Purpose:

To ensure that clinical and response quality is maintained.

Policy:

West Des Moines EMS will have in place a CQI program to monitor both clinical and response quality.

Required elements of the CQI program shall at a minimum include:

1. Run Audits

   1. A supervisory review / run audits will be performed on 100% of calls involving patient contact. The run reports and the care administered during a division shift will be reviewed by the division reporting for duty the next day. Runs will be electronically audited as part of Zoll RescuNet workflow. Each complete PCR will be passed through a “Pre-bill” phase. In this phase reports are reviewed for completeness and demographic accuracy by the Division Chiefs. This phase also allows an opportunity for the Division Chiefs to review documentation of care they may be familiar with by direct observation or from daily radio traffic and conversations with on-duty crews.

   Every patient care report with interventions equal to one or more of the following will be directed to designated staff for further review. Interventions equal to one or more of the following: “Advanced Airway Monitoring”, “Arterial Blood Draw”,


The purpose of this intervention list is to funnel all Critical Care Level transports as well as all Medicated Assisted airways for detailed analysis. The expected outputs will be to report standard airway statistics (Intubation success rates, methods, trends), recognize any medication errors, as well as assist in formulating a CCP level educational plan for the department based on trends in CCP level transports.

Additionally, a quarterly “focused” chart review will be conducted by an audit team selected by the Deputy Chief. This additional chart review will focus on specific criteria (dispatch type, patient presentation, outcome, etc..) each quarter.

The Medical Director for West Des Moines Emergency Medical Services designates the following to positions as designees in the EMS Quality Assurance/Improvement areas of Medical Audits (Run Reports) and/or Skills Maintenance (Logs/Training).

- Chief
- Assistant Chief
- Deputy Chief
- Division Chief

Information from run audits may be used for annual employee evaluations.

2. Random Audits

In addition to the calls for service forwarded to the Medical Director, the Medical Director will reserve the right and is encouraged to perform random audits.

3. Clinical Indicators

At a minimum the following clinical indicators will be regularly assessed.

- Timely, accurate patient assessment: Vital signs acquired within 10 minutes of patient contact.
- Timely medical intervention: As appropriate for patient
  Care provided is done in accordance with established protocols
  IV success rate 70% for each employee
  - Success rates are calculated based on reporting software using the formula of number of successful IV’s divided by the number unsuccessful. A successful IV is a procedure that results in cannulation of a peripheral vein with a single puncture of the skin, regardless of fluid or medication administration.
- Intubation success rate of 80% for each employee
  - Success rates are calculated based on reporting software, using the formula of number of successful intubations divided by the number of unsuccessful intubations.
  - Successful intubation is defined by placement of an endotracheal tube into the patient’s trachea, confirmed by multiple clinical assessments and tools, and is achieved prior to transfer of care to another healthcare provider, without any decompensation of the patient.
  - Numbers of attempts will still be tracked and reported. An attempt at intubation is defined as the passage of an endotracheal tube into the mouth of the patient during an attempt to manage the patient’s airway.
- Trauma scene time < 15 minutes
- Medical scene time < 20 minutes
- Scene times will be defined as the time interval from the transporting units on scene arrival until time of transport to the hospital.
- Clinical documentation quality: Performed within departmental documentation guidelines
- 12 lead ECG prior to treatment and within 15 minutes of patient contact on patients with a potential underlying cardiac event.

4. Response Indicators
- Call received to dispatch < 1 minute
- Dispatch to en route: Day < 1 minute, Night < 90 seconds
- Arrival times 90% of calls in 8 minutes and 59 seconds or less for code emergent responses.
- Arrival times 90% of calls in 9 minutes and 59 seconds or less for non-emergent responses.

5. Adherence to Protocols
• Any ECP who is found consistently not adhering to protocols will be counseled and remediated by the Deputy Chief of QA/Education and/or Service Medical Director
• Continual failure to adhere to protocols will result in the initiation of the progressive discipline policy.
• The Medical Director reserves the right to remove employees from patient care duties at his/her discretion, based on demonstrated proficiencies.

6. Westcom QA/QI Audit Process

As part of the general audit process, the dispatch process will also be monitored. The Deputy Chief of QA/Education will investigate all EMS requests for service for a “call received to dispatch” time that is greater-than 2 minutes.

All calls with a “call received to dispatch” time greater-than two minutes will be reviewed. This process will include but not be limited to:

• Reviewing dispatch data for time entry errors on the part of EMS crew members.
• Requesting recorded dispatch tapes.
• Interviewing parties involved.

On a regular basis, the Deputy Chief of QA/Education will meet with representatives from the Westcom dispatch center to review requests for service that failed to meet the two minute “call received to dispatch” goal. It will be the purpose of this group to address issues that may arise and propose procedural changes and/or provide education to EMS crew members or Westcom dispatchers to remedy problems or improve dispatch times.

7. Educational Audit Reviews

At least monthly, the Deputy Chief of QA/Education will gather patient care reports to be used for educational review and the advancement of departmental care. These reports should be reviewed with the assistance of the Medical Director during a department training session.

8. Employee Counseling and Remediation

Employees found to be below minimums in clinical indicators or displaying a consistent pattern of not meeting response guidelines as well as failing to meet other CQI initiative in the pre-hospital chart audit process will be counseled on the process and given further education and remediation if deemed needed by the Deputy Chief of QA/Education.

9. Reporting CQI Data
• Clinical Indicator Data

Data regarding clinical indicators will be reviewed on an annual basis. Each employee will be provided with a report of their performance related to the clinical indicators. Employees with skills or practices not meeting the established thresholds will be notified and if needed remediation will be given.

A summary report of clinical performance will be provided to the department, management staff and the Medical Director.

• Response Indicator Data

Data regarding response indicators will be reviewed on a monthly basis. The Lieutenant in charge of each division shall be responsible for reporting this data. Calls not meeting the response goal of 8 minutes and 59 seconds will be reviewed for cause and entered into the exception data base.

Fractile response reports containing calls not meeting the response goal and monthly response percentage totals will be given to the Assistant Chief of Operations for review. In addition, the Assistant Chief will be provided with an exception report displaying responses not meeting the departmental goal and citing determined reasons for the failure.