Fauquier County Volunteer Fire and Rescue Association
EMS Committee

Quality Assurance Form A

Year: _____ __Jan-Mar __April-June __Jul-Sep __Oct-Dec

Department Name: _____

Total calls for this period: _____ Total calls reviewed for this period: _____

Are there any calls the provider or agency would like the committee to review? Y/N

If yes, please list date/report # and briefly describe the reason for review:

_____
_____
_____

Were any calls considered a "major event?" Y / N

If yes, please list date/report # below:

_____

_____

_____

_____

Totals:

ALS _____

BLS _____

Date submitted: _____ Submitted by: _____

Contact email: _____ Contact phone: _____

Version 1.1

Fauquier County Volunteer Fire and Rescue Association
EMS Committee

Quality Assurance Form B

Year: _____ __Jan-Mar __April-June __Jul-Sep __Oct-Dec

Department Name: _____

Indicator #1: *C-Spine/Immobilization Rule out*

How many reports involved c-spine/immobilization rule out in this quarter?

_____

How many of those reports had clear documentation as to why the rule out was used? _____

Was the protocol followed for each case? Y/N

If no, how many cases involved the protocol not being followed: _____

Indicator #2: *CPAP use*

How many times was CPAP used by a provider in this quarter? _____

Was the protocol followed for each case? Y/N

How many times did the patient's condition improve with CPAP use? _____

Were there any cases where CPAP was discontinued or the patient did not improve? Y/N

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Quality Assurance Form B

Indicator #3: *BLS drug box usage*

How many calls involved using the BLS drug box: _____

Please indicate the following:

Report #	Call Type	Medication used

Date submitted: _____ Submitted by: _____

Contact email: _____ Contact number: _____

Unless otherwise specified, it is not necessary to submit copies of any reports that meet the indicators outlined on Form B.