Ambulance Control Policy

Ambulance Control Quality Assurance System

National Ambulance Service (NAS)

Document reference number	NASCC033	**Document developed by**	Quality Improvement Unit
Revision number	5	**Document approved by**	NAS Leadership Team & Dispatch Steering Committee
Approval date	5th December 2017	**Responsibility for implementation**	Control Manager
Revision Date	5th June 2020	**Responsibility for review and audit**	Control Manager

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1.0 POLICY

1.1 Quality management and medical control are essential for the safe and efficient use of Emergency Medical Dispatch protocols.
1.2 Quality improvement is the continuous measurement, feedback and education associated with a given process.
1.3 This continual Quality Improvement practice reduces variance amongst Staff and helps to ensure compliance to protocols.
1.4 Compliance to protocol is essential in order to measure protocol effectiveness, standardise the quality of care delivered to patients, enable decisions regarding resource allocation / response, and ensure safety and the delivery of important information to responders to reduce the risk of litigation.

2.0 PURPOSE

2.1 The Quality Improvement Auditing Process is a key part of Emergency Medical Dispatch. An agreed % of all 999 calls handled daily within the Ambulance Control Centre are to be audited using the AQUA computer system. This % is monitored in accordance with IAED requirement and current call volume.
2.2 This system enables a Medical Priority Dispatch System (MPDS) Auditor to review the calls and feedback performance to staff.

3.0 SCOPE

3.1 This Policy applies to all MPDS users within the National Ambulance Service.
3.2 This Policy also applies to Control Supervisors/Staff/Officers involved in the support function of AMPDS

4.0 LEGISLATION/ OTHER RELATED POLICIES

- NAED – Quality Improvement Programme
- PHECC EMS Dispatch Standard

5.0 GLOSSARY OF TERMS AND DEFINITIONS

5.1 Not Applicable

6.0 ROLES AND RESPONSIBILITIES

The following roles and responsibilities within the National Ambulance Service are detailed as follows:

6.1 The Control and Performance Manager will take ultimate responsibility for the overall implementation of this policy.

6.2 Duty Control Managers will ensure that the policy is implemented and that suitable audit methods are in place and reviewed periodically.

6.3 Quality Improvement Unit will provide support to all Staff who requires assistance, re-training or re-certification.

6.4 Emergency Dispatch Quality Improvement specialists (EDQ) will ensure a fair and balanced approach is taken to the randomised audit of the % of 999 calls handled daily.

7.0 PROCEDURE/ PROCESS

7.1 AQUA AUDITING SYSTEM

7.1.1 This computer-based system enables an MPDS Auditor to audit the calls effectively and efficiently, ensuring that compliance levels are maintained at Accreditation - Centre of Excellence standards. Individual case review provides the data necessary to implement a continuous feedback loop, an essential part of the Quality Improvement Process.

7.1.2 This process is to be undertaken by an MPDS Auditor trained as an EDQ. An Auditor will listen to audio files of randomly selected calls and compare the staff member's actions to the protocol, completing a case Review Template (AQUA).

7.2 QUALITY ASSURANCE CASE REVIEW

There are 7 components of the Quality Assurance case review:

7.2.1 Case Entry

Case Entry interrogation is evaluated to ensure completeness, accuracy regarding script compliance, correct order, proper verification practices and emotional content/co-operation score.

Emotional Content/Co-operation score is separated into five Stages:

1. Hysterical
2. Not listening, yelling, uncooperative
3. Moderately upset
4. Anxious but co-operative
5. Normal conversational tone and volume

When reviewing a case you must measure the caller's emotional state. Monitor the application of calming techniques and then record the change in the caller's emotional content.

7.2.2 Chief Complaint Selection

The Chief Complaint selected by the Staff member should correspond with the information obtained from the caller and be asked correctly.

7.2.3 Key Question Interrogation

This section is evaluated to ensure that all appropriate key questions were asked, asked in order and asked as written.

