed and revised by the Protocol Education Committee and are now available for public comment and recommendations. ICEMA encourages all system participants to submit recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until December 10, 2010 at 5 P.M.** Comments may be sent hardcopy, faxed to (909) 388-5825 or via e-mail to SShimshy@cao.sbcounty.gov. Comments submitted and any revisions made will be presented at the January 2011 Emergency Medical Care Committee (EMCC) meetings held in all three counties.

Protocol

Reference #:

- 1050 MICN Certification Requirements
- 1080 Flight Nurse Authorization
- 3020 Continuing Education Provider Requirements
- 3030 EMT Continuing Education Requirements
- 5040 Radio Communication Policy
- 6020 AED Service Provider Policy (BLS) – DELETE POLICY
- 6090 Fireline Paramedic
- 10160 Axial Spinal Stabilization
- 11040 Bradycardias – Adult
- DRAFT QI Plan

RV/VH/DWS/SS/mae

Attachments: Nine (9) Protocols, QI Plan & Protocol Comments Form



MICN CERTIFICATION REQUIREMENTS

PURPOSE

To define the requirements for Mobile Intensive Care Nurse (MICN) certification within the ICEMA Region.

PROCEDURE

Initial MICN Certification

1. Possess a current California RN License
2. Successfully complete the ICEMA approved MICN course with a passing score of at least eighty percent (80%), and within six (6) months of course completion, submit the appropriate ICEMA application with:
 - a. Fee as set by ICEMA. The fee is not refundable or transferable.
 - b. Written verification of employment at a designated Base Station within the ICEMA Region.
 - c. A signed copy (front and back) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.
 - d. A signed copy (front and back) of the individual's current Advanced Cardiac Life Support Card.
 - e. Copy of current government issued photo identification (i.e. Driver's License)
3. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
4. Upon completion of 1-3 above, the applicant will be scheduled to take the ICEMA written examination.
5. Upon passing the ICEMA written examination with a minimum score of eighty percent (80%), a provisional MICN card will be issued.

- a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the examination with a score of at least 85%.
 - b. A candidate who fails to pass the ICEMA written examination on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training given by their PLN/Medical Director relating to ICEMA protocols, policies/procedures and pass the ICEMA written examination with a minimum score of 85%.
 - c. If the candidate fails to pass the ICEMA written examination on the third attempt, the applicant must repeat the course and reapply.
6. A provisional MICN may function under the direct supervision of the Base Station MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms. This timeframe may be extended upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.
 7. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Station PLN for review.
 8. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
 9. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Continuous MICN Certification

1. Possess a current California RN License and current ICEMA MICN certification.
2. Submit the appropriate completed ICEMA application with:
 - a. Written verification of employment at a designated Base Station within the ICEMA Region.

(This requirement may be waived for RN's that work in EMS for non base stations in administrative or supervisory positions that require MICN certification. Written request for waiver from the RN's supervisor or Fire Chief must be submitted to ICEMA. Evidence of field care audits and other

CE classes taught will replace the radio time. Requests will be reviewed on an individual basis by ICEMA)

- b. A signed copy (front and back) of the individual's current American Heart Association BLS Healthcare Provider or American Red Cross Professional Rescuer CPR card.
- c. A signed copy (front and back) of the individual's current Advanced Cardiac Life Support Card.
- d. Documentation of eight (8) hours of field time.
- e. Documentation of one (1) ICEMA approved Skills Day.
- f. Documentation of six (6) hours of field care audits obtained within the ICEMA region.
- g. Documentation of two (2) consecutive ICEMA Annual Review Class (ARC), one during each year of certification.
- h. Continuous certification applicants not meeting the above requirements must pay the ICEMA approved fee and successfully pass the ICEMA written examination with a minimum score of 80%.

ICEMA written examination does not replace or fulfill the requirement for a Skills Day or Field Care Audits. These must be completed prior to recertification.

3. Current photo (within last 6 months) on file at ICEMA. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
4. If the certification has lapsed for more than one (1) year, the applicant must comply with the above Initial Certification Procedure.
5. **Individuals certified less than six (6) months must submit a new application and a current state license. No education is required and a fee is not applicable.**

Individuals certified more than six (6) months but less than one (1) year must submit a new application, items a-c above and complete one (1) ARC, three (3) hours of field care audits and either a skills day or eight (8) hours of field time.

Individuals certified more than one (1) year must complete all requirements.

Inactive MICN Certification

1. Maintain a current California RN License.
2. Submit the appropriate completed ICEMA application with all of the following documentation every two (2) years of inactivation.
 - a. Copy of front and back of a current, signed ACLS Card.
 - b. Copy of front and back of current California RN License.
 - c. Documentation of one (1) ICEMA approved Skills Day taken during the year of inactivation.
 - d. Documentation of six (6) hours of field care audits obtained within the ICEMA region.
 - e. Documentation of one (1) ICEMA Annual Review class for each year of inactivation.

Return to Active MICN Status

1. Submit the appropriate ICEMA application with documentation of all inactive MICN Certification requirements and written verification of employment at a designated Base Station within the ICEMA Region.

(This requirement may be waived for RN's that work in EMS for non base stations in administrative or supervisory positions that require MICN certification. Written request for waiver from the RN's supervisor or Fire Chief must be submitted to ICEMA. Evidence of field care audits and other CE classes taught will replace the radio time. Requests will be reviewed on an individual basis by ICEMA.)
2. A provisional MICN may function under the direct supervision of the Base Station MD, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms.
3. After obtaining a provisional MICN, the individual must complete eight (8) hours of field time.
4. The PLN will choose three (3) tapes for review (one trauma, one medical and one other) and submit them to their partnered Base Station PLN for review.
5. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.

6. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

Certification by Challenge Examination

1. Possess a current California RN License.
2. Meet one (1) of the following eligibility requirements:
 - a. MICN in another county within previous twelve (12) months
 - b. MICN in ICEMA Region, but has let certification expire within the previous forty-eight (48) months, and has not fulfilled requirements for inactive MICN status
3. Submit the appropriate ICEMA application with:
 - a. Fee as set by ICEMA.
 - b. Written verification of employment at a designated Base Station within the ICEMA Region.
 - c. Copy of front and back of a current, signed ACLS Card.
 - d. Copy of front and back of current California RN License.
4. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
5. Upon completion of 1-4 above, the applicant will be scheduled to take the ICEMA written examination.
6. Upon passing the ICEMA written examination with a minimum score of 80%, a provisional MICN card will be issued.
 - a. A candidate who fails to pass the ICEMA written examination on the first attempt will have to pay the ICEMA approved fee and re-take the written examination with a minimum score of 85%.
 - b. A candidate who fails to pass the ICEMA written examination on the second attempt will be deemed ineligible for challenge certification. Applicant will

need to take an ICEMA approved MICN course and comply with initial certification requirements.

7. The individual may then function as a provisional MICN under the direct supervision of the Base Station MD, PLN or ICEMA approved designee. The supervising individual must sign all MICN call forms.
8. The PLN will choose three (3) tapes for review (one trauma, one medical and one other).
9. When three (3) tapes meet ICEMA criteria, a MICN card will be issued with the same expiration date as the candidates RN license.
10. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

MICN Recertification for RN's Working in a Non-Base Station (MICN – A)

Applies to MICN's working in administrative/supervisory positions which have been approved by ICEMA:

- a. Must complete 2c~~b~~ through 2e~~d~~ under Initial Certification above.
- b. Fee as set by ICEMA
- b.c. Must submit proof of employment with an approved non base station employer.
- e.d. Must teach or attend an additional skills day.
- d.e. Must teach or attend an additional six (6) hours of field care audits.

If employment with approved entity is terminated the MICN must change status to inactive unless employed by a Base Station or another approved non Base Station employer.

This certification may be converted to regular MICN status upon written verification of employment at a designated Base Station within the ICEMA Region.



FLIGHT NURSE AUTHORIZATION

PURPOSE

To define the requirements for EMS Aircraft Flight Nurse Authorization within the ICEMA Region.

PROCEDURE

Initial Authorization

1. Fee as set by ICEMA. The fee is not refundable or transferable.
2. Written verification of employment with an authorized EMS Aircraft provider within the ICEMA Region.

If employment with authorized EMS Aircraft provider is terminated, Flight Nurse Authorization will be rescinded unless proof of other qualifying EMS Aircraft employment is received by ICEMA within thirty (30) days.

3. Copy of current government issued photo identification (i.e. Drivers License).
4. Copy of front and back of a current, signed ACLS Card.
45. Copy of front and back of current California RN License.
65. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
76. Proof of attendance of four (4) hour Flight Nurse Orientation course.
87. Upon passing the local authorization written examination with a minimum score of eighty percent (80%), a Flight Nurse Authorization card will be issued with the same expiration date -as the candidate's RN license.
9. Flight Nurse Authorizations issued within six (6) months of nursing license expiration are exempt from reauthorization fee.

- a. ~~A candidate who fails to pass the local authorization written examination on the first attempt will have to pay the ICEMA approved fee and re-take the examination with a minimum score of 85%.~~
- b. ~~A candidate who fails to pass the ICEMA local authorization written examination on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in relation to ICEMA protocols, policies and procedures given by their EMS/QI Coordinator and pass the local authorization written examination with a minimum score of 85%.~~
- c. ~~If the candidate fails to pass the local authorization written examination on the third attempt, the individual will be ineligible to retest for a period of six (6) months.~~

REAUTHORIZATION

Submit the Flight Nurse Reauthorization application form with the following:

1. Fee as set by ICEMA. The fee is not refundable or transferable.
2. Written verification of employment with an authorized EMS Aircraft provider within the ICEMA Region.

If employment with authorized EMS Aircraft provider is terminated, Flight Nurse Authorization will be rescinded unless proof of other qualifying EMS Aircraft employment is received within thirty (30) days.

3. Copy of front and back of a current, signed ACLS Card.
4. Copy of front and back of current California RN License.
5. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.



CONTINUING EDUCATION PROVIDER REQUIREMENTS

PURPOSE

To define the requirements for approval of Continuing Education (CE) Providers within the ICEMA Region.

AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

DEFINITIONS

Emergency Medical Services (EMS) Continuing Education (CE) Provider: An individual or organization approved by the requirements of Title 22, Division 9, Chapter 11, to conduct continuing education courses, classes activities or experiences and to issue earned continuing education hours to EMS personnel for the purpose of maintaining certification/licensure or re-establishing lapsed certification or licensure.

Continuing Education: A course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.

Clinical Director: A person currently licensed as a physician, registered nurse, physician assistant or paramedic. The clinical director shall have had two (2) years of academic, administrative or clinical experience in Emergency Medicine or EMS care within the last five (5) years. The clinical director shall be responsible for monitoring all clinical and field activities approved for CE credit, approving instructors and monitoring the overall quality of the EMS content of the program.

Program Director: A person qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty (40) hours in teaching methodology. The program director will administer the CE program, ensure adherence to all state regulations, local policies, approve course content and assign course hours to any sponsored CE program per State regulations and ICEMA policy.

~~**Continuing Education:** A course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of~~

~~providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.~~

Instructor: A person approved by the program director and clinical director as qualified to teach the topics assigned or have evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one (1) year of experience within the last two (2) years in the specialized area in which they are teaching or be knowledgeable, skillful and current in the subject matter of the course, class or activity.

