DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL
CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

INSPECTIONS AND EVALUATIONS DIVISION

REPORT OF INSPECTION

FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT

REPORT NUMBER 03 – 0001FB
OCTOBER 2002

Inspections and Evaluations Division

Mission Statement

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) Government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness and economy in operations and programs. I&E goals are to help ensure compliance with applicable laws, regulations, and policies; to identify accountability; recognize excellence; and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

October 17, 2002

Adrian Thompson
Interim Fire & EMS Chief
Fire and Emergency Medical Services Department
1923 Vermont Avenue, N.W.
Suite 201
Washington, DC 20001

Dear Chief Thompson:

Enclosed is our *Report of Inspection of the Fire and Emergency Medical Services Department (FEMS)*. Comments from FEMS on the 16 findings and 30 recommendations by the inspection team are included in the report. We are pleased to note your agreement with all recommendations. This clearly shows the efforts being made to create a more efficient and well-run FEMS.

Also enclosed are Compliance Forms on which to record and report to this Office any actions you have taken concerning each outstanding recommendation. These forms will assist you in tracking the completion of actions taken by your staff, and will assist this Office in its inspection follow-up activities. We track agency compliance with all agreed-upon recommendations made in our reports of inspection. We request that you and your administrators establish response dates on the forms and advise us of those dates so we can enter them on our copies of the Compliance Forms. We know that in some instances, things beyond your control, such as budget decisions, impact on trying to set specific deadlines. In those instances we request that you assign target dates based on whatever knowledge and experience you have about a particular issue. Please ensure that the Compliance Forms are returned to the OIG by the response date, and that reports of "Agency Action Taken" reflect actual completion, in whole or in part, of a recommended action rather than "planned" action.

We appreciate the cooperation shown by you and your employees during the inspection and we hope to continue in a cooperative relationship during the upcoming follow-up period.

If you have questions or require assistance in the course of complying with our recommendations, please contact me or Alvin Wright, Jr., Assistant Inspector General for Inspections and Evaluations at (202) 727-5052.

Sincerely,

Charles C. Maddox, Esq.
Inspector General

Enclosure/Attachment

CCM/AW/jcs

cc: See **Distribution**

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ACRONYMS

ALS	Advanced Life Support
BLS	Basic Life Support
CAD	Computer Aided Dispatch
CQI	Continuing Quality Improvement
DOH	Department of Health
EMS	Emergency Medical Services
EMSB	Emergency Medical Services Bureau
EMT	Emergency Medical Technician
EMT/B	Emergency Medical Technician – Basic
EMT/P	Emergency Medical Technician – Paramedic
FEMS	Fire and Emergency Medical Services
MPD	Metropolitan Police Department
NFPA	National Fire Prevention Association
OEHMS	Office of Emergency Health and Medical Services
PEC	Paramedic Engine Company
PSAP	Public Safety Answering Point

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EMERGENCY MEDICAL SERVICES TRAINING ACADEMY

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EXECUTIVE SUMMARY

Background

The Inspections and Evaluations (I&E) team of the Office of the Inspector General (OIG) conducted an inspection of the District of Columbia Fire and Emergency Medical Services Department, from September 2001 to January 2002. The team found significant deficiencies in all inspected areas.

Scope and Methodology

The inspection focused on the management, accountability, and operations of key areas that impact response time to critical medical emergencies, including field operations, staffing, administrative issues, and data analysis techniques. The team conducted 97 interviews, toured facilities, directly observed work processes and reviewed pertinent files and documents. This report contains 16 findings and 30 recommendations, all of which were reviewed and commented upon by FEMS senior management prior to publication of this report. The inspection team found FEMS management and employees cooperative and responsive throughout the inspection.