7.2.4 Determinant Descriptor Selection

The Determinant Descriptor selected by the Staff member should correspond appropriately with the information obtained from the caller during the questioning sequence.

7.2.5 Dispatch Life Support

The staff member is expected to give Post-Dispatch and Pre-Arrival Instructions. Post-Dispatch Instructions are to be given when possible, appropriate and necessary. Pre-Arrival Instructions must be given when directed by the protocol. Errors are now classed as Deviations. The performance determinations for DLS are marked as either Correct or broken down in the following deviation categories :

Critical Deviations (Marked as Absolute in AQUA}:

- Absolute failure to read any DLS (PDI/PAI) instruction at all.
- Failure to provide any instruction considered the minimum standard of care.
- Call taker makes 2 or more errors listed under Critical deviations (marked as Critical Deviations in AQUA-please see below).

Critical Deviations {Marked as Critical in AQUA):

- Adhering to a DLS compliance of between 0.01% & 50%
- Failure to follow an appropriate DLS (PDI/PAI) link.
- Failure to read a complete panel(or set) or set of instructions
- Failure to complete full DLS (PDI/PAI)Instructions (inappropriately discontinued)
- Failure to move to a more appropriate section after receiving new or updated information (Universal Standard Protocol 11).

Major Deviations:

- Adhering to a DLS (PDI/PAI) compliance percentage of between 50.01% and 75% (with no other DLS deviations).

Moderate Deviations:

- Adhering to a PAI compliance percentage between 75.01% and 95% (with no other DLS deviations).

Minor Deviations:

- Adhering to a PDI compliance percentage of between 75.01% and 95% (with no other PDI deviations).

Correct:

- Adhering to a DLS (POI/PAI) compliance percentage between 95.01% and 100% (with no other DLS deviations)

7.2.6 Final Code

- The dispatch code is reviewed, through the auditing of the call.

7.3 Customer Service

7.3.1 In line with HSE Policy, the National Ambulance Service is dedicated to providing a caring, compassionate and efficient service to our patients and clients. All Control Centre staff complies with this process by submitting to a random audit of calls as part of this Quality Assurance System.

7.3.2 The scoring areas for customer service are as follows:

Desired Behaviour:

A. Attitude I Mannerism
B. Correct volume and tone
C. Use of Empathy & Compassion
D. Avoid gaps
E. Explains actions
F. Provides Reassurance
G. Don't create / uncontrollable explanation
H. Questioning the integrity of the caller
I. Use of calming techniques

Scoring

Each above area is marked as set out below:

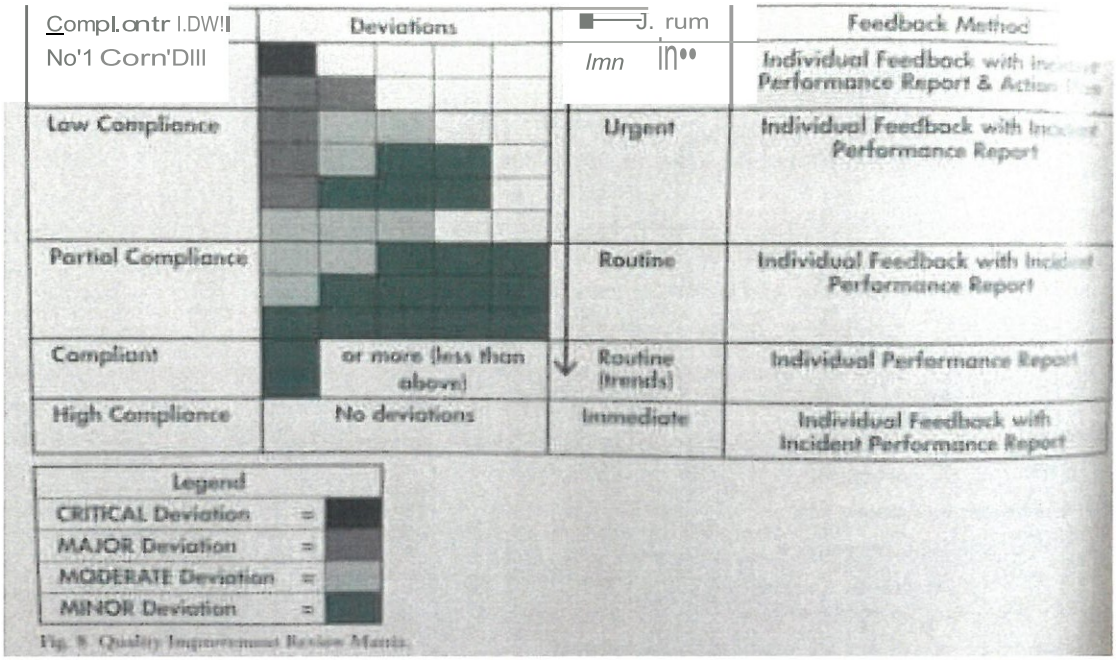
A. Correct
B. Minor discrepancy
C. Failure to apply universal standards
D. Use of prohibited Behaviour
E. Use of specific calming techniques