~~**Program Director:** A person qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty (40) hours in teaching methodology. The program director will administer the CE program, ensure adherence to all state regulations, local policies, approve course content and assign course hours to any sponsored CE program per State regulations and ICEMA policy.~~

PROCEDURE

1. To become an approved CE provider, an organization or individual shall submit an application packet at least sixty (60) days prior to the date of the first educational activity. The application packet shall include:
 - a. Name and address of the applicant;
 - b. Name of the program director, program clinical director, and contact person, if other than the program director or clinical director;
 - c. Type of organization requesting approval;
 - d. Program director and clinical director resumes including copies of all licenses/certifications; and,
 - e. ICEMA approved fee.
2. The applicant will be notified in writing within fourteen (14) working days that their request was received and informed if any information is missing.
3. Notice of approval or disapproval of the application will be made in writing to the applicant within sixty (60) calendar days of receipt of the completed application.
4. If the application is approved, an EMS CE provider number will be issued and valid for four (4) years.

5. If an application is disapproved and the organization or individual elects to submit a new application, the application packet must include all items listed in “1” above.

MAINTAINING RECORDS

1. All records will be maintained by the CE provider for four (4) years, and shall include:
 - a. Complete outlines for each course given including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance.
 - b. Record of time, place, date and CE hours granted for each course.
 - c. A resume and copies of licenses/certifications for all instructors.
2. An ICEMA approved CE roster:
 - a. Signed by course participants to include name and license/certification/accreditation number of each participant. Signing for another individual is strictly prohibited and subject to actions against certification or licensure.
 - b. A line should be drawn through any empty lines after the last attendee has signed the roster.
 - c. Copies of class rosters shall be sent to ICEMA within fifteen (15) days of class completion. These rosters shall be considered final and revisions will not be accepted.
 - d. A record of all CE certificates issued.
3. CE providers will notify ICEMA within thirty (30) calendar days of any changes in name, address, ~~telephone~~ and ~~telephone~~ number of the program director, clinical director or contact person.
4. All records shall be made available to ICEMA upon request.
5. The Clinical Director shall submit a complete list of courses with the number of individuals attending each course on a monthly basis to ICEMA on the ICEMA approved form. The form shall be submitted to ICEMA by the 10th of every month for the previous month. If no classes were taught, submit form with “No Classes This Month”

6. It is the responsibility of the CE provider to submit an application for renewal with the ICEMA approved fee at least sixty (60) calendar days prior to the expiration date in order to maintain continuous approval.
7. All CE provider requirements required by State legislation must be met and maintained.

POLICY

1. When two (2) or more CE providers cosponsor a course, only one (1) approved provider number may be used for that course, class or activity. The CE provider assumes the responsibility for all applicable provisions of Chapter 11 EMS Continuing Education.
2. The State EMS Authority shall be the agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out-of-state if not approved by the Continuing Education Board for Emergency Medical Services (CECBEMS) or approved by the EMS offices of other states or courses in physical, social or behavioral sciences offered by accredited colleges and universities.
3. An approved CE provider may sponsor an organization or individual located within California that wishes to provide a single activity or course. The CE provider shall be responsible for ensuring the course meets all requirements and shall serve as the CE provider of record. The CE provider shall review the request to ensure that the course/activity complies with the minimum requirements.



EMT-~~I~~ CONTINUING EDUCATION REQUIREMENTS

PURPOSE

To define requirements for continuing education for certified Emergency Medical Technicians-~~I~~ (EMT's-Is) in the Counties of San Bernardino, Inyo and Mono.

AUTHORITY

California Code of Regulations, Title 22, Division 9, Chapter 11 EMS Continuing Education

POLICY

To maintain certification, an EMT-~~I~~ shall:

1. Obtain at least twenty-four hours' (24) continuing education hours (CEH) from an approved continuing education provider *or*
2. ~~Successfully~~Complete a twenty-four (24) hour refresher course-meeting National Standard Curriculum from an approved EMT-~~I~~ training program.
3. Complete a verification of skills. (EMSA Form SCV)

DEFINITIONS

1. Continuing education (CE) is a course, class, activity or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as the knowledge to enhance individual and system proficiency in the practice of pre-hospital emergency medical care.
2. A ~~One~~ continuing education hour (CEH) ~~is~~ consists of ~~any one of the following~~: a minimum of fifty (50) minutes of approved classroom or skills laboratory activity. CE courses or activities shall not be approved for less than one (1) hour of credit. For courses greater than one CEH, credit may be granted in no less than half hour increments.

CONTINUING EDUCATION

1. Continuing education hours may be earned in the following manner:
 - a. Any of the topics contained in the respective National Standard Curricula for training EMS personnel.
 - b. Each hour of structural clinical or field experience when monitored by a preceptor assigned by an EMS training program, EMS service provider, hospital or alternate base station approved according to this division.
 - c. Each hour of media based/serial production CE ~~as approved by ICEMA.~~ (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules) A maximum of twelve (12) CE hours may be obtained in a twenty-four (24) hour period.
 - d. Classroom, didactic and/or skills laboratory with direct instructor interaction
 - e. Organized field care audits of patient care records
 - f. Advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care
 - g. Courses offered by accredited universities and colleges, including junior and community colleges. Acceptable courses include physical, social or behavioral sciences (i.e. anatomy, physiology, sociology, psychology) Credit shall be given on the following basis:
 - 1) One academic quarter unit shall equal ten (10) CE hours
 - 2) One academic semester unit shall equal fifteen (15) CE hours
 - h. Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual;
 - i. Sixteen hours (16) ~~Fifty percent (50%)~~ of required CEHs must come from courses involving medical management of patients. Non-medical EMS system courses (e.g. ICS, HazMat ~~FR~~~~o~~, Vehicle Extrication, Rope Rescue, etc) will be limited to eight (8) ~~twelve (12)~~ hours maximum per certification cycle.
 - j. Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by the EMS training program, EMS service provider, hospital or base

hospital. In order to receive CEHs for precepting, all the requirements for a course including objectives and student evaluations of the preceptors. CEHs for precepting are limited to a maximum of fifty percent (50%) of required continuing education hours per licensure/certification cycle for all EMS personnel.

- k. At least fifty percent (50%) of the required CE hours must be in an instructor-based format, where an instructor is readily available to the student to answer questions, provide feedback, (e.g., on-line CE course where an instructor is available to the student). The CE provider approving authority shall determine whether a CE course, class or activity is instructor based.
- l. An instructor for a CE course, class or activity will earn credit equal to the same number of CEHs applied to the course, class or activity. This shall be documented on a separate roster, clearly labeled "Instructor" and include the course name. Credit will be given, one time only, for each specific course, during a certification/licensure cycle.
- m. Credit may be given for taking the same CE course, class or activity no more than two (2) times during a single certification cycle.
- n. At the time of the educational event, the student must sign and provide certification/licensure number on the Continuing Education Course Roster. Failure to do so will result in loss of CE credit.
- o. An individual shall provide proof of approved continuing education hours obtained to ICEMA upon request and at the time of application.
- p. An individual who is currently licensed in California as a Paramedic or certified as an EMT-II or who has been certified within six (6) months of the date of application may be given credit for continuing education hours earned as a Paramedic or EMT-II to satisfy the continuing education requirement for EMT recertification.
- q. Continuing education may be obtained at any time throughout the current certification period.

~~CE courses or activities shall not be approved for less than one (1) hour of credit.~~

~~For courses greater than one (1) CEH, credit may be granted in no less than half hour increments.~~

~~Ten (10) CEHs will be awarded for each academic quarter unit or Fifteen (15) CEHs will be awarded for each academic semester unit for college courses in~~

~~physical, social, or behavioral sciences (e.g., anatomy, physiology, sociology, psychology);~~

~~CE hours will not be awarded until the written and or skills competency based evaluations, as required have been passed.~~

CONTINUING EDUCATION

1. ~~Continuing education hours may be earned in the following manner:~~

a. ~~Any of the topics contained in the respective National Standard Curricula for training EMS personnel;~~

b.

m. ~~Classroom, didactic and/or skills laboratory with direct instructor interaction;~~

n. ~~Organized field care audits of patient care records;~~

o. ~~Courses offered by accredited universities and colleges, including junior and community colleges. Acceptable courses include physical, social or behavioral sciences (i.e. anatomy, physiology, sociology, psychology) Credit shall be given on the following basis:~~

1) ~~One academic quarter unit shall equal ten (10) CE hours~~

2) ~~One academic semester unit shall equal fifteen (15) CE hours~~

e. ~~Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual;~~

d. ~~Media based and/or serial productions (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules) A maximum of twelve (12) CE hours may be obtained in a twenty four (24) hour period;~~

~~Core classes will be accepted for a maximum of twelve (12) hours of CE. (e.g. Haz Mat Fro, ICS, NEMS, SEMS, EVOC, Vehicle Extrication, Rope Rescue, etc.) ICEMA shall determine whether a CE Course or activity is EMS related and approve the appropriate hours. The content of all CE need to be relevant, and designed to enhance the practice of EMS emergency medical care. A maximum of twelve (12) CE hours may be obtained in a two (2) year certification period.~~

- e. ~~Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by the EMS training program, EMS service provider, hospital or base hospital. In order to receive CEs for precepting, all the requirements for a course including objectives and student evaluations of the preceptors. CE hours for precepting are limited to a maximum of fifty percent (50%) of required continuing education hours per licensure/certification cycle for all EMS personnel;~~
 - f. ~~Advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care;~~
 - g. ~~An instructor for a CE course, class or activity will earn credit equal to the same number of CE hours applied to the course, class or activity. This shall be documented on a separate roster, clearly labeled "Instructor" and include the course name. Credit will be given, one time only, for each specific course, during a certification/licensure cycle.~~
2. ~~At least fifty percent of the required CE hours must be in an instructor based format, where an instructor is readily available to the student to answer questions, provide feedback, (e.g., on line CE course where an instructor is available to the student). The CE provider approving authority shall determine whether a CE course, class or activity is instructor based.~~
- m. ~~Credit may be given for taking the same CE course, class or activity no more than two times during a single certification cycle.~~
 - n. ~~At the time of the educational event, the student must sign and provide certification/licensure number on the Continuing Education Course Roster. Failure to do so will result in loss of CE credit.~~
 - o. ~~An individual shall provide proof of approved continuing education hours obtained to ICEMA upon request and at the time of application.~~
 - p. ~~An individual who is currently licensed in California as a Paramedic or certified as an EMT-II or who has been certified within six (6) months of the date of application may be given credit for continuing education hours earned as a Paramedic or EMT-II to satisfy the continuing education requirement for EMT-I recertification~~
 - m. ~~Continuing education may be obtained at any time throughout the current certification period.~~



RADIO COMMUNICATION POLICY

PURPOSE PURPOSE:

To define the requirements for communication reports between EMS personnel and hospitals. The purpose of communication between EMS and hospitals is to relay essential information to allow the hospital to prepare for the patient, and as necessary, to allow a Base Station to provide Medical Control and consultation to the ALS provider. The communication report should be brief, concise, and include only the information that impacts the care of the patient in the field, and when the patient initially arrives in the hospital. It should not include unnecessary information, or impede the EMS providers focus on patient care. The communications report is not intended to be the complete patient report nor is it equivalent to the “face-to-face” report to the Emergency Department staff at the hospital. Communication reports should be given to the hospital by EMS while on scene, or as soon as possible after departing the scene. Transport of unstable patients, or patients meeting Trauma Triage Criteria shall not be delayed for a communications report. ALS providers may only accept orders from Base Stations within the ICEMA region. Patient names shall not be given over the radio except at the request of the base station physician, and with the prior approval of the patient. Base Station Physicians may give any medically appropriate order within the prehospital provider’s scope of practice.

