

EMERGENCY MEDICAL SERVICES QUALITY ASSURANCE REPORT

STATE OF NEBRASKA
HEALTH & HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
LICENSURE UNIT
TELEPHONE # (402) 471-2299

Your Emergency Medical Services Quality Assurance Report Form **MUST BE RECEIVED BY THE DEPARTMENT PRIOR TO YOUR SERVICES LICENSE BEING RENEWED.** You will be notified by the Department whether your self-inspection is determined to be in full compliance with the Emergency Medical Services Act and 172 NAC 12 Nebraska Regulations Governing Emergency Medical Services. Please complete the information below:

| | | | |
|------------------------|-----------------|----------------------------|---|
| Service | Service Phone # | Physician Medical Director | Owner's Name (Entity Responsible for Support and Direction of the Service) |
| | Service Fax # | | |
| Service Email Address | | | |
| Service Contact Person | License | | |
| Telephone # | | | |

Service Personnel including RNs, LPNs and Physician Assistants

Please provide a current copy of the Services' roster. A copy can be printed at the following website <http://dhhs.ne.gov/publichealth/Pages/crIEMSQuickLinksforServices.aspx> under Roster of Providers or from ENARSIS. Please make all corrections and updates to the roster.

**Submit a copy of an updated roster for your service with this
Emergency Medical Services Quality Assurance Form.**

For the following areas of quality assurance, you are to indicate "Yes" if you are in compliance, "No" if you are not in compliance, or "N/A" if it does not apply to your service. For each item not in compliance, you are to go to the Compliance Page and list:

- The item number that is not in compliance;
- Why it is not in compliance; and
- Your plan to correct or how corrected within 30 days of report completion

Section #1 – Service & Equipment

A – Service Qualifications – 12-003.01

| | Yes | No | N/A |
|---|-----|----|-----|
| 1. Does your service have a qualified physician medical director as defined in 12-002? | | | |
| 2. If your service is a non-transport service does it have a written agreement with a licensed transport service that meets the standards defined in 12-004 | | | |
| 3. Does your service have a current Mid-Level Practitioner Controlled Substance Registration? | | | |
| 4. Does your service have a current Clinical Laboratory Improvement Amendments (CLIA) certificate if your service is utilizing a glucose monitor? | | | |

B – Ambulance Standards – 12-004.01

| | Yes | No | N/A |
|--|-----|----|-----|
| 1. All overland vehicles meet KKK-A-1822C or newer specifications or were owned by a licensed service prior to March 9, 1999 or purchased from another licensed service. | | | |
| 2. Aircraft are in compliance with FAR 14. | | | |

C – Equipment Standards – 12-004.02**Yes No N/A**

| | | | | |
|--|---|--|--|--|
| 1. A PMD Signed equipment list is available on all service ambulances to provide the following: | a. Patient assessment/diagnostic measurement | | | |
| | b. Airway Management | | | |
| | c. Bleeding control and wound management | | | |
| | d. Extremity fracture immobilization | | | |
| | e. Cervical and spinal immobilization | | | |
| | f. Burn Care | | | |
| | g. Cardiac Care | | | |
| | h. Care of ingested poisons | | | |
| | i. Obstetrics and gynecology care | | | |
| | j. Intravenous Administration sets and fluids | | | |
| k. Medications/Controlled Substances | | | | |
| 2. Ambulances used for the transportation of patients have patient transport and patient comfort supplies and equipment. | | | | |
| 3. Ambulances used for the transportation of patients have supplies and equipment for the protection of personnel and patients from infectious diseases and for personal safety. | | | | |
| 4. Service has a communications system that is capable of two way communications with receiving hospitals, dispatchers, and medical control authorities. | | | | |

D – Maintenance Standards – 12-004.03**Yes No N/A**

| | | | | |
|--|--|--|--|--|
| 1. Motor vehicles used for the transportation of patients are maintained as specified in the chassis manufacturer's owner's manual and the recommendations of the ambulance manufacturer/contractor. | | | | |
| 2. Aircraft used for the transportation of patients is maintained in accordance with Federal Aviation Regulation 14 CFR Part 135 and/or 14 CFR Part 91 and related bulletins and supplements. | | | | |
| 3. Operational equipment, used for patient care or support, are maintained in accordance with the manufacturers recommended procedures. | | | | |
| 4. Owner's manuals are available at the service's location for #1-3 above. | | | | |
| 5. All applicable maintenance records for items #1-3 are on file. | | | | |