7.4 Compliance Summary

AQUA software automatically determines the Compliance Level for any combination of deviations. However determining the Compliancy Level is a means to an end. The important thing to remember is to give feedback in priority of deviations (critical & majors for moderates and minors). Compliancy is no broken into 5 categories which are:

A. High Compliance
B. Compliant
C. Partial Compliance
D. Low Compliance
E. Non-Compliant

Please review the Quality Improvement Review Matrix below along with the Legend to determine Compliancy Levels and when feedback should be provided.



7.4.1 Accreditation compliance

FOR IMMEDIATE RELEASE: April 11, 2014

The International Academies of Emergency Dispatch® is pleased to announce the release of new Standards for Accreditation. The new standards will replace Point 9a in the 20 Points of Accreditation. All other points remain unchanged.

Standards for Accreditation

	ACE
High Compliance	
Compliant	
Partial Compliance	10%
Low Compliance	10%
Non-Compliant	7%

Percentage of Deviation Accepted	Critical Deviation	Major Deviation	Moderate Deviation	Minor Deviation
Case Entry	2%	3%>	3%	3%
Chief Complaint	5%	3%	4%	5%
Key Questions	3%	3%	5%	5%
Dispatch Life Support	4%	3%	3%	6%
Final Code	6%	8%	10%	10%
Customer Service	2%	2%	2%	5%
Total Accreditation Acceptance	3%	3%	3%	3%

The new Standards for Accreditation are fully compliant with the recently released EMD-Q™ 9a, EFD-Q™ 4a, and EPD-Q™ 4a Performance Standards. As shown in the chart above, they are based on both Compliance Levels and deviation percentages in Case Entry, Chief Complaint, Key Questions, Dispatch Life Support, Final Code, and Customer Service. To meet this standard, an agency must demonstrate that no more than 10% of cases fall in the Partial Compliance Level, no more that 10% of cases fall in the Low Compliance Level, and no more than 7% of cases fall in the Non-Compliant Level. An agency must also demonstrate that the total percentage of Critical, Major, Moderate, and Minor deviations fall within the thresholds shown on the chart. These percentages are derived by dividing the number of deviations recorded by the total number of possible deviations for each category.
An ACE Standards report containing the required information is available in AQUA® 6 software under the ACE tab. Agencies who have upgraded to AQUA 6 and the new 9a/4a Performance Standards must use this new report effective immediately. By March 2015 all Accreditation applications must use the new report. Please contact Priority Dispatch® Technical Support for information on upgrading to AQUA 6.

To ease the transition for currently Accredited Centres of Excellence, the Academy has produced a graduated compliance scale.