BLS UNITS:

BLS communication reports contain minimal information since BLS units:

- a) Cannot be diverted; and
- b) Cannot carry out medical control orders

BLS communications reports contain:

- a) The EMS unit identifier, and that it is a BLS report;
- b) The patient’s age, sex, chief complaint/injury, and ETA;
- c) Vital signs, Glasgow Coma Scale, and other pertinent signs/symptoms and information.

ALS UNITS:

Receiving Hospital communication reports are designed for:

Informing the receiving hospital (Base station or otherwise) of incoming patients not requiring medical control orders or consultation.

Receiving Hospital communications reports contain:

- a) The EMS unit identifier, that it is a *receiving hospital* report, and the provider's name/certification level;
- b) The patient's age, sex, chief complaint/injury, and ETA;
- c) Information that impacts patient care.

Base Station communication reports are for:

1. Requesting consultation or medical control orders from a Base Station;
2. Informing or consulting with a Specialty Base Station (Trauma, STEMI, Stroke Center, etc...)
3. Patients receiving ALS interventions:
 - a. Who do not improve; or
 - b. Who are not being transported by ambulance; or
 - c. Prior to terminating resuscitative efforts.
4. All patients under nine years old that are not transported by ambulance. Base Station contact shall be made while the EMS provider is on scene (if safe).
5. Interfacility transfers needing medications and/or a destination change per protocol #8010.
6. Multiple Casualty Incidents (MCI) per protocol #5050

Base Station communications reports are to contain:

- a) The EMS unit identifier, that it is a **Base Station** report, and the provider's name/certification level;
- b) The severity of the patient, and if the patient is a "specialty" patient (Trauma, STEMI, Stroke, etc.);
- c) Patient age, sex, general appearance, weight in kilos, and level of responsiveness (or Glasgow Coma Scale when appropriate);
- d) Chief complaint/injuries, and mechanism of injury/patient situation;
- e) Vital signs, cardiac monitor reading, and remarkable physical exam findings;

- f) Pertinent medical history;
- g) Prior to contact treatment initiated and patient response;
- h) Information that impacts patient care;
- i) ETA.

Base Stations will provide:

- a) Contact time, and the name of the MICN (and Base Station Physician when present);
- b) Consultation and medical control orders appropriate to the patient condition.

PATIENT DESTINATION:

Patient/guardian/family/law enforcement requests for a given hospital with Emergency Department capability should be honored. Exceptions may include:

- a) Patient condition and/or protocol requires transport to a closer, or more appropriate (Specialty) hospital.
- b) All patients on a 5150 hold must go to the closest facility for medical clearance prior to transfer to a psychiatric facility.
- c) Requested hospital is on internal disaster.
- d) Requested hospital is significantly beyond the primary transport area of the transporting department or division.

In cases where the patient/guardian is demanding transport to a facility against the judgment of the paramedic, Base Station contact will be made, and patient destination becomes the responsibility of the Base Station Physician. If the patient/guardian continues to demand transport to a facility against the judgment of the Base Station Physician, they must be informed of the risks of their decision, up to and including death. The patient/guardian may sign a Release of Liability to go to their hospital choice. The Patient Care Report will document the circumstances of the refusal.

HELICOPTER TRANSPORTS:

In San Bernardino County, the San Bernardino County Communications Center (Comm Center) will assign the destination hospital for trauma patients when a request for a helicopter is received.

1. When possible, Comm Center will notify both the ground EMS units and the responding helicopter of the assigned destination hospital.

2. Trauma Base Contact should be made as soon as practical by the ground EMS personnel or the aircrew.
3. Whenever possible, Trauma Base Contact will be made with the Trauma Hospital that will actually be receiving the patient.
4. Upon arrival of the helicopter, the ground EMS personnel will give a patient report to the aircrew, and include:
 - a) The assigned destination hospital (if known);
 - b) If Trauma Base Contact has been made (and with which Trauma Base); and
 - c) If the assigned destination hospital was changed (and the reason for the change).
5. The helicopter aircrew will contact the actual receiving Trauma Hospital to:
 - a) Request a landing pad assignment;
 - b) Provide a patient report, or update on patient condition; and
 - c) Inform them if Trauma Base Contact was originally made with a different Trauma Base.
 - a. If the original Trauma Base Contact was made with a different Trauma Base, the actual receiving Trauma Hospital will notify the original Trauma Base of the change in destination.

For Interfacility Protocol #8010:

Interfacility transport patients with a deteriorating condition significant enough to require medication administration and/or a destination change require Base Station contact.

- a. Paramedics may initiate Prior to Contact protocols, and shall make Base Station contact. The Base Station will be notified of the status change of the patient, the medications administered prior to contact, and any need for further orders or destination changes.
- b. The Base Station shall notify both the sending facility and the original receiving facility of a destination change.
- c. The Base Station will include an evaluation of any destination change in their ICEMA CQI report.

~~To define the requirements for medical communications between all prehospital personnel, basestations and receiving hospitals. All patient information, treatment and the time initiated will be recorded accurately and completely on the patient care report. No patient names will be given over the radio except at the request of the base station physician and with patient approval. ALS transport/non-transport agencies may only accept orders from Base Station within the ICEMA Region. The base station physician may vary deviate from ICEMA protocol if it is deemed medically appropriate and if the orders are within the provider scope of practice.
(The Base Station Physician may, if medically appropriate give any order within the provider's scope of practice.~~

BLS PROCEDURE

- ~~1. Each BLS transport will be equipped with a county approved communication device.
(this statement will be moved to the standard drug and equipment list)~~
- ~~2. For any acute or unstable patient a receiving hospital must be contacted prior to arrival as soon as possible with the following information:
 - ~~a. The unit number, EMT-I name and the situation.~~
 - ~~b. The patient description to include age, sex and approximate weight in kilograms (kg).~~
 - ~~c. Patient's chief complaint and related signs and symptoms, and the mechanism of injury, if appropriate.~~
 - ~~d. Vital signs to include blood pressure, pulse, respiratory rate and effort, pupil response, skin vital signs, capillary refill and Glasgow Coma Scale and ETA.~~~~
- ~~3. For stable patients or for routine transfers a receiving hospital must be contacted as soon as possible with the following information:
 - ~~a. The unit number, EMT-I name and the situation.~~
 - ~~b. The patient description to include age, sex, chief complaint/injury BP, pulse, respirations and ETA.~~~~

ALS PROCEDURE

- ~~1. Each ALS unit (transport and non-transport) will be equipped with a minimum of one (1) mandatory communication device and one (1) optional communication~~

device:

a. ~~Mandatory Communication Devices:~~

- i. ~~800 MHZ radio in San Bernardino County.~~
- ii. ~~VHF (MED NET) radio approved for Inyo & Mono Counties only.~~

b. ~~Optional Communication Devices:~~

- i. ~~UHF (COR) radio approved for Mono County only.~~
- ii. ~~Cellular phone approved for all counties.~~
- iii. ~~Other device as approved.~~

~~This section under review by ICEMA Communication committee and will be included in the Standard Drug and Equipment~~

~~station~~

2. ~~Base Station contact shall be initiated on the following:~~

a. ~~Any patient receiving ALS interventions and remaining symptomatic following ALS interventions.~~

b. ~~Any patient receiving ALS interventions who refuses transport.~~

c. ~~Any patient contact with a child under the age of nine (9), and the . When a caregiver refuses transport, base station contact shall be made prior to the EMS provider leaving the scene.~~

d. ~~Any patient receiving ALS Interventions prior to Determining Death on Scene (Protocol Reference #12010). (What is the purpose of this statement)~~

e. ~~During an interfacility transfer, any change in patient status that requires a medication order or change in destination.~~

f. ~~Base Station contact may also be made on Any patient who, in the judgment of the EMT-P's judgment, would benefit from base station consultation.~~

3. ~~In a declared MCI, base station contact will be established per Protocol Reference #5050, Medical Response to a Multi-Casualty Incident.~~

~~In areas with short transport times or when functioning in radio communication failure (RCF), contact must be made as early as possible with the receiving facility on all transported patients not meeting criteria for base station contact.~~

4. ~~When base station contact is initiated; the following information will be given by the EMT-P unless the base station waives this information:~~
 - a. ~~The unit number, EMT-P name and the situation.~~
 - b. ~~The patient description to include age, sex and approximate weight in kilograms (kg).~~
 - c. ~~Patient's chief complaint and related signs and symptoms, and the mechanism of injury, if appropriate.~~
 - d. ~~Vital signs to include blood pressure, pulse, respiratory rate and effort, and oxygen saturation if appropriate.~~
 - e. ~~Physical assessment and general appearance.~~
 - f. ~~Pertinent past medical history, including medications and allergies~~
 - g. ~~Cardiac Monitor interpretation, if appropriate.~~
 - h. ~~Prior to contact therapy initiated and response including all medication dosages and route given.~~

6. ~~After contact, the MICN will provide the following:~~
 - a. ~~Both the MICN and physician names, with time of contact.~~
 - b. ~~Acknowledge any interventions or medications given prior to contact.~~
 - c. ~~All medication orders given will state the medication name, dosage and route.~~

7. ~~Patient destination is the responsibility of the base station physician, based upon patient condition and patient and/or family/law enforcement request.~~
 - a. ~~Patient request for a certain facility should be honored unless:~~
 - i. ~~Patient medical condition is acute and meets criteria for diversion to a closer facility.~~
 - ii. ~~Request is for a facility further than thirty (30) minutes away and outside of the transporting agency's EOA. In these cases, the patient will be offered transport to the closest appropriate facility.~~
 - iii. ~~Requested facility is closed due to Internal Disaster.~~

~~iv. Requested facility is not a designated paramedic receiving facility.~~

~~b. In cases when a patient request may be determined by the base station physician to be detrimental to the patient's condition, the patient and/or family/law enforcement must be informed as to the risks up to and including death. All circumstances should be documented on the patient care report.~~

~~c. If a patient is adamant about the destination explain all risks, patient may sign AMA to go to the destination of their choice. Document all information appropriately.~~

~~8. During an Interfacility Transfer:~~

~~a. If patient condition significantly deteriorates requiring ALS interventions during transport, patient destination may be changed by contacting a base station.~~

~~b. If patient destination is changed, it is the responsibility of the base station to notify both the sending facility and the original designated receiving facility of this change.~~

~~c. The base station hospital will include an evaluation of any destination change in their ICEMA CQI report.~~

~~d. Base station contact is required for any medication order during an inter facility transport. Paramedics may initiate prior to contact protocols if the patient's condition deteriorates, then must contact the Base Station for further orders or destination changes.~~

~~9. In San Bernardino County, the San Bernardino County Communications Center will determine the destination of trauma patients when a request for an aircraft is received. Upon arrival of the aircraft:~~

~~a. The ground crew shall give report and inform the designated aircrew member regarding trauma base station contact: and receiving facility if known~~

~~i. If trauma base station contact was made the aircrew shall maintain contact with that trauma base station regardless of destination.~~

~~ii. In the event that the ground crew did not contact a trauma base, the aircrew shall contact the receiving trauma base.~~

~~b. LLUMC Receiving hospital must be contacted directly by the aircrew for pad assignment or changes in destination.~~

~~e. If the designated trauma receiving facility destination is changed for any reason, the trauma base station initially contacted shall be immediately notified of destination change by the aircrew.~~

~~d.a. ICEMA shall be notified of any destination change and a QI report forwarded to ICEMA within five (5) days of the transport.~~



EMT AED SERVICE PROVIDER POLICY ~~-BLS~~

DELETE POLICY

PURPOSE

To establish a standard mechanism for approval and designation of EMT AED Service Providers in the ICEMA region.