Perspective

The Fire and Emergency Medical Services Department's stated mission is: **[t]o improve the quality of life for each and every customer (internal and external) of this agency by providing the most effective and efficient service possible.**[1]

The Department's vision statement is:

> **[t]o be a performance-based organization in which a well-trained, highly skilled workforce utilizes state-of-the-art equipment, technology, apparatus and facilities to provide the highest quality fire and emergency medical services with**

[1] Fire and Emergency Medical Services: Mission and Vision http://fems.dc.gov/home/fems_mission.shtm

minimal response time. Additionally, the agency will involve the private sector and the civic community in public education and awareness activities. The realization of this vision will help to make our city the very best in providing efficient and effective customer service.[2]

Compliance and Follow-Up

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. The Inspections and Evaluations Compliance Officer will coordinate with FEMS on verifying compliance with the recommendations in this report over an established time period.

FINDINGS, RECOMMENDATIONS, FEMS COMMENTS

Office of Fire and EMS Chief

Emergency units do not meet some FEMS management and national standards related to response time. The National Fire Protection Association (NFPA) recommends that the fire department establish the following time objectives, (1) One minute (60 seconds) for the call taker to locate an emergency unit to respond; and (2) One minute (60 seconds) for the emergency response unit to acknowledge the emergency call and the emergency vehicle to be en route to the medical emergency. The majority of FEMS emergency response units who respond to medical emergencies are not meeting these standards. **Recommendation:** That FEMS management ensure that emergency response units adhere to both FEMS and national standards when responding to emergency medical calls. **FEMS Comments:** Agree. (Page 15).

[2] *Id.*

EXECUTIVE SUMMARY

Once en route, FEMS does an excellent job of getting to the scene of an emergency quickly. A review of the records that FEMS maintains to monitor en route times revealed that FEMS emergency response employees arrive at the scenes of emergencies very quickly. From July 2001 through December 2001, employees took, on average, only 6 minutes and 21 seconds to get to the scene of an emergency, once they were en route. The nationally recognized standard for en route time is 8 minutes or less.
Recommendation: None. (Page 18).

Time intervals in the Call Center that may affect response time are not measured. Response time data reported by FEMS does not accurately reflect the time it actually takes to respond to emergency calls. FEMS and MPD management stated that they do not measure the interval between the time the Public Safety Answering Point (PSAP) receives a call to the time that the call is transferred to FEMS. Additionally, FEMS managers stated they have not measured the average delays in answering calls transferred from the PSAP. A consultant recently hired to look at the call center stated that FEMS management had never attempted to measure these time intervals because they were not aware that they existed in the system.
Recommendation: That Chief/FEMS and the Deputy Chief of the Communications Division ensure that data on all time intervals that affects response time is collected and reviewed on a regular basis. **FEMS Comments:** Agree. Has been implemented and is ongoing. (Page 19).

Some residents misuse the 911 system to get priority help for non-emergencies. FEMS employees complained that District residents abuse the services of the Emergency Medical Services Bureau (EMSB) by calling 911 and reporting a false medical emergency. When they arrive on the scene, FEMS employees find that the caller simply needs a ride to a scheduled medical appointment, or the medical need is less than serious. FEMS should develop an outreach plan to educate the community on the appropriate use of 911 versus the use of the District's non-emergency numbers.
Recommendation: That Chief/FEMS and the PIO develop and implement a written community outreach plan to disseminate information to the public

on how abusing the emergency medical response system affects the timeliness of emergency medical services in the District. **FEMS Comments:** Agree. Community outreach proposal submitted for review. (Page 20).

Despite independent reports citing deficiencies in the critical medical emergency response system, many problems have not been corrected. The inspection team reviewed previous reports, which outlined deficient operational issues in FEMS. Many of the same issues identified in these reports still negatively affect response time. **Recommendation:** That Chief/FEMS and the FEMS Medical Director organize a committee or task force comprised of management and line employees to review the 1989 and 1997 reports and develop a strategic plan to address the issues identified. Chief/FEMS should ensure that a strategic plan is developed and implemented. **FEMS Comments:** Agree. (Page 21).