Standards for Reaccreditation

	ACE	6 mos	9 mos	12 mos
High Compliance				
Compliant				
Partial Compliance	10%	13%	17%	20%
Low Compliance	10%	13%	17%	20%
Non- Compliant	7%	11%	15%	20%

Percentage of Deviation Accepted	**Critical Deviation**	**Major Deviation**	**Moderate Deviation**	**Minor Deviation**
Case Entry	2%	3%	3%	3%
Chief Complaint	5%	3%	4%	5%
Key Questions	3%	3%	5%	5%
Dispatch Life Support	4%	3%	3%	6%
Final Code	6%	8%	10%	10%
Customer Service	2%	2%	2%	5%
Total Accreditation Acceptance	3%	3%	3%	3%
Total ReACE Acceptance 6 months	3%	5%	4%	3%
Total ReACE Acceptance 12 months	3%	5%	6%	3%

This graduated scale applies to the required biannual reports. If the submitted reports meet the ACE Standard, no additional reporting is necessary. f the submitted reports do not meet the ACE Standard, but fall within the 12 month, 9 month, or 6 month thresholds shown on the chart above, the agency will be required to provide quarterly reports until compliance reaches the ACE Standard. If the submitted reports fall below the thresholds shown on the chart above, the agency will be placed on notice and will need to submit an Action Plan for improvement.

7.4.2 Performance

The overall performance for individual Staff members is based on the number of deviations in the number of cases reviewed per staff member and Case Incident Reviews are done by the EDQ's, and feedback given to the staff members based on the above matrix.

7.4.3 Exemplary

An overall performance of High Compliance is classed as exemplary and the feedback report is sent to the Staff member and a copy retained in the Staff member's training file.

7.4.4 Monthly Compliance

The EDQ's will produce monthly reports for management in order to monitor the Control Centre and Staff performance.

7.4.5 Individual Reports

These are produced to monitor individual Staff member performance levels. If Staff is non-compliant an action plan will be put in place by the Education and Competency Assurance Team and an action plan set up.

7.5 COMPLIANCE / NON COMPLIANCE PROCEDURE

The Compliance/Non-compliance procedure is in place to ensure that compliance is monitored through the AQUA system . Staff will be given feedback reports on all audited calls and tutorials are held quarterly by the Education and Competency Assurance Team to review individual performance.

The compliance levels are:

- **High Compliance**
- **Compliant**
- **Partial Compliance**
- **Low Compliance**
- **Non-Compliant**

7.5.1 Non-Compliance

If Staff are non-compliant Quality Improvement Unit will work with the staff member to put an action plan in place. The Staff member along with the Quality Improvement Unit member will listen to the call, if requested by Staff member, to review the call together and evaluate each section, highlighting to the Staff member where the non-compliance arose.

7.5.2 Discussion / Debrief

A tutorial will be held by a member of the Quality Improvement Unit with the Staff member and documented in the Staff member's training file, highlighting all strengths and weaknesses, and if necessary, mutually agreeing a monitoring period, normally 1month.

7.5.3 Protocol Information

The Staff member is supplied with an information sheet relating to the particular protocol on which they need to develop and must then complete a questionnaire. If a score of 80% or above is achieved, 1 hour Continuous Dispatch Education (CDE) is obtained.

If, after the second month review, there has been no improvement, a second tutorial will be held between a Quality Improvement Unit member and the Staff member.

The Staff member will be advised that this situation will be highlighted to a Control Manager. The Staff member will be advised that if no significant improvement is seen by the end of the second month then an Audit Review program may be implemented.

If, after the third month review, there has been no improvement, a third tutorial will be held between a member of the Control Manager responsible for Training and the Staff member . The Staff member will be advised that an Audit Review program will be enforced for a period of four weeks, at the end of the third month.

At the end of the three-month cycle, the four-week Audit Review program will commence. If no significant improvement in compliance has been seen following the four-week Audit Review period, then the Staff member may be considered for re-training and the issue will be addressed at the DRC meeting.