E – Sanitation Standards – 12-004.04**Yes No N/A**

| | | | | |
|--|---|--|--|--|
| 1. The Service has written sanitation and infection control policies approved by the PMD that include: | a. Pre-Exposure Precautions | | | |
| | b. Post-exposure procedures for personnel must be in accordance with <u>Neb. Rev. Stat. §§ 71-506 to 71-514</u> | | | |
| | c. Procedures for decontamination/cleaning of the ambulance | | | |
| | d. Procedures for the decontamination/cleaning of equipment | | | |
| | e. Procedures for the disposal of contaminated equipment and supplies | | | |
| 2. Equipment and supplies identified by the manufacturer as single use or disposable are NOT reused and are disposed of in accordance with written procedures approved by the PMD. | | | | |

F – Inspection Standards – 12-004.05**Yes No N/A**

| | | | | |
|---|--|--|--|--|
| 1. Ambulances used for the transportation of patients, are checked at least monthly to assure that the vehicle's emergency warning devices, electrical systems, engine, and fuel systems are in proper working order. | | | | |
| 2. Operational equipment, used for patient care or support, is inspected and tested for proper operation or function at least monthly. | | | | |
| 3. Checklists are used by the service to conduct inspections of #1 & #2 and are available for review | | | | |
| 4. Completed checklists are maintained for five years. | | | | |
| 5. Controlled substances or prescription medications carried are inventoried/inspected monthly or more frequently if directed by the service's PMD. | | | | |

Section #2: Personnel. Review a minimum of ten, or all, whichever is less, personnel records

G – Personnel Standards – 12-004.06

Yes No N/A

| | | | |
|---|--|--|--|
| 1. All members of the service who provide care have current licenses/certificates and copies of these are maintained in the service files. | | | |
| 2. All out-of-hospital emergency care providers are only providing the level of care that the service is licensed to provide, i.e. basic or advanced. | | | |
| 3. On all runs an ambulance or aircraft is staffed by at least one EMT, AEMT, EMT-Intermediate, or Paramedic to provide patient care and a person to drive the ambulance or operate the aircraft. | | | |
| 4. Did you have any runs in which only EMR's staffed the ambulance? If you answer yes, please submit documentation of appropriate training and physician medical director approval for those individuals. | | | |

H – Personnel Training Standards – 12-004.07

Yes No N/A

| | | | | |
|---|---|--|--|--|
| Personnel records contain documentation (including Date, Name of Participant, Topic, Hours, and Name of Instructor) that training has been provided within the last 2 years for service members in the following areas: | 1. Emergency vehicle driving for operators of motor vehicles or aircraft safety for operators of aircraft | | | |
| | 2. Infection control | | | |
| | 3. Extrication | | | |
| | 4. Extraction and victim recovery for special conditions as may be determined in the response area of the emergency medical service | | | |
| | 5. Procedures for dealing with hazardous materials | | | |
| | 6. Personal safety issues | | | |
| | 7. Other training as directed by the physician medical director of the service program. | | | |

I – Records Maintenance Standards – 12-004.09

Yes No N/A

| | | | | |
|--|---|--|--|--|
| 1. Personnel files are maintained by the service and contain the following information: | a. Name, address, and telephone number | | | |
| | b. Current level of certification | | | |
| | c. Current cardiopulmonary resuscitation certification. | | | |
| 2. Each personnel file contains documentation (certificate of attendance) of the member's emergency medical continuing education training that includes the following information: | a. Name of the course taken | | | |
| | b. Date of the course | | | |
| | c. Name of the instructors of the course | | | |
| | d. Number of hours of training for each course taken. | | | |
| 3. Record of PMD option to verify personnel competency for renewal of a license in the members file | | | | |

Section 3 – Review a minimum of 15, or all, whichever is less, patient care reports (NARSIS) since the last Emergency Medical Services Quality Assurance Form was completed.