Communications Division

The Communications Division's performance contributes to slower response times to critical medical calls. Response time standards are not being met, potentially jeopardizing the lives of those with life-threatening emergencies. Only 68% of emergency calls meet the processing standard of one-minute or less, and only 44% of calls are dispatched in line with the standard time of one minute or less. FEMS employees noted that problems with the new 911 system, in addition to insufficient staffing and training, contribute to their failure to meet the standards. **Recommendations:** (a) That Chief/FEMS ensure that there is adequate staff for the Communications Division and that key positions are filled as soon as possible. (b) That Chief/FEMS and the Assistant Fire Chief of Fire Operations ensure that the emergency response system is reprogrammed so that only emergency calls are routed to call takers. **FEMS Comments:** Agree. (Page 27).

EXECUTIVE SUMMARY

Emergency Medical Services Bureau

Inadequate number of paramedics prevents timely responses. Advanced Life Support (ALS) units are responsible for responding to critical medical emergencies within the District. Supervisors stated that the lack of adequate staffing and abuse of sick leave is causing many of these units to be placed out of service or downgraded to a Basic Life Support (BLS) unit on a daily basis. As a result, response time to critical medical emergencies can be negatively affected. **Recommendations:** (a) That Chief /FEMS, the FEMS Medical Director and the Assistant Chief of EMSB Operations assess the staffing shortages within EMSB to determine how many additional paramedics should be hired. (b) That Chief/FEMS coordinate with all senior level managers and take appropriate action with respect to employees who have patterns of abusing sick and annual leave. **FEMS Comments:** Agree. (Page 34).

FEMS paramedics provide emergency medical care without valid certifications. FEMS paramedics with expired certifications are providing emergency medical care to District patients. This occurs for a number of reasons: (1) FEMS and Department of Health staff use an outdated District regulation to govern certification and recertification licenses; (2) there are no written regulations that authorize extensions of expired paramedic licenses; (3) the quality assurance unit for the EMSB does not have the necessary staff or resources to conduct required field evaluations on paramedics' performance. **Recommendations:** (a) That Chief/FEMS coordinate with Director/DOH to develop a policy on certification extensions. (b) That the FEMS Medical Director ensure that FEMS paramedics comply with the most recent version of District regulations governing paramedic certification and recertification. (c) That Chief/FEMS and the FEMS Medical Director ensure that additional evaluators are hired for the Continuing Quality Improvement (CQI) Unit. (d) That Chief/FEMS immediately reassign all detailed CQI Unit evaluators back to the CQI office. (e) That the FEMS Medical Director take steps to ensure that the CQI Unit has the necessary staff and resources to complete field evaluations. **FEMS Comments:** (a) Agree the current Medical Director has requested additional positions for some time now. This is being investigated now and we are awaiting DCOP

to post multiple position announcements. (d) Agree. DC Fire and Emergency Medical Services Department has requested this be accomplished for over 3 years. (Page 36).