AUTHORITY

Health and Safety Code, Division 2.5, Sections 1797.196, California Code of Regulations Title 22 Division 9., Chapter 2 Emergency Medical Technician I.

POLICY

ICEMA shall approve all EMT AED service providers prior to beginning service. Approval may be revoked or suspended for failure to comply with requirements of this policy or Title 22.

EMT~~BLS~~ AED SERVICE PROVIDER APPROVAL

Provider agencies that are seeking approval to implement AED services shall submit the following to ICEMA for review and approval prior to beginning service:

1. Description of the area served by the provider agency.
2. The model name of the AED(s) to be utilized.
3. Identify the individual responsible for managing the AED program.
4. Identify the primary instructor with qualifications and the training program to be used.
5. Policies and procedures to ensure orientation of AED authorized personnel.
6. Procedures for maintenance of the AED.
7. Policies and procedures to collect, maintain and evaluate patient care records. Attached AED Event Summary Worksheet may be utilized.

RECORD KEEPING AND REPORTING REQUIREMENTS

1. The following data will be collected and reported to ICEMA by March 1 for the previous calendar year.
 - ~~1. The total number of patients defibrillated who were discharged from the hospital alive.~~
 - a. The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.
 - b. The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed.
 - c. The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation.
2. Provider must maintain a listing of all AED personnel and provide upon request to ICEMA.

DELETE POLICY



FIRELINE PARAMEDIC EMERGENCY PROTOCOL

PURPOSE

To provide guidance and medical oversight for an ICEMA paramedic deployed to function as a fireline paramedic.

This protocol is for use by authorized fireline paramedics during fire suppression activities and treatment of fire suppression personnel only.

AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220 California Code of Regulations, Title 22, Division 9, Sections 100165 and 100167 California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan, (3-2002). California Code of Regulations Title 22, Division 9, Section 100165 (1) states: “*During a mutual aid response into another jurisdiction, a paramedic may utilize the scope of practice for which s/he is trained and accredited according to the policies and procedures established by his/her accrediting local EMS agency.*”

DEFINITIONS

Fireline Emergency Medical Technician-P (FEMP): A paramedic who meets all prerequisites established by FIRESCOPE and is authorized by the paramedic’s department to provide ALS treatment on the fireline to ill or injured fire suppression personnel.

REQUIREMENTS

1. Must be a currently licensed paramedic in California.
2. Must be currently accredited paramedic in the ICEMA region.
3. Must be currently employed by an ICEMA approved ALS provider.
4. The FEMP will follow FIRESCOPE FEMP ICS 223-11 Position Manual and all other ICS protocols.
5. The FEMP will check in and obtain briefing from the Logistics Section Chief or the Medical Unit Leader, if established. Briefing will include current incident situation, anticipated medical needs, and local emergency medical system orientation.
6. The FEMP will provide emergency medical treatment to personnel operating on the fireline.

7. The FEMP will follow ICEMA prior to contact protocols if unable to contact the assigned base station.
8. The FEMP may not perform skills outside of the ICEMA scope of practice.

PROCEDURE

1. The provider agency will notify ICEMA of the deployment of the FEMP to an incident.
2. The FEMP will carry inventory in the ALS pack as per the attached inventory list. Inventory will be supplied and maintained by the employing provider agency. Additional items for restock should also be maintained and secured in a vehicle or in the Medical Unit trailer.
3. Incident Medical Units may not have the capability of resupplying controlled substances (narcotics). Providers should stock sufficient quantities of medical supplies and medications, especially controlled substance medications, to assure adequate supplies and medications.
4. Narcotics must be under double lock and maintained on the FEMP person or secured in his/her vehicle at all times as per the ICEMA Drug and Equipment List.
5. FEMP may carry an inventory of controlled substances (i.e. Morphine and Midazolam) if authorized by the employing agency's Medical Director. The authorizing Medical Director is responsible to assure full compliance with all federal and state laws relating to purchase, storage and transportation of controlled substances. Only controlled substances approved for use in the ICEMA region may be carried and their use must be in accordance with current ICEMA patient care protocols.
6. Radio communication failure protocols will not be used. Prior to base contact protocols will be followed. If further treatment is needed, radio contact with the base station should be established as soon as possible.
7. Documentation of patient care must follow ICEMA protocol utilizing the ePCR, if available, or a paper O1A form. All patient care reports will be reviewed by the provider agency and ICEMA for QI purposes.
8. A FEMP will be paired with a fireline EMT (FEMT) or another FEMP who will assist with BLS treatment and supplies.

FIRELINE EMT-P (ALS) PACK INVENTORY

Minimum Requirements. The weight of the pack will dictate if the paramedic chooses to carry additional ALS supplies.

ALS AIRWAY EQUIPMENT

1. Endotracheal intubation equipment
 - a. 6.0, 7.0 and/or 7.5 ET
 - b. Mac 4, Miller 4, and handle (pediatric suggested for weight)
 - c. Stylet and/or gum elastic intubation stylet
2. King Airway -- one each - Size 3, 4 and 5
3. ET tube holder
4. End tidal CO2 Detector
5. Needle cricothyrotomy kit
6. Needle thoracostomy kit

IV/MEDICATION ADMINISTRATION SUPPLIES

1. IV administration set macro drip (2)
2. Veneguard (2)
3. Alcohol preps (6)
4. Betadine swabs (4)
5. Tourniquet (2)
6. Razor (1)
7. Tape (1)
8. IV catheters 2 each - 14, 16, 18 and 20 gauge
9. 10cc syringe (2)
10. 1 cc TB syringe (2)
11. 18 gauge needle (4)
12. 25 gauge needle (2)
13. Lancets

MISCELLANEOUS

1. Sharps container (1)
2. Narcotic storage per protocol
3. FEMP pack inventory sheet (1)
4. Patient care record or ePCR (Toughbook)
5. AMA forms (3)

EQUIPMENT

1. Compact AED or compact monitor defibrillator combination
2. Appropriate cardiac pads
3. Pulse oximetry (optional)
4. Glucometer and test strips (4)

MEDICATIONS

1. Albuterol Solution 2.5 mg (4) Handheld Nebulizer or Multidose Inhaler
2. Atropine Sulfate 1 mg (2)
3. Ipratropium Bromide Solution 0.5mg (4) -Handheld Nebulizer or Multidose Inhaler
4. Lidocaine 100 mg IV pre-load (2)
5. Aspirin 80 mg chewable bottle (1)
6. Dextrose 50% 25gm pre-load (1)
7. Diphenhydramine 50 mg (4)
8. Epinephrine 1: 10,000 1mg (2)
9. Epinephrine 1: 1000 1mg (4)
10. Glucagon 1mg (1)
11. Midazolam 20 mg
12. Morphine Sulfate 10 mg/ml (amount determined by the medical director)
13. Nitroglycerin spray 0.4 metered dose (1)
14. Saline 0.9% IV 1000 ml may be divided in two 500ml bags or four 250 ml bags.

The BLS pack and supplies will be carried by the FEMT or accompanying FEMP. Personal items and supplies cannot be carried in either the ALS pack or the BLS pack.



AXIAL SPINAL STABILIZATION

FIELD ASSESSMENT/TREATMENT INDICATORS

Any patient in which axial spinal stabilization is clinically indicated, including but not limited to the following:

1. ~~1. Patient meets Mechanism of injury as described in Protocol reference #15030, Trauma Triage Criteria and Destination Policy~~
2. ~~2. Soft tissue damage associated with trauma and/or blunt trauma above the clavicles~~
3. ~~3. Any blunt trauma above the clavicles.~~
4. ~~4. Unconscious patients where the mechanism of injury is unknown.~~
5. ~~5. All intubated neonatal and pediatric patients.~~
6. ~~Cervical pain or pain to the upper 1/3 of the thoracic vertebrae. Spinal tenderness or pain, with or without movement of the head or neck, distal numbness, tingling, weakness or paralysis.~~
7. ~~Altered mental status.~~
8. ~~Appear to be under the influence of alcohol or other drugs (even if the patient is alert and oriented).~~
9. ~~Additional sites of significant distracting pain or is experiencing emotional distress.~~
10. ~~Less than four (4) years of age with appropriate injuries requiring axial spinal stabilization.~~
11. ~~Unable to adequately communicate with the EMS personnel due to a language barrier or other type of communication difficulty.~~
12. ~~Any other condition that may reduce the patient's perception of pain.~~

ALS personnel may remove patients placed in axial spinal stabilization by First Responders and BLS personnel if the patient does not meet any of the above indicators after a complete assessment and documentation on the patient care record:

BLS INTERVENTIONS

1. Apply manual axial stabilization.
2. Assess and document distal function before and after application.
3. For pediatric patients: If the level of the patient's head is greater than that of the torso, use an approved pediatric spine board with a head drop or arrange padding on the board to keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.
4. For patients being placed on a board, consider providing comfort by placing padding on the backboard.
5. Any elderly or other adult patient who may have a spine that is normally flexed forward should be stabilized in patient's normal anatomical position.
6. When a pregnant patient **in the third trimester** is placed in axial spinal stabilization, **place in the left lateral position** ~~the board should be elevated at least four (4) inches on the right left side~~ to decrease pressure on the Inferior Vena Cava.
7. Certain patients may not tolerate normal stabilization positioning due to the location of additional injuries. These patients may require stabilization in their position of comfort. Additional materials may be utilized to properly stabilize these patients while providing for the best possible axial spinal alignment.

ALS INTERVENTIONS/INDICATIONS (move up above interventions)

~~ALS personnel may remove patients placed in axial spinal stabilization by First Responders and BLS personnel if the patient does not meet **any** of the following indicators after a complete assessment and documentation on the patient care record:~~

- ~~1. Cervical pain or pain to the upper 1/3 of the thoracic vertebrae. Spinal tenderness or pain, with or without movement of the head or neck, distal numbness, tingling, weakness or paralysis.~~
- ~~2. Altered mental status.~~
- ~~3. Appear to be under the influence of alcohol or other drugs (even if the patient is alert and oriented).~~
- ~~4. Additional sites of significant distracting pain or is experiencing emotional distress.~~

~~5. Less than four (4) years of age with injuries.~~

~~6. Unable to adequately communicate with the EMS personnel due to a language barrier or other type of communication difficulty.~~

~~7. Any other condition that may reduce the patient's perception of pain.~~

ALS personnel may remove patients placed in axial spinal stabilization by First Responders and BLS personnel if the patient does not meet **any** of the above indicators after a complete assessment and documentation on the patient care record:



BRADYCARDIAS - ADULT

ASYMPTOMATIC BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Heart rate less than 60 bpm.~~bmp~~.
2. Signs of adequate tissue perfusion.

BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm.~~bmp~~.
2. Reduce anxiety, allow patient to assume position of comfort.
3. Administer oxygen as clinically indicated.

ALS INTERVENTIONS

1. Establish vascular access if indicated. If lung sounds clear, consider bolus of 300cc NS, may repeat.
2. Place on cardiac monitor and obtain rhythm strip for documentation with copy to receiving hospital

SYMPTOMATIC BRADYCARDIA

FIELD ASSESSMENT/TREATMENT INDICATORS

Signs of inadequate tissue perfusion/shock.

