

APPENDIX A

Continuing Education, Skills Competency and Continuous Quality Improvement (CQI) Appointment Form

Type or print service name: Carroll County EMS

PERSONNEL APPOINTMENTS

As Medical Director I hereby appoint the following to act on my behalf for these EMS CQI activities:

Appointee Name	CQI Activity	Yes	No	CQI Activity	Yes	No
Darrell Baker Mike Lloyd	Medical audits, action plan, follow-up, loop closure, and resolution	x		Skill Competency and CEH	x	
Bill Fish	Medical audits, action plan, follow-up, loop closure and resolution	X		Skill Competency and CEH	X	

TYPE OF RESPONSES FOR WRITTEN AUDIT

At least quarterly, the above named appointee(s) will complete written audits of the following types of EMS responses:

Type of Response	Yes	No	Type of Response	Yes	No
Cardiac arrest/CPR	x		Death at scene	x	
Unstable or potentially unstable trauma	x		Refusal of transport	x	
Medication administration other than O2		x			
Deviation from approved protocol	x				
Unconsciousness	x				

PHYSICIAN REVIEW OF WRITTEN AUDITS

As Medical Director, I will review the written audits performed by the above named appointees **quarterly**.

EMS PERSONNEL CONTINUING EDUCATION REQUIREMENTS

To remain an active participant of this EMS service program, EMS providers shall maintain the following:

- A. Continuing education hours (CEH) as required for renewal of the Iowa EMS certification.
- B. Continuing education hours (CEH) for RN/PA exception (select one):
same as certified EMS providers _____ OR other (describe) _____ as required by RN/PA _____
- C. Documentation of course completion in any or all of the following nationally recognized courses:

Course Description	Acronym	Yes	No
CPR, AED, obstructed airway procedures for all age groups	CPR	x	
Advanced Cardiac Life Support	ACLS	P	
Pediatric Advanced Life Support	PALS		x
Basic Trauma Life Support	BTLS		x
Basic Trauma Life Support-Pediatrics	BTLS-P		x
Pre-hospital Trauma Life Support	PHTLS		x
Advanced Medical Life Support	AMLS		x
Pediatric Pre-hospital Care	PPC		x
Pediatric Education for Pre-hospital Professionals	PEPP		x
All the above marked 'no' are recommended but not required			

EMS SKILL MAINTENANCE REQUIREMENTS

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As a minimum, the CQI appointee(s) shall ensure and document that the certified EMS providers maintain competency in the following skills as allowed by protocol and within their Scope of Practice:

Indicate level of provider and frequency of practice:

Q = Quarterly **B** = bi-annually **A** = annually **N/A** = not-applicable

SKILL DESCRIPTION	Level of Provider	Q	B	A	N/A
Cardiac arrest management: CPR; AED; BVM; suctioning; oral/nasal, double-lumen, bridge, and/or ET airways; Rx	All levels	x			
Immobilization devices: cervical collars, long and short backboard, extremity splints including traction	All levels			x	
Medication administration: patient assisted and/or per protocol	All levels			x	
ADULT airway devices: double-lumen, bridge, endotracheal : Write # of successful attempts: _____ Circle method: patient OR manikin OR both	Paramedic = 3 All other levels = 1	x			
ADULT – IV/IO access: Write # of successful attempts: ____6_____ Circle method: patient OR manikin OR both	Paramedic	x			
PEDIATRIC airway devices: double-lumen, endotracheal: Write # of successful attempts: ____4_____ Circle method: patient OR manikin OR both				x	
PEDIATRIC - IV/IO access: Write # of successful attempts: ____4_____ Circle method: patient OR manikin OR both				x	
Needle cricothyrotomy and/or Needle thoracostomy	CCP			x	

The complete list of skills is available in the **Scope of Practice for Iowa EMS Providers** document at www.idph.state.ia.us/ems >>Providers>>Scope of Practice.

APPOINTEE STATEMENT OF AFFIRMATION

I acknowledge that I am appointed, by the medical director, as an official CQI designee. I understand my duties and will implement and maintain this CQI program as directed.

Type or print name, sign and date:

Mike Lloyd
Darrell Baker

Type or print name, sign and date:

Bill Fish

MEDICAL DIRECTOR STATEMENT OF AFFIRMATION

As medical director, I reserve the right to audit any patient care report, skill competency log, continuing education file or compliance with this CQI directive at any time. I hereby direct those acting on my behalf to promptly bring to my attention any significant deviation from written protocol and/or standard medical practice.

Type or print name, sign and date: