

CENTRAL NEW YORK EMERGENCY MEDICAL SERVICES



CQI MANUAL

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Preface

The intent of this manual is to provide guidance regarding the development, implementation and maintenance of the continuous quality improvement program at the service, the county and regional levels.

Table of Contents

Introduction _____	2
Mission Statement _____	3
Purpose _____	3
Authority _____	3
Standards _____	4
Requirements and guidelines for each level _____	5
Decision Algorithm _____	12
Attachments	

Introduction

The primary goal of an EMS system is to reduce death and disability from injuries and or illnesses. As research continues into the impact that prehospital care has on the ultimate outcome of patients, the need to evaluate the quality of the care that we as individuals and organizations provide becomes paramount. However, because EMS does not exist in isolation, care must be evaluated as it relates to the healthcare system in Central New York.

Health care is a dynamic field constantly in a state of change. New discoveries and new technologies are constantly on the horizon. This is especially true in the field of EMS. In order to ensure patients are receiving the best care that can be provided, standards of care must be routinely evaluated to identify areas of strengths and weaknesses.

Continuous Quality Improvement (CQI) is a program of systematic evaluation to ensure excellence. Instead of asking “Who caused this to happen?” CQI asks, “What is wrong with the process that caused this to happen and what can be done to improve the system?”

A quality improvement program has several components. These are case reviews, evaluation of indicators, tracking and evaluation of the program. CQI also evaluates concerns and recognizes excellence.

To meet the requirement of Article 30 section 3006 every ambulance and ALS first response agency must participate in the CQI process. The preferred method is to follow the recommendations and guidelines included in this manual.

Notwithstanding any other provision of law, none of the records or documentation or committee actions or records required pursuant to section 3006 of Article 30 shall be subject to disclosure under Article 6 of the Public Officers Law or Article 31 of the Civil Practice Law and Rules, except as provided in any other provision of law. No person in attendance at any quality improvement committee shall be required to testify as to what transpired thereat. The prohibition related to disclosure of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding, the subject of which was reviewed at the meeting. Prohibition of disclosure of information from the prehospital care reporting system shall not apply to information that does not identify the ambulance service or individual. Any person in good faith and without malice provides information to further the purpose of this section or who, in good faith and without malice participates on the service; county and or regional quality improvement committee shall not be subject to any action, civil damages or other relief as a result of such activity.

Quality improvement activity is a means to guarantee continuous quality of care to patients, educational programs for providers and a means for identifying areas of concern before they become problems. CQI requires the cooperation of all EMS providers from first responders to the New York State SEMAC. It must recognize common needs for education, structured feedback, professionalism, mutual respect and above all, confidentiality.

Mission Statement

Under the direction of the Central New York Regional Emergency Medical Advisory Committee (REMAC), the Central New York Regional CQI Program (CNYRCQI) will develop, maintain and enhance the quality of prehospital care within our region.

Purpose

It is the intent of the Regional CQI Program to support all levels of the quality improvement process. The goal of CNYRCQI is to ensure the highest quality prehospital care attainable in accordance with NYS Public Health Law Article 30, Section 3006.

Authority

The activities, guidelines, and requirements in this manual are written in accordance with and within the authority of the regulations listed below. Copies of each have been included in the back of this manual for reference.

1. New York State Health Law Article 30, Section 3006
2. Codes, Rules and Regulations of the State of New York 405.19 (c8, f1, and f3)
3. New York State Education Law 6527 Special Provisions

Standards

The activities, tasks, and decisions made in the course of the CQI process are guided by the following standards:

1. New York State Health Law Articles 28, 30 and 30A
2. New York State Emergency Medical Services Code Part 800
3. New York State Department of Health Statewide Basic and Advanced Life Support Adult and Pediatric Treatment Protocols.
4. Central New York EMS Advanced Life Support Protocols
5. New York State Department of Health Policy Statements regarding EMS
6. New York State CQI Manual
7. NYS SEMAC Advisory Statements regarding EMS

When specific medical standards are not available, the Regional Medical Director shall provide needed guidance.

Requirements and Guidelines

The CNYRCQI program operating as a subcommittee of the REMAC has set forth the following requirements and guidelines specific to each level of the CQI process. This three-tier system consists of service, county, and regional levels. This program will focus on ways to improve prehospital care rather than to administer discipline and criticism. Also included in these guidelines, is a process for appealing decisions made at each level of the CQI program.