BLS INTERVENTIONS

1. Recognition of heart rate less than 60 bpm.
2. Reduce anxiety, allow patient to assume position of comfort.
3. Administer oxygen as clinically indicated.

ALS INTERVENTIONS

1. Consider advanced airway, as indicated.
2. Administer IV bolus of 300cc. Maintain IV rate at 300cc/hr if lungs remain clear to auscultation.
3. Place on Cardiac monitor and obtain rhythm strip for documentation. Provide copy to receiving hospital.
4. Administer Atropine 0.5mg IVP. May repeat every five (5) minutes up to a maximum of 3mg or 0.04mg/kg.
5. **Consider TCP**, per Protocol Reference #10110, instead of Atropine for documented MI, 3rd degree AV Block with wide complex and 2nd degree Type II AV Block.
6. Attempt transcutaneous cardiac pacing of a bradycardic rhythm with continued symptoms of inadequate tissue perfusion.
7. Consider Dopamine 400mg in 250 cc of NS to infuse at 5-20 mcg/ kg/min, titrated to sustain a systolic B/P greater than 90mmHg, and signs of inadequate tissue perfusion/shock.
8. Contact Base Station.

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INTRODUCTION

In 1991, the California Emergency Medical Services Authority (EMSA) promulgated legislation which mandated that local Emergency Medical Services (EMS) agencies establish a system-wide quality assurance program. This legislation requires Advanced Life Support (ALS) service providers and base stations to develop and implement a quality assurance program approved by Inland County Emergency Medical Agency (ICEMA).

On January 1, 2006, EMSA implemented regulations related to quality improvement for EMS throughout the State. ICEMA's Continuous Quality Improvement Program (CQIP) satisfies the requirements of Title 22, Chapter 12, Section 4 of the California Code of Regulations.

Continuous Quality Improvement (CQI) is an ongoing process in which all levels of health care are encouraged to team together, without fear of management repercussion, to develop and enhance the EMS system. Based on EMS community collaboration and a shared commitment to excellence, CQI reveals potential areas for improvement of the EMS system, training opportunities, highlights outstanding clinical performance, audits compliance of treatment protocols and allows the review of specific illnesses or injuries and their associated treatments. This program contributes to the continued success of our emergency medical services system through a systematic process of review, analysis and improvement.

CQI implements the principles of quality improvement by defining standards, monitoring the standards and evaluating their effectiveness. It places increased emphasis on the processes of care and service rather than on the performance of individuals. It also emphasizes the role of leadership in continuous quality improvement rather than only on solving identified problems and maintaining improvement over time.

The by-product of the program is the alliance of municipal agencies and private providers that offer EMS within the ICEMA region. This provides all participants the opportunity to provide optimal service and to provide input and support to an EMS system in which they have ownership.

The ICEMA CQIP has been written in accordance with the Emergency Medical Services System Quality Improvement Program Model Guidelines #166 (Rev. 03/04).

PURPOSE

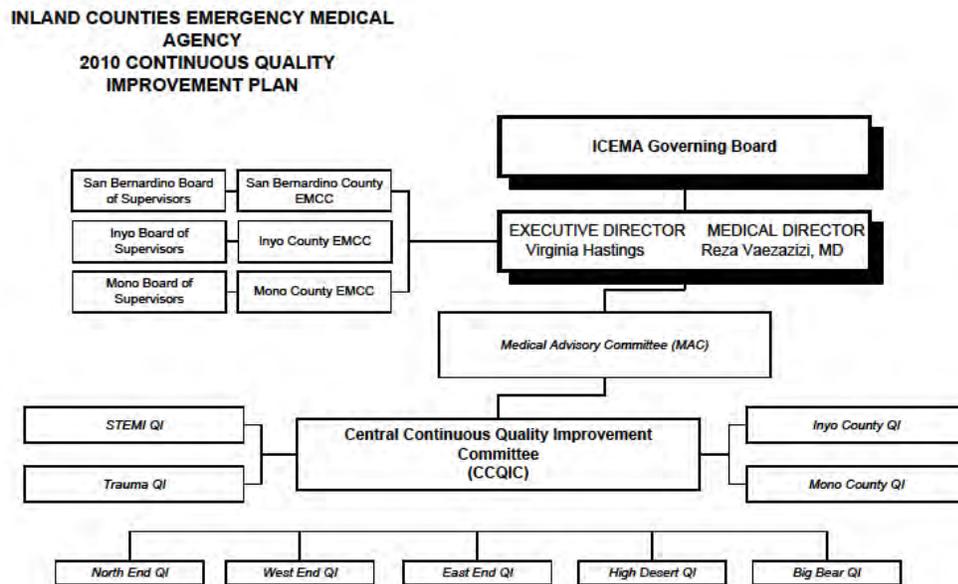
The purpose of the ICEMA CQIP is to establish a system-wide process and provide an effective tool for evaluating and improving the quality of prehospital care within the ICEMA region. This tool will focus on improvement efforts to identify root causes of problems and interventions to eliminate or reduce those problems. While striving to improve the system, the CQIP will also recognize excellence in performance and service to the stakeholders.

SECTION I - STRUCTURE & ORGANIZATIONAL DESCRIPTION

I. ORGANIZATION

ICEMA is a three county Emergency Medical Services Agency serving the counties of San Bernardino, Inyo, and Mono counties. The three counties largely provide advanced life support and basic life support services.

A. Organizational Chart



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B. Mission Statements

ICEMA

ICEMA is tasked with ensuring an effective system of quality patient care and coordinated emergency medical response by planning, implementing and evaluating an effective EMS system including prehospital providers and specialty care hospitals.

CQI

The CQI mission is to promote the highest level of quality in prehospital care within the ICEMA region by providing CQI, education, monitoring tools and anticipatory planning.

C. Goals of the Continuous Quality Improvement Program

1. Empower EMS providers to provide consistently the highest quality of emergency medical care in the ICEMA region.
2. Provide leadership and guidance in promoting quality in the local EMS system with the cooperation of EMS providers in an educational and non-punitive environment.
3. Develop leadership to create an acceptance and belief in quality improvement and educate provider management regarding the importance of the commitment to quality improvement.
4. Provide leadership in developing programs that implement the CQI process by providing examples of high quality training and educational resources.
5. Develop and provide an atmosphere of encouragement and support that promotes excellence and personal accountability to provider personnel in all levels of management and field staff.
6. Create constancy in the CQI process to maximize efficiency and effectiveness in each EMS provider organization.
7. Promote rapid and appropriate quality treatment of all patients regardless of economic or social status in the quickest and most efficient manner possible.
8. Evaluate the benefits of new programs and procedures to provide “State of the Art” health care within the ICEMA region.
9. Provide a conduit for communication between EMS providers and other agencies to positively resolve issues in addition to providing education and encouraging growth within the EMS system.

II. STRUCTURE

A. ICEMA CQI Team

1. ICEMA is responsible for the oversight and implementation of the regional CQIP, data collection and evaluation of the EMS system in the region.
2. ICEMA CQI Team will function with direction and under the auspices of the Medical Director and Executive Director. This team shall include an educational coordinator, QI Coordinator, data analyst, ICEMA Medical Director and Executive Director.

B. ICEMA's Duties

Shall include but not be limited to:

1. Serve as the central repository of data gathered from CQI activities.
2. Provide an annual review of the CQIP for compatibility to the system and update, if needed.
3. Facilitate a performance improvement action plan with the cooperation of the appropriate EMS providers when the CQIP recognizes a need for improvement. EMS system clinical issues will require ICEMA Medical Director involvement.
4. Provide information to EMS provider advisory groups to assist in the development of performance improvement plans.
5. Work in conjunction with the EMSA to:
 - Participate in the EMSA Technical Advisory Group.
 - Assist with the responsibilities of the state-wide CQIP.
 - Assist in development, approval and implementation of State required and optional EMS system indicators.
6. Provide monitoring, data collection, reporting and evaluation of EMS system indicators from EMS providers and hospitals in the ICEMA region.
7. Identify and develop specific indicators for system evaluation based on the unique needs of the ICEMA region.
8. Annually review, expand on and improve State and local EMS system indicators as needed.

9. Provide opportunities for review of QI indicators and performance improvement plans by designated EMS providers.
10. Provide technical assistance, training and in-service education to all organizations participating in the ICEMA CQIP.
11. Provide an annual summary of activity and CQIP implementation. The summary will be provided annually to the EMSA and should include but not limited to a summary of QI indicators.

C. Description of Committees

1. Medical Advisory Committee

The Medical Advisory Committee (MAC) will function under the direction of the ICEMA Medical Director. The ICEMA Medical Director shall serve as chair and may appoint an alternate chair in his absence. The members shall have education and experience in EMS systems and regional prehospital care. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- Base Station Physician
 - Trauma Base Physicians (2 representatives)
 - Non Trauma Base Physicians (2 representatives)
- Non Base Station Physician
- Public Transport Medical Director
- Private Transport Medical Director
- Fire Department Medical Director
- Ambulance Association Representative
- EMS Nurses Representative
- EMS Officers Representative
- Inyo County Representative
- Mono County Representative

2. Central Continuous Quality Improvement Committee

The Central Continuous Quality Improvement Committee (CCQIC) will function under the direction of the ICEMA Medical Director and Executive Director. The members shall have education and experience in evaluation of EMS data systems and EMS QI program management. The members will participate in monitoring and evaluating the CQIP. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director
- ICEMA Representative(s)
 - CQI Program Coordinator

- Educational Coordinator
- Data Program Coordinator
- Regional Continuous QI Committee Members (7, one from each committee)
- EMS Service Provider Medical Director (2)
(one public and one private provider representative)
- Base Station Medical Director (2)
(one Trauma Center and one non-Trauma Center)
- EMS Provider QI Program Coordinator (2)
(one public and one private provider representative)
- Paramedic Training Program Representative (2)
 - Crafton Community College
 - Victor Valley Community College
- Base Station Nurse Coordinator (2)
(one Trauma Center Paramedic Liaison Nurse (PLN) and one non-Trauma Center PLN)
- Nurse from a non-base STEMI Center
- Representatives from 9-1-1 receiving facilities emergency department representatives (2)
(Non Base Station)
- EMT and EMT-P Representative
Certified/licensed personnel accredited within ICEMA (2)
(one public and one private provider representative)

3. Regional Continuous Quality Improvement Committees

Due to the size of the ICEMA region, QI Committees are regionalized under the umbrella of the CCQIC. The Regional CQI Committees (RCQIC) function under the direction of the ICEMA Medical Director and Executive Director. The members shall have education and experience in the evaluation of EMS data system and CQIP management. The members will participate in monitoring the process as it unfolds within the system. These committees meet monthly. The members shall be multidisciplinary and include the following established committees:

- West End CQI Committee
- East End CQI Committee
- North End CQI Committee
- Big Bear CQI Committee
- Hi Desert CQI Committee (Joshua Tree/29 Palms)
- Inyo County CQI Committee
- Mono County CQI Committee

4. STEMI CQI Committee

The STEMI CQI Committee (STCQIC) functions under the direction of the ICEMA Medical Director and Executive Director. The members will have education and experience in the evaluation of Cardiovascular QI program management. The members will participate in ongoing monitoring and evaluation of the ICEMA STEMI program as it unfolds in the system. This committee meets quarterly. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director
- ICEMA Representative(s)
 - STEMI CQIP Coordinator
 - Educational Coordinator
 - Data Program Coordinator
- STEMI Center Medical Director(s)
(One from each facility either ED Director or Cath Lab Director, or their designee)
- Base Station Medical Director (2)
(one STEMI center and one non-STEMI center)
- EMS Provider CQI Program Coordinator (2)
(one public and one private provider representative)
- Base Station Nurse Coordinator (2)
(one STEMI center PLN and one non-STEMI center PLN)
- Representatives from local receiving facilities emergency department physicians (2)
(Non STEMI center)
- Representative Advanced Life Support (ALS) Providers Certified/licensed personnel accredited within ICEMA (2)
(one public and one private provider representative)
- Cath Lab Nursing Directors or designee

5. Trauma System Advisory Committee

The Trauma System Advisory Committee (TSAC) monitors trauma related care and system related issues, including air utilization. TSAC also serves as the prehospital and hospital medical care and system advisory committee. This committee meets quarterly.