8.0 IMPLEMENTATION PLAN

8.1 On approval, this Policy will be circulated electronically to all Managers, Supervisors and Staff

8.2 This Policy will be available electronically in Ambulance Control Centres for ease of retrieval and reference

8.3 Each Control Manager will ensure that the Confirmation Form is returned to NAS Headquarters to confirm document circulation to all staff.

9.0 REVISION AND AUDIT

9.1 This computer-based system enables MPDS Auditors to audit the calls effectively and efficiently, ensuring that compliance levels are maintained at Accreditation - Centre of Excellence standards. Individual case review provides the data necessary to implement a continuous feedback loop, an essential part of the Quality Improvement Process.

9.2 Individual compliances will be circulated to Control & Performance Managers and the Quality Improvement Unit so as to monitor the effectiveness of this policy.

9.3 Ambulance Control Centre Compliances will be shared with Operations Performance Managers to inform progress against the overall Performance Improvement Plan.

9.4 **Revision History:**

(This captures any changes that are made to a SOP when it has been revised. This may be placed at the back or close to the front of the document according to local preference.)

No	Revision No	Date	Section Amended	Approved by
1	5	5th June 2018	N/A	Control Manager

10.0 REFERENCES

- International Academy of Emergency Medical Dispatch
- Accreditation
- www.prioritydispatch.co.uk

11.0 APPENDICES

Appendix I- Policy Acknowledgement Form

12.0 Signatures of Approval

National Control Operations Manager
On Behalf of the National Ambulance Service

Date 10/01/18

National Ambulance Service Director
On Behalf of the National Ambulance Service

Date 10/01/18

Document Control No. 1 (to be attached to Master Copy)

NAS

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to a peer reviewer (internal or external), in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy or Procedure or Protocol or Guideline that you have reviewed and agreed the content and recommend the approval of the following Policy, Procedure, Protocol or Guideline:

Title of Policy, Procedure, Protocol or Guideline:

NAS

I acknowledge the following:

- I have been provided with a copy of the Policy, Procedure, Protocol or Guideline described above.
- I have read Policy, Procedure, Protocol or Guideline document.
- I agree with the Policy, Procedure, Protocol or Guideline and recommend its approval by the committee developing the PPPG.

_____	_____	_____
Name	Signature (Block Capitals)	Date

Please return this completed form to:

Name: **Niamh Murphy**
Contact Details: **Corporate Office**
National Ambulance Service
Rivers Building
Tallaght Cross
Dublin 24
email niamhf.murphy1@hse.ie

Document Control No. 2 (to be attached to Master Copy)

Key Stakeholders Review of Policy, Procedure, Protocol or Guidance Reviewer Statement

Reviewer: The purpose of this statement is to ensure that a Policy, Procedure, Protocol or Guideline (PPPG) proposed for implementation in the HSE is circulated to Managers of Employees who have a stake in the PPPG, in advance of approval of the PPPG. You are asked to sign this form to confirm to the committee developing this Policy or Procedure or Protocol or Guideline that you have seen and agree to the following Policy, Procedure, Protocol or Guideline:

Title of Policy, Procedure, Protocol or Guideline:

NAS

I acknowledge the following:

- I have been provided with a copy of the Policy, Procedure, Protocol or Guideline described above.
- I have read Policy, Procedure, Protocol or Guideline document.
- I agree with the Policy, Procedure, Protocol or Guideline and recommend its approval by the committee developing the PPPG.

_____	_____	_____
Name	Signature (Block Capitals)	Date

Please return this completed form to:

Name: **Niamh Murphy**
Contact Details: **Corporate Office**
National Ambulance Service
Rivers Building
Tallaght Cross
Dublin 24
email niamhf.murphy1@hse.ie

Document Control No. 3 Signature Sheet:
(to be attached to Master Copy)

Policy, Procedure, Protocol or Guideline:

NAS

I have read, understand and agree to adhere to the attached Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date