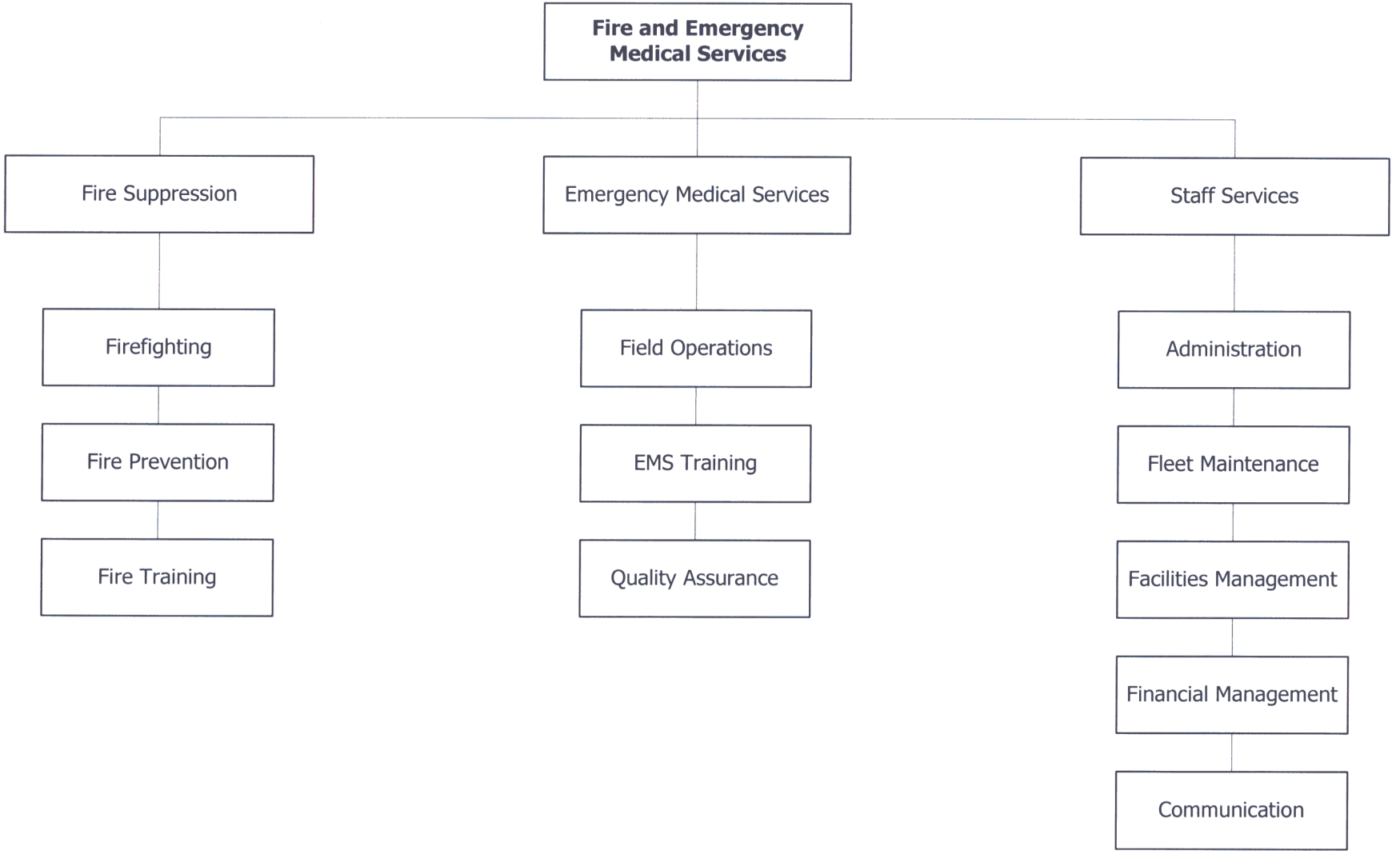
There is no official process to monitor the field performance of basic EMTs. The CQI Unit does not monitor the field performance of basic EMTs because this is not a recertification requirement. Consequently, FEMS does not have an official way to evaluate basic EMT performance or to ensure that they are not violating any medical protocols. **Recommendations:** (a) That the FEMS Medical Director develop a field evaluation process for basic EMTs similar to that used for paramedics. (b) That Chief/FEMS and the FEMS Medical Director hire sufficient staff to perform field evaluations on basic EMTs. **FEMS Comments:** (a) Agree. A Draft of such project has been developed. The current Medical Director recognized this problem and ordered the CQI Unit to evaluate all EMTs in the year 2000. That was the first year that the CQI Unit successfully evaluated all EMTs assigned to BLS units. (b) Agree. The Medical Director has made a request for additional staffing. (Page 45).

Emergency Medical Services Training Academy

FEMS paramedics and basic EMTs state that they are not receiving adequate training from instructors at the Training Academy. Many paramedics and basic EMTs stated that they are not receiving the required number of training hours for many of their recertification classes because many instructors are detailed to the Training Academy and do not have prior experience teaching paramedic and basic EMT courses. Additionally, they state that instructors arrive late to class, allow students to take long lunches, dismiss classes early and sometimes are not prepared to teach. **Recommendations:** (a) That the FEMS Medical Director establish qualifications and create a hiring policy for EMS training instructors. (b) That the FEMS Medical Director immediately assess the qualifications of all EMS training managers and instructors to ensure that