TSAC functions under the direction of the ICEMA Medical Director and Executive Director. TSAC members will have education and experience in the management and evaluation of the Trauma QIP. The members will participate in ongoing monitoring and evaluation of the Trauma QIP. The members shall be multidisciplinary and include the following:

- ICEMA Medical Director
- ICEMA Executive Director

- ICEMA Representative(s)
 - Trauma Coordinator
 - Educational Coordinator
 - Data Program Coordinator
- Trauma Center Medical Director(s)
(one from each trauma center)
- Pediatric Trauma Attending(s)
(one from each trauma center)
- Base Station Medical Director (2)
(one from a trauma center and one from a non-trauma center)
- Non-Trauma Center Emergency Department Physicians
(with an interest in trauma care)
- Trauma Center Coordinator (2)
 - ARMC
 - LLUMC (Adult)
 - LLUMC (Pediatric)
- Trauma Center PLNs
(one from each trauma center)
- EMS CQI Program Coordinators
- Prehospital Personnel
 - Fire Chief's Association Representative
 - Ambulance Representative
 - Air Rescue Representative
 - Coroner or Representative

6. Trauma and Air Audit Committee

ICEMA participates in a joint San Bernardino County and Riverside County Quality Improvement committee called Trauma and Air Audit Committee (TAAC). TAAC is a closed, regional QI committee addressing multi-county system and medical issues. This committee meets quarterly. The TAAC committee is comprised of representatives from both San Bernardino and Riverside Counties:

- Riverside EMS Agency Representatives
- ICEMA Representatives
- Medical Directors (ED/Trauma and non-trauma hospital)
- Nurse Managers (ED/Trauma and non-trauma hospital)
- Trauma Hospital Paramedic Liaison Nurses (PLNs)

D. Term of Committee Memberships

Term of Membership shall be two (2) years expiring December 31 and subsequent new terms shall begin January 1. The terms shall be staggered so that no more than two-thirds of the membership shall expire in any one-year period. A member whose term has expired shall continue to serve until a new appointment is confirmed. Members may be reappointed.

E. Attendance

1. Members will notify ICEMA in advance of any scheduled meeting they will be unable to attend.
2. At the discretion of ICEMA, other individuals may participate in the meetings when their expertise is essential to make appropriate determinations.
3. The absence of a committee member from two (2) consecutive meetings of the committee shall be cause for the Chairman to contact the committee member to discuss participation in the meetings. Whenever a committee member fails to attend two (2) consecutive meetings or three (3) total meetings in a calendar year, without good cause, the Chairman shall discuss with the committee and recommend the members removal from the committee.
4. Resignation from the committees must be submitted, in writing, to ICEMA, and is effective upon receipt, unless otherwise specified.

F. Chairperson

The ICEMA Medical Director shall serve as chair of the CCQIC. Other committees will allow nominations and voting for a Chairperson and a Co-Chairperson. The term of elected members will be for two (2) years.

G. Voting

Due to the advisory nature of these committees, many issues will require input rather than a vote process. Vote process issues will be identified as such by the Chairperson. When voting is required, a simple majority of the members present will constitute a quorum. The chair will break any tie vote.

H. Alternate Members

Alternate members may serve as a representative of an appointed member in the event that an appointed member is unable to attend scheduled meetings due to conflict in scheduling and/or illness. The appointed member must designate in writing the alternate member to serve in his/her absence. The written notice must be submitted to and approved by ICEMA at least five (5) working days prior to a scheduled meeting. Alternate members shall not be utilized on a regular basis.

I. Minutes

Minutes will be kept by a designee from ICEMA and distributed to the members prior to each meeting. Due to the potential need for confidentiality, certain documents may be collected by the ICEMA staff at the close of each meeting and no copies may be made or processed by members of the committee without written consent from ICEMA.

J. Responsibilities

1. If a representative is unable to attend a meeting, he or she is responsible to appoint an alternate for attendance and representation as mentioned above under “Alternate Members”.
2. Disseminate non-confidential information, as appropriate, and discuss at meetings to the represented groups.
3. Determine indicators for system evaluation based on EMS QI indicators and identify and develop other indicators as deemed necessary.
4. Re-evaluate and improve locally developed EMS system indicators annually or as needed.
5. Establish a mechanism to incorporate input from EMS provider advisory groups for the development of performance improvement CQIP templates.
6. Recommend the chartering of RCIQCs and review of their reports.
7. Seek and maintain relationships with all EMS participants including, but not limited to:
 - State EMSA
 - Other Local EMS Agencies (LEMSAs)
 - EMS Service Providers
 - Local Departments of Public Health
 - Specialty Care Centers
 - Law Enforcement
 - Public Safety Answering Points (PSAPs)
 - Dispatch Centers
 - Constituent Groups

K. Confidentiality

All proceedings, documents and discussion of the committees are confidential and are covered under Sections 1040, 1157.5, and 1157.7 of the Evidence Code of the State of California. The prohibition relating to the discovery of testimony provided to the committees shall be applicable to all proceedings and records of this group, which is established by a local government agency as a professional standards review organization. This organization is designed in a manner which makes available professional competence to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including but not limited to prehospital care services. Guests may be invited to discuss specific issues in order to assist in making final determinations. Guests may only be present for the portion (s) of the meeting about which they have been requested to review or testify.

All members shall sign a confidentiality agreement not to divulge or discuss information that would have been obtained solely through committee membership. Prior to the invited guests participating in the meeting, the Chairperson is responsible for explaining and obtaining a signed confidentiality agreement for invited guests.

III. PARAMEDIC BASE STATION REQUIREMENTS

A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS

The Base Station CQIP should involve all EMS system participants including, but not limited to dispatch agencies, ALS and BLS service providers, receiving hospitals and specialty care hospitals.

1. Structure

The Base Station CQIP shall be reviewed by ICEMA for compatibility with the State CQIP guidelines. The organizational chart should reflect the integration of the CQIP in the organization.

Listed below are minimum requirements of Base Station CQIP:

- a. A CQI Team under the direction of the Base Station Medical Director. Lead staff should have expertise in management of the Base Station's CQIP. The following staffing positions are identified (note: organizations with limited resources may combine positions):

- Base Station Medical Director (or designee)
- EMS QI Program Coordinator
- Data Specialist

NOTE: Availability of resources can vary greatly between urban and rural facilities. It is understood that there are variances in staffing and staff responsibilities.

- b. An internal CQIP Technical Advisory Group with members, which include but are not limited to:

- Base Station Medical Director
- Prehospital Liaison or Equivalent
- Base Station Mobile Intensive Care Nurse (MICN)

2. Responsibilities

The Base Station CQI Team should be a primary source of EMS activity reporting for state-wide and regional EMS system indicators. The Base Station CQIP will perform the following functions:

- a. Cooperate with ICEMA in carrying out the responsibilities of the ICEMA CQIP and participate in the ICEMA CQI process.

- b. Cooperate with ICEMA in the implementation of State required EMS system indicators.
- c. Cooperate with ICEMA in monitoring, collecting data, and evaluating State required and ICEMA EMS system indicators.
- d. Cooperate with the EMSA and ICEMA in the re-evaluation and improvement of State and local EMS system indicators.
- e. Participate in meetings for internal review of Base Station indicators and development of performance improvement programs related to the findings.
- f. Establish a mechanism to incorporate input from ICEMA, service providers and other hospitals for the development of performance improvement programs.
- g. Assure reasonable availability of CQIP training and in-service education for Base Station personnel.
- h. Prepare plans for expanding or improving the Base Station CQIP.
- i. Provide technical assistance to all EMS provider's CQIPs in the Base Station's jurisdiction.

3. Annual Reports

Base Stations must maintain on-going records ensuring compliance to the requirements set forth in the CQIP. This monitoring system should provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the EMS system.

B. REVIEW OF PATIENT CARE DATA

1. Mobile Intensive Care Nurse Report

A minimum of 30 (or the total if <30) randomly selected MICN reports with waveforms, or 10%, whichever is greater, will be reviewed monthly by the PLN and/or Base Station Medical Director, or designated peer review staff, for the following:

- a. Complete documentation.
- b. Prehospital patient care treatment orders.
- c. Compliance with ICEMA protocols.

2. Base Station Wave Reviews

All waves that fall into the following categories must be reviewed for determination of cause and must be logged and included in the quarterly report submitted to ICEMA:

- a. A case review request is submitted.
- b. Any call where a physician has ordered an EMT-P to administer a medication or perform a skill that is out of his scope of practice, or in deviation with protocol.
- c. Runs involving internal disaster or trauma diversion.
- d. High profile cases.

3. Concurrent/Retrospective Clinical Review Report

The CCQIC may select a clinical topic on a quarterly basis to be audited by the Base Stations and provider agencies. Examples are cardiac arrest, head trauma and respiratory distress patients. The audit may be used to evaluate efficacy of prehospital care in relation to the topic chosen, utilizing data obtained from electronic patient care records (e-PCRs). Examples may include timely administration of ACLS medications, documentation of responses to the administration of medications and/or procedures. This report will be forwarded to ICEMA and may be used to determine recommendations to the ICEMA Medical Director regarding the appropriateness of certain drugs, equipment, procedures, etc., for improvement in the delivery of quality patient care in the EMS system.

4. Base Station Statistics

Base Stations are required to keep on-going statistics for periodic review by the EMS agency staff. Requirements for documentation in this log are included in the Base Station Statistics Policy and Base Station Data Collection Tool. Monthly reports shall be submitted as required by ICEMA.

5. Case Review Reports

A confidential file of case review reports will be maintained by the PLN and/or Base Station Medical Director. Documentation should include the case review report and any other pertinent data. The case review report is confidential information and will not be reviewed by anyone other than ICEMA's designated staff, the involved parties and/or their immediate supervisors without prior written notification. See QI Form 008, 009 and 010.

The laws protecting the discoverability of information received through the quality assurance process state very clearly that information must be maintained in a confidential manner. Breaches that result in loss of the confidentiality of these records allow the information to be accessible to

discoverability and seriously jeopardize the quality assurance/quality improvement process. All case review records must be kept in a confidential file and maintained to protect all parties involved.

6. Radio Communication Failure Reports

The Base Station Medical Director or PLN will be required to report any radio equipment failures to ICEMA within 72 working hours. See QI Form 001.

7. Quarterly Reports

Quarterly reports must include all relevant information and be forwarded to ICEMA at the first of every quarter (the first of January, April, July and October). Requirements for these reports are illustrated in the Quarterly Report Form. See QI Form 007.