Service Level CQI

The service level is the primary level of the CQI program. The majority of CQI activities will occur at this level. Each service is encouraged by this region to have a CQI Committee and is required to send a designated representative to staff the county level that meets their requirement by law (Articles 30 and 30A). The service level CQI committee may only make recommendations to the Director/ chief about educational corrective actions for a provider. The Director/Chief prior to implementation must first approve all policies and procedures developed by the service level CQI.

Membership Composition:

The CQI committee should consist of a variety of providers from within the agency. Additionally, the highest level of certification of that service must be represented. The makeup of the committee shall be determined by each individual agencies needs. The Director/Chief may be a member of the service agency CQI Committee.

A quorum shall consist of a minimum of three people (except for unusual circumstances), and at least 1 member must be a provider of the highest level of certification provided by the service

Investigations and Notifications

Investigations of serious issues need to begin within twenty-four hours upon notification of the incident.

All agencies should have policies and /or procedures outlining the procedure and reporting structure for internal and external notifications of serious CQI issues. All policies and procedures must be reviewed and approved by the Director/ Chief of Operations for that Service Agency.

The following must to be referred immediately to the Regional Clinical Coordinator for review:

- Esophageal Intubations
- Practicing medicine without a license
- Patient abandonment issues
- Situations that might immediately place patients in danger
- Medication Errors

The following are reportable to NYS Dept. of Health and to the Regional Clinical Coordinator within twenty-four hours:

- Noncompliance with Part 800.15
- Noncompliance with Part 800.16
- A patient dies, is injured, or otherwise harmed due to actions of commission or omission by a member of an ambulance or ALSFR service.

**The following will necessitate notification of the Regional CQI Executive Committee:
Who will determine the appropriate action:**

- A provider has two call reviews in one year involving patient care concerns.

Meeting Frequency:

Service level CQI committees should meet as often as is needed but not less than four times per year Additional meetings to address patient care concerns, should be scheduled as needed. Investigations of patient care concerns and serious issues must begin within twenty-four hours upon notification. Serious issues need to be reviewed not more than 30 days from the date the issue was initially reported.

Meeting Content:

Each meeting should consist of the following agenda items:

- Reading of the confidentiality statement
- Discussion of emergent patient care concerns
- Recognition of good patient care practice
- Review of PCRs in accordance with county and regional requests
- Follow up discussion of any open reviews
- Ongoing PCR reviews- suggested but not limited to the following examples:
 - a. Pediatric transports
 - b. Cardiac arrest/obvious death
 - c. Multiple trauma
 - d. Shock of any origin
 - e. Unconscious-unknown cause
 - f. Heart rate less than 60 or greater than 120
 - g. BP greater than 160/90 or SBP less than 90
 - h. Respirations greater than 28 or less than 12
 - i. Service/provider/patient/family/hospital complaint
 - j. Protocol deviation
 - k. GCS less than 13
- Review of medical control actions associated with above
- Review of dispatch/pre-arrival instruction/communication activities and actions
- Establish and or provide continuing educational programs for service improvement.
- Review current issues that affect patient care and the service.
- Research and development of current techniques and technologies.

Record Keeping:

The information that is required to be collected and maintained, including information from the Prehospital Care Report shall be kept confidential and shall not be released except to the department or pursuant to section 3004-A of Article 30. All records pertaining to the CQI process must be kept in a separate locked and secured file away from all other service records (employee files, etc). There will be no release of records per Article 30 section 3006.

Individual Call Reviews:

Documentation of individual call reviews must be detailed and specific. This documentation must be kept in the locked file with other CQI related records.

Breach of Confidentiality:

Any breach of confidentiality will result in a review by the regional CQI executive committee for determination of action. These situations will be reviewed on a case-by-case basis, and could result in removal from CQI activities to restriction of privileges to practice in this region.

Appeal Process:

If an individual provider disagrees with the educational corrective action set by the service CQI committee, he or she may appeal this decision in writing to the Director/ Chief of Operations within 30 days of the decision. The Director / Chief of Operations will decide if the issue is appropriate for them to review.

Service CQI issues that cannot be resolved at the service level will look to the Region for assistance.

County Level CQI

The county CQI committee is the portion of the statutory requirement of Article 30, Section 3006 of the Public Health Law. All ambulance agencies (BLS & ALS) and ALS first response agencies will participate at this level. Each county shall have written operational guidelines based on Article 30, Section 3006. Each county will appoint a representative to attend regional CQI meetings.

Membership Composition:

County CQI committees shall have at least five members and must include the following: A Physician (or NP or PA) and RN, and BLS provider, advanced provider, County EMS Coordinator, and a designated representative from each service CQI committee.

The regional EMS Program suggests the following additional members to the county CQI committee: an MD and RN from each hospital in the county, member of dispatch, a member of fire service and a member of law enforcement.