J – Patient Care Records – 12-004.09c

Yes No N/A

| | | Yes | No | N/A | |
|--|--|---|----|-----|--|
| 1. A patient care record has been completed for each response that the service made in the past year | a. The name, age, and sex of the patient(s) | | | | |
| | b. The address or location from which the patient(s) is taken | | | | |
| | c. The date of the incident | | | | |
| | d. The time of dispatch and the time the ambulance are en route to the incident | | | | |
| | e. The time of arrival at the scene | | | | |
| | f. A record of the chief complaint of the patient and/or the signs and symptoms of the patient | | | | |
| | g. A record of the patient(s) vital signs and the times at which these were noted | | | | |
| | h. A brief patient history | | | | |
| | i. A description of the treatment provided and equipment used | | | | |
| | j. A record or time, rate, type and delivery location of intravenous fluids administered | | | | |
| | k. A record of the time of each electrotherapy attempt and the results of each administration | | | | |
| | 2. All patient care records have as a minimum the following data completed on each record: | l. The name and address of the receiving facility or location | | | |
| | | m. The name or code number of the individual providing the primary care for the patient | | | |
| | | n. A record of any care provided to the patient prior to the arrival of the out of hospital personnel | | | |
| | | o. Location type | | | |
| | | p. Time unit left scene | | | |
| | | q. Time arrival at destination | | | |
| | | r. Time back in service | | | |
| | | s. Race/ethnicity of the patient | | | |
| | | t. Destination determination | | | |
| | | u. No patient treatment/no patient transportation | | | |
| | | v. Factors affecting EMS delivery | | | |
| | | w. Time CPR discontinued in the field | | | |
| | | x. Adult/pediatric Glasgow coma scale | | | |
| | | y. Trauma score | | | |
| | z. The name of the incident commander responsible for all incident activities | | | | |
| | aa. Reading and unit for each use of the glucose monitoring device | | | | |
| bb. A record of each dry run, refused transportation and stand by service is maintained in the service office. | | | | | |
| 3. Based on the patient's complaints, the medical records adequately document treatment and care needed and or provided. | | | | | |
| 4. Prior to December 15, 2014, patient care records and run information was submitted to the Department quarterly, within 30 days after the end of each quarter. | | | | | |
| 5. Medical records are destroyed only when they are in excess of the retention requirements specified in 12-004.09C3 Item 1. | | | | | |
| 6. All confidential medical records are maintained in a secure environment. | | | | | |
| 7. All patient care data is made available to receiving health care facility. | | | | | |

Section 4: Medical Direction. This section must be completed by the PMD.

K – Medical Direction Standards – 12-004.08

Yes No N/A

| | | | |
|--|---|--|--|
| 1. Approved the medical protocols and standing orders by signing the documents. | | | |
| 2. A written document delegates responsibilities to my physician surrogate and is on file in the service office. | | | |
| 3. A written document is on file in the service office that authorizes out-of-hospital emergency care providers to practice the additional skills as stated in 172 NAC 11-009 upon completion of training. | | | |
| 4. The service has a medical quality assurance/quality control program approved by the PMD. The quality assurance/quality control program includes, but is not limited to: | a. An annual review of protocols and standing orders | | |
| | b. Medical care audits as needed | | |
| | c. Continuing medical education for the emergency medical services personnel. | | |
| 5. An annual review of protocols and standing orders has been conducted. | | | |
| 6. Medical care audits are completed and documented. | | | |
| 7. The PMD provides monitoring and supervision of the medical quality control program or it has been delegated in writing to my qualified physician surrogate. | | | |
| 8. The PMD supervises the overall medical aspects of the emergency medical service. | | | |
| 9. The PMD has ensured that each written standing order and/or protocol is appropriate for the certification and skill level of each of the individuals to whom the performance of medical acts is delegated and authorized. | | | |
| 10. Documentation is on file in the service office for providers that I opted to attest on members renewal notice that they are competent to practice and meet the requirements for renewal. | | | |
| 11. The service has a current CLIA certificate that allows use of a glucose monitor. (Code of Federal Regulations (CFR) 493)) | | | |
| 12. The service has a written backup Response Plan in the event that the service cannot/or does not respond to an emergency. | | | |
| 13. The service that anticipates the use of EMR's to transport patient(s) must have prior written approval by the PMD | | | |
| 14. Proper records are maintained for Emergency Drug Boxes as directed by PMD (Neb. Rev. Stat. § 71-2413) | | | |

We, the Physician Medical Director and the Service Officer, state that all of the statements herein contained are each and strictly true in every respect. We have read Neb. Rev. Stat. §§ 38-1201 – 38-1237, the Emergency Medical Services Practice Act, and the rules and regulations Title 172 NAC 12 Licensure of Emergency Medical Services, and are familiar with its provisions, and agree to abide by all said provisions. We understand that false or forged statements made in connection with this Quality Assurance Report may be grounds for action against the service license and if audited be able to provide physical documentation to support this Emergency Medical Services Quality Assurance Form.

| | |
|--------------------------------------|------|
| Physician Medical Director Signature | Date |
| Service Officer Signature | Date |

Please submit your completed Emergency Medical Service Quality Assurance Report (EQAR) to the Licensure Unit at the address provided below and maintain a copy of the report for your service:

301 Centennial Mall South
P O Box 94986
Lincoln, NE 68509-4986
Phone 800-422-3460 (ext.1-2) or 402-471-2299