IV. EMERGENCY MEDICAL SERVICE PROVIDER

A. QUALITY IMPROVEMENT INFORMATION AND DATA REQUIREMENTS

The EMS Provider's CQIP should involve EMS system participants including but not limited to dispatch agencies, ICEMA, training programs, hospitals, specialty care centers and other EMS service providers. A regional approach, with collaboration between EMS service providers serving neighboring communities, is highly recommended.

CQIP's should include indicators, covering the areas listed in the California Code of Regulations, Title 22, Chapter 12 of the Emergency Medical Services System Quality Improvement Program, which address, but are not limited to, the following:

- Personnel
- Equipment and Supplies
- Documentation and Communication
- Clinical Care and Patient Outcome
- Skills Maintenance/Competency
- Transportation/Facilities
- Public Education and Prevention
- Risk Management

Indicators should be tracked and trended to determine compliance with their established thresholds as well as reviewed for potential issues. Indicators should be reviewed for appropriateness on a quarterly basis with an annual summary of the indicators performance. Air Medical Providers may reference **CAMTS** to identify potential indicators they may wish to implement in their system.

ALS Provider agencies must maintain on-going records ensuring compliance to the requirements set forth in the CQIP. This monitoring system should provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the EMS system.

1. Structure

The EMS Provider's CQIP shall be reviewed and approved by ICEMA for compatibility with the guidelines.

The organizational chart shall reflect the integration of the CQIP in the organization. The EMS Provider's CQIP should include the following:

- a. An EMS CQI Team under the direction of the EMS Provider's Medical Director or EMS Administrator. Lead staff should have

expertise in management of the EMS provider's CQIP. The following staffing positions are identified:

- EMS Provider's Medical Director or designee having substantial experience in the practice of emergency medicine. A practicing ED physician or a physician practicing in emergency medical care is highly recommended.
- QI Program Coordinator
- Data Specialist

NOTE: Availability of resources can vary greatly between urban and rural agencies. It is understood that there are variances in staffing and staff responsibilities (organizations with limited resources may combine positions).

- b. An internal CQI Technical Advisory Group with members including, but not limited to:
 - EMS Provider's Medical Director or designee having substantial experience in the practice of emergency medicine. A practicing ED physician or a physician practicing in emergency medical care is highly recommended.
 - Chief/EMS Administrator or designee.
 - QI Program Coordinator.
 - Service Personnel (Physicians, RNs, Paramedics, EMTs).
 - Other system participants.

2. Responsibilities

The EMS Provider's CQIC should be the primary source of CQIP activity reporting for state-wide and local EMS system information. The EMS Provider's CQIC will perform the following functions:

- a. Cooperate with ICEMA in carrying out the responsibilities of ICEMA's CQIP and participate in ICEMA's CCQIC.
- b. Cooperate with ICEMA in the implementation of State required EMS system indicators.
- c. Cooperate with ICEMA in monitoring, collecting data, and evaluating the State and regional/local EMS system indicators, both required and optional.
- d. Cooperate in the re-evaluation and improvement of State and local EMS system indicators.

- e. Conduct meetings for internal review of EMS provider information and development of performance improvement programs related to the findings.
- f. Establish a mechanism to receive input from ICEMA, other service providers and other EMS system participants for the development of performance improvement programs.
- g. Assure routinely scheduled CQIP training and in-service education for EMS provider personnel.
- h. Prepare plans for expanding or improving the EMS Provider's CQIP.
- i. Participate in meetings and presentations of state and local EMS system information for peer review to local designated advisory groups and other authorized constituents.

3. Annual Reports

The EMS Provider's CQI Team will annually publish summary reports of CQIP activity for distribution to ICEMA and other groups as determined.

B. ALS STAFFING REQUIREMENTS AND RESPONSIBILITIES

1. ALS Provider Agency Medical Director Guidelines

Shall be a physician licensed in the State of California with experience in emergency medical care. Must be knowledgeable of the policies, protocols, and procedures set forth by ICEMA.

2. ALS Provider Agency Medical Director Responsibilities

- a. Demonstrate management's commitment and dedication to the goals outlined in the CQIP by serving as a team leader for the organization, providing educational opportunities, training, support and encouraging communication of skills to facilitate the team building network.
- b. Shall be responsible for coordinating and implementing an approved provider agency CQIP that focuses on the opportunity for improvement as well as identification and prevention of potential concerns within the organization, implements resolutions to these problems and evaluates the outcome, as well as provides the positive recognition when an opportunity is provided.
- c. Shall provide a written operational protocol manual for approval by ICEMA (applies only to Air Transport Teams utilizing flight nurses in the EMS region).

3. ALS Provider Agency Quality Improvement Coordinator Requirements

Each ALS provider agency shall have a CQI Coordinator. This person shall be either: 1) a physician, registered nurse or physician assistant that is licensed in California and has experience in emergency medicine and emergency medical services or 2) a paramedic who is or has been licensed in California within the last two (2) years and who has at least two (2) years experience in prehospital care.

4. ALS Provider Agency Quality Improvement Coordinator Responsibilities

- a. Shall act as a liaison between the prehospital personnel and the Base Station Medical Director, PLN, ED physician, other provider agencies and ICEMA.
- b. Shall initiate, implement and evaluate the agency's quality improvement program.
- c. Shall be responsible for monitoring documentation of program operations within the agency, as required for evaluation by ICEMA.
- d. Shall monitor EMS personnel compliance to policies, procedures and protocols and ability to function within the scope of practice.
- e. Shall demonstrate management's commitment and dedication to the goals outlined in the CQIP by serving as a team leader when providing training and educational opportunities, encouragement, support and communication skills to promote an EMS system that delivers the best available patient care.
- f. Shall participate in their regional CQI committees and Base Station CQI process.

C. REVIEW OF PATIENT CARE DATA

1. ALS Run Report Forms

A minimum of thirty (or the total if <30) randomly selected ALS runs, or 10 %, whichever is greater, must be reviewed each month by the CQI Coordinator or by the designated peer review staff for at least the following:

- a. Complete documentation.
- b. Ordering of prehospital patient care treatment.
- c. Compliance with protocols.

- d. Response times and prolonged on-scene times
- e. E.T. attempts and placement.
- f. MCI as defined by Protocol Ref. #5050, Multi-Incident Operational Procedures (review with Paramedic PLM).
- g. Proper documentation of Against Medical Advice (AMA) forms (review with PLN).

2. Concurrent and Retrospective Clinical Review Topics

The ICEMA Regional CQIC may select a clinical topic on a quarterly basis to be audited by the Base Station and ALS Provider agencies; examples; cardiac arrest patients, patients with head trauma, respiratory distress patients. The audit may be used to evaluate efficacy of prehospital care in relation to the topic chosen (utilizing data obtained from e-PCRs). Examples of this may include: timely administration of ACLS drugs, documentation of responses to the administration of medications and/or procedures. These reports will be forwarded by the Base Station to the committee and may be used to determine recommendations to the ICEMA Medical Director.

3. ALS Provider Agency Log

ALS Provider agencies will be required to keep an on-going log for periodic review by ICEMA. Requirements for documentation in this log are spelled out in the Quality Improvement Log Form. See QI Form 005.

A confidential file of case review reports will be maintained by the Provider Agency CQI Coordinator and/or ALS Provider Agency Medical Director in accordance with specifications under CASE REVIEW FORMS, Section IV. Documentation should include the case review report and any pertinent data. This is confidential information and will not be reviewed by anyone other than ICEMA's designated staff, the involved parties and/or their immediate supervisors.

V. CASE REVIEW FORMS/CASE REVIEW CONFERENCE

A. INITIATING A CASE REVIEW

To request that a call be reviewed, a Case Review Form must be initiated, and forwarded to the QI Coordinator, ALS Provider Agency Medical Director, PLN or Base Station Medical Director. The report should be forwarded to the person responsible for reviewing the incident within the agency or facility. For example, if an EMT-P initiates a report, EMT-P should forward it to the agency QI Coordinator for review. If an MICN initiates a report, MICN should forward the report to the PLN. See QI Form 008.

A Case Review Form may be initiated by any physician, MICN, EMT-P, or EMT, who feels that any of the following have occurred:

- Treatment/action resulting in positive patient outcome.
- Patient care related to an adverse patient outcome.
- Deviation from ICEMA treatment protocols.
- Conflicts with existing State law and/or ICEMA policy.
- Situations that pose a threat to the safety of patients or providers of prehospital care.
- Situations that serve as an educational tool for EMS providers.

When the request involves the QI Coordinator, PLN or Medical Director normally responsible for the initiation of the case review form, the request should be forwarded to ICEMA.

If there is any doubt as to who is the responsible reviewing party, ICEMA will provide direction.

B. CONDUCTING A CASE REVIEW

Upon receipt of a Case Review Form, the person responsible for the investigation shall:

- Review the EMS patient care record, MICN record, Base Station wave, and the patient outcome records (if applicable).
- Collect statements from the involved personnel if needed to determine action necessary.
- Establish the need for further action.
- Involve the appropriate agency representatives (i.e., ALS Provider Agency QI Coordinator should contact the PLN and Base Station Medical Director if determination of further action is necessary).
- Conduct a Case Review Conference, if necessary. See QI Form 010.

C. CONDUCTING A CASE REVIEW CONFERENCE

1. Responsible Reviewing Party

The responsible reviewing party shall notify the appropriate personnel and determine a time and date that the Base Station Medical Director, PLN and all involved personnel can attend the Case Review Conference (CRC). A CRC must be done within thirty (30) days of the decision to conduct a CRC unless it meets the exception criteria.

Exception Criteria:

- a. Involved personnel could not be contacted (written explanation required in summary).
- b. Documents needed for review could not be gathered in this time frame (explanation must be included in summary).

2. Review of Information

The Case Review Conference will require a review of all information necessitating the conference and any additional information that may be pertinent to the review. The Medical Director is responsible for determining the need for further action. The Medical Director may make the determination that the incident requires one of the following:

- a. Positive Recognition:

A CRC may be held to evaluate outstanding performance to be utilized for positive education feedback. An evaluation and recommendations report shall be forwarded to the ICEMA Medical Director.

- b. No Further Action Necessary:

Complete a Case Review Conference Report stating the conclusion of the investigation and forward a copy of the report to the ICEMA Medical Director. Maintain the original document in the Case Review Report File.

- c. Need For Education:

The Base Station Medical Director shall determine if the need for education is related to an individual or is of an educational value to the EMS system, or both.

d. EMS System Education:

The review has led to the opportunity to provide educational value to benefit the system (i.e., a piece of equipment has proven to be defective when used in certain environments). A Case Review Conference Report shall be completed and a copy forwarded to the ICEMA Medical Director. Maintain the original report in the Case Review Report File. Suggestions for system-wide improvements will be submitted to ICEMA CCQIC and the EMCC, and addressed through education.

3. Plan of Action

The determination has been made that an individual or individuals would benefit from the initiation of the education process.