The county CQI committee will maintain a list of names and phone numbers of service and county CQI members in case of questions and or concerns.

The county CQI committee shall appoint a chairperson.

A quorum shall consist of five members of the committee. Findings at service level CQI regarding system issues shall be brought forth to the County meeting for further Review /discussion and possible recommendations.

Meeting Frequency:

The county CQI committee shall meet no less than quarterly.

Meeting Content:

Each meeting should consist of the following agenda items:

- Reading of county specific confidentiality statement
- Recognition of good patient care practice
- Individual case presentations
- Review of PCRs in accordance with regional/service/hospital requests
- A presentation of service and dispatch CQI activities
- Develop data and trends based on the above activities and:
 - a. Determine the need for protocol or system management changes
 - b. Determine the need for individual/service/county-wide training
- Service reports on status of Regional/Statewide studies and initiatives.
- Research and development
- Review of current issues that affect patient care and the service agencies

Record Keeping:

The information required being collected and maintained, including information from the Prehospital Care Report shall be kept confidential and shall not be released except to the department or pursuant to section 3004-A of Article 30. All records pertaining to the CQI process must be kept in a separate locked and secured file. There will be no release of records per Article 30 section 3006.

Breach of Confidentiality:

Any breach of confidentiality will result in a review by the regional CQI executive committee for determination of action. These situations will be reviewed on a case-by-case basis, and could result in removal from CQI activities to restriction of privileges to practice in this region.

Regional CQI Level

The Regional CQI Committee is the tertiary level of the CNYRCQI Program and is a requirement of REMAC and the CNY Regional Emergency medical Services Council (REMSCO). Resolution of concerns brought to the attention of the Regional Clinical Coordinator will be answered in writing. The written answer will be non-specific to the individual or the educational corrective action.

Membership Composition:

The Regional CQI Committee shall consist of the following:

- 3 non physician members of the REMAC
- 1 representative from each county CQI committee
- 1 representative from each hospital, MD or RN
- EMS Coordinator from each county or his/her designee
- 1 representative from dispatch agencies
- 1 representative from police agencies
- Medical Director
- 3 REMAC MDs as AdHoc members
- 5 additional members seated by the chairperson

The committee chairperson will be recommended by the group and approved by the REMAC

Executive Committee:

The committee chairperson shall identify an executive group of 5 committee members. Members of this committee must support all levels of the CQI process. Any member can raise an issue of no confidence to the executive committee of the REMSCO regarding any other member of this committee, and request a vote. The results of this vote may result in a member's removal from the committee.

Meeting Frequency:

The Regional CQI Committee shall meet every other month prior to the REMAC meeting unless an urgent patient care issue arises that requires immediate attention.

Meeting Content:

The Regional CQI Committee will review the overall performance of the system by:

- Developing/measuring/analyzing CQI indicators using the results of this data to make recommendations to the REMAC for system, protocol changes and educational programs.
- Reviewing county CQI activity
- Reviewing quality of care issues that have a potential service, county or regional effect.

- Identify providers and or services that demonstrate excellence

Agenda items should include the following:

- Reading and signing off on the confidentiality statement
- Review of emergent patient care concerns
- Follow up discussion of any open reviews
- Recognition of good patient care practice
- County CQI reports
- Hospital reports
- Old business
- New business

Record Keeping:

The information required being collected and maintained, including information from the Prehospital Care Report shall be kept confidential and shall not be released except to the department or pursuant to section 3004-A of Article 30. All records pertaining to the CQI process must be kept in a separate locked and secured file. There will be no release of records per Article 30 section 3006.

Individual Call Reviews:

The executive committee will handle all call reviews at the regional level an equally trained provider must sit on the committee for the review. The physician must review all information and recommendations prior to implementation. Documentation of individual call reviews must be detailed and specific. This documentation must be kept in the locked file with other CQI related records. Any findings that may have system impact will be reported to and reviewed by the full committee.

Breach of Confidentiality:

Any breach of confidentiality will result in a review by the regional CQI executive committee and the REMAC. These situations will be reviewed on a case-by-case basis and could result in removal from CQI activities to restriction of privileges to practice in this region.

Appeal Process:

Any individual provider, service, or county that disagrees with the educational or disciplinary action set forth by the Regional CQI Committee may appeal this decision in writing to the REMAC within 30 days of the decision.

Any ambulance service (BLS or ALS), ALS first response agency, or hospital that does not meet the minimum requirements set forth by New York State will be subject to

disciplinary action by the Regional Medical Director or the New York State Department of Health.