- a. Identify the Area of Improvement - i.e., skills deficiency, lack of working knowledge of ICEMA protocols, etc.
- b. Recommend a Plan of Action - For example, the Base Station or ALS provider agency may be requested to provide skills training, further monitoring, protocol updates, etc. In this circumstance, the ICEMA Medical Director will request follow-up in writing from the ALS provider agency and will determine the period in which this is to be provided. Complete the Case Review Conference Report (QI Form 008) providing the appropriate information and forward a copy to the ICEMA Medical Director upon completion of the conference. Maintain the original Case Review Conference Report in the Case Review Report File.
- c. Initiate the Plan of Action - Provide the education, monitoring, etc., as determined by ICEMA Medical Director.
- d. Evaluation of the Outcome - The ICEMA Medical Director will evaluate the outcome of the process, the need to re-evaluate at a future date if necessary or to provide further education. This information should be included in follow-up form on a Case Review Conference Report and a copy submitted to the ICEMA Medical Director. Maintain the original report in the Case Review Report File.

4. Disciplinary Action Needed

The need for disciplinary action should only be initiated if ICEMA's Medical Director determines the situation reflects grounds for disciplinary action under Chapters 4 and 6 of the California Code of Regulations (CCR), Title 22. All pertinent information should then be forwarded immediately to the ICEMA Medical Director for consideration of further action.

SECTION II - DATA COLLECTION AND REPORTING

Data collection and reporting are two of the most important elements in CQI. The data collected must be valid, reliable, and standardized with all other system participants. ICEMA encourages the sharing of data through summary reports among all EMS system participants.

This chart provides suggested indicators for each Indicator category per organizational structure. Use of these indicators is not mandatory.

Assumptions: 1. California EMS Information System (CEMSIS) will provide state-wide data.

INDICATOR	EMS AUTHORITY	ICEMA	PROVIDER	HOSPITAL
Personnel	WELLNESS WORKLOAD POLICIES AND PROCEDURES LICENSURE ED1 Education and Training Indicator A - H	WELLNESS WORKLOAD POLICIES AND PROCEDURES CERTIFICATION /ACCREDITATION ED1 Education and Training Indicator A - D, G, H	WELLNESS WORKLOAD POLICIES AND PROCEDURES ED1 Education and Training Indicator A, B (if provider has EMT-I training school)	WELLNESS WORKLOAD POLICIES AND PROCEDURES BH1 Base Hospitals-Activity Indicator B - D
Equipment and Supplies	ePCR INVENTORY CONTROL	COMMUNICATIONS COVERAGE	PREVENTIVE MAINTENANCE PLANS PHARMACEUTICALS	INVENTORY CONTROL
Documentation		DATA VALIDATION ePCR POLICIES AND PROCEDURES QUALITY REVIEW PROCESSES	DATA VALIDATION NARCOTIC RECORDS ePCR POLICIES AND PROCEDURES QUALITY REVIEW PROCESSES	TIMELINESS ACCURACY OUTCOME REPORTING QUALITY REVIEW PROCESSES
Clinical Care and Patient Outcome	SCOPE OF PRACTICE COMMITTEE STRUCTURE RESEARCH CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A - B	TREATMENT PROTOCOLS COMMITTEE STRUCTURE MEDICAL OVERSIGHT RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - N CA2 Pulseless V-Fib/V-Tach -Witnessed Indicator A - N CA3 Chest Pain-Suspected Cardiac Origin Indicator A - J MA1 ALS Staffing Levels Indicator A - D RE1 Shortness of Breath/Bronchospasm Indicator A - G RE2 Shortness of Breath/Fluid Overload Indicator A - K	TREATMENT PROTOCOLS COMMITTEE STRUCTURE MEDICAL OVERSIGHT RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A - N CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A - N CA3 Chest Pain-Suspected Cardiac Origin Indicator A - J RE1 Shortness of Breath/Bronchospasm Indicator A - G RE2 Shortness of Breath/Fluid Overload Indicator A - K	TREATMENT PROTOCOLS RESEARCH QI and CASE REVIEW CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B, N CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B, N CA3 Chest Pain-Suspected Cardiac Origin Indicator J RE1 Shortness of Breath Bronchospasm Indicator G RE2 Shortness of Breath Fluid Overload Indicator K

INDICATOR	EMS AUTHORITY	ICEMA	PROVIDER	HOSPITAL
Skills Maintenance/Competency	SCOPE OF PRACTICE	SCOPE OF PRACTICE SKILLS UTILIZATION BENCHMARKING SK1 Skills-Advanced Provider Indicator A - J	SCOPE OF PRACTICE SKILLS UTILIZATION INFREQUENT SKILLS REVIEW SUCCESS RATES (BENCHMARKING) SK1 Skills-Advanced Provider Indicator A - J	SCOPE OF PRACTICE SKILLS UTILIZATION INFREQUENT SKILLS REVIEW SUCCESS RATES
Public Education and Prevention	COMMUNITY INVOLVEMENT PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	COMMUNITY INVOLVEMENT REWARD AND RECOGNITION PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	COMMUNITY INVOLVEMENT REWARD AND RECOGNITION PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1A Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B	PREVENTION PROGRAMS PATIENT EDUCATION CUSTOMER SATISFACTION CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B CA2 Pulseless V-Fib/V-Tach Witnessed Indicator A, B PP1 Public Education and Prevention Indicator A, B
Risk Management	ISSUE RESOLUTION PROCESS SYSTEM MONITORING	ISSUE RESOLUTION PROCESS SYSTEM MONITORING CA1 Pulseless V-Fib/VTach Unwitnessed Indicator A, B MA1 ALS Staffing Levels Indicator A - D	ISSUE RESOLUTION PROCESS OSHA COMPLIANCE POST-INCIDENT PEER REVIEW PERSONNEL SAFETY SYSTEM MONITORING MA1 ALS Staffing Levels Indicator A - D RS1 Response Indicator A - C SK1 Skills – Advanced Provider Indicator A - J	OSHA COMPLIANCE POST-INCIDENT PEER REVIEW PERSONAL SAFETY SYSTEM MONITORING

SECTION III - EVALUATION OF INDICATORS

The ICEMA QI Coordinator will analyze the quality indicators on a monthly basis and then create relevant reports for presentation to the MAC and/or EMCC.

SECTION IV - ACTION TO IMPROVE

I. FOCUS-PDSA

Once a need for improvement in performance has been identified by ICEMA, MAC or the EMCC, ICEMA will be utilizing the FOCUS-PDSA model for performance improvement. FOCUS-PDSA involves the following steps:

Find a process to improve - the CCQIC will identify improvement needs.

Organize a team that knows the process - the CQI Team will form Task Force(s) as needed and review process documents.

Clarify current knowledge of the process - review indicator trends relevant to the process, collect other information

Understand - causes of process variation utilizing tools, such as fishbone diagrams, Pareto analyses, etc.

Select - process improvement to reduce or eliminate cause(s).

Plan - State objective of the test, make predictions, develop plan to carry out the test (who, what where, when).

Do - Carry out the test, document problems and unexpected observations, begin analysis of the data.

Study - Complete the analysis of the data, compare the test data to predictions, and summarize what was learned.

Act - What changes are to be institutionalized?
What will be the objective of the next cycle?
What, if any, re-education or training is needed to effect the changes?

Once a Performance Improvement Plan has been implemented, the results of the improvement plan will be measured. Changes to the system will be standardized and/or integrated. A plan for monitoring future activities will be established.

II. MEETINGS

During its quarterly or other meetings, ICEMA or MAC may identify indicators that signal a need for improvement and make recommendations for chartering a Quality Task Force, if needed. ICEMA or the CCQIC may select members and charter a Task Force with a specific objective for improvement. Each Task Force will use the FOCUS-PDSA model to conduct improvement planning and prepare recommendations or a report for review by ICEMA. ICEMA will prepare a report including the findings and recommendations of the Task Force and make recommendations to the Task Force and prepare the report for distribution to the MAC. ICEMA will also disband the Quality Task Force at the appropriate time.

Presentation of quality indicator analyses will most frequently be in a run chart, a Pareto chart, or a histogram format. This will enable ICEMA and/or MAC to easily identify trends and to rapidly interpret the data.

ICEMA, CCQIC and MAC will meet at least quarterly to evaluate and discuss the data provided by the ICEMA QI Coordinator according to the following agenda:

- Review of prior meeting action items.
- Presentation of indicators and results/trends.

For each indicator that the CCQIC reviews, the following process will be followed:

- Identify the objectives of the evaluation.
 - Present indicators and related EMS information.
 - Compare performance with goals or benchmarks.
 - Discuss performance with peers/colleagues.
 - Determine whether improvement or further evaluation is required.
 - Establish plan based upon decision.
 - Assign responsibility for post-decision action plan.
- Examine correlations between/among trends.
 - Acknowledgement of positive trends; discussion of unsatisfactory trends.
 - Receive reports from Quality Task Forces, if any.
 - Discuss changes needed to indicators.
 - Recommend the chartering of Quality Task Forces, if any.
 - Provide input to ICEMA to regarding improvement priorities.
 - Summarize action items identified at this meeting.

- Recommend training/educational needs.
- Evaluation of the meeting.

SECTION V - TRAINING AND EDUCATION

Once the decision to take action or to solve a problem has occurred, training and education are critical components that need to be addressed. Education needs will be identified in reports given at quarterly MAC and CCQIC meetings. The EMS Agency will make recommendations for educational offerings county-wide based on these reports and reports from CQI Task Forces.

Once a Performance Improvement Plan recommended by a Task Force, the ICEMA QI Team, or MAC has been implemented, ICEMA will standardize the changes within the appropriate policies and procedures. The EMS Specialist responsible for educational oversight maintains the Policy and Procedure Manual, which is updated twice per year. Changes recommended by a Quality Task Force or other system participants are implemented via policy changes or new policies being written as indicated. The new policy or change in policy is presented at the various EMCCs for discussion. Changes may be made based on those discussions. The policy is then posted on the ICEMA website at www.ICEMA.net for a 45-day public comment period. Final changes to the policy are made based on public comments received. The new or improved policy is then implemented. If additional training is required of system participants, time is allotted for that training prior to the implementation of the policy. Policies also may be changed to comply with State or Federal mandates. These changes are written into the policies and are discussed at various committee meetings and the EMCCs and posted on the ICEMA website, but do not go out for a public comment period.

The EMS Specialist who is responsible for educational oversight also ensures that providers submit documentation that all training requirements have been met by all EMS system participants, usually twice per year and on an as-needed basis. This is accomplished via training memos, training program development, or by train-the-trainer programs. Providers are ultimately responsible for ensuring that staff is adequately trained. The rosters and records of training are available to ICEMA upon request.

SECTION VI - ANNUAL UPDATE

The Annual Update is a written account of the progress of an organization's activities as stated in the EMS CQIP. An EMS Specialist is responsible for annually updating the EMS Plan, in alignment with current EMS strategic goals. The CQI Coordinator will do an initial review of the CQIP, identifying what did and did not work. The CQI Coordinator will work in conjunction with the EMS Specialist responsible for updating the EMS Plan to ensure that both the CQIP and the EMS Plan are focusing on the same objectives. Once both the CQIP and the EMS Plan have been reviewed in this fashion, the CQI Coordinator will present his/her findings to the CCQIC and to the CQI Team.

The following chart will be the template for the presentation of the update.

Indicators Monitored	Key Findings/Priority Issues Identified	Improvement Action Plan/Plans for Further Action	Were Goals Met? Is Follow-up Needed?

As part of the Annual Update, the ICEMA CQI Team and the CCQIC will offer recommendations for changes needed in the CQIP for the coming year, including priority improvement goals/objectives, indicators monitored, improvement plans, how well goals/objectives were met, and whether follow-up is needed.

A current CQIP will be submitted to the State EMS Authority every five (5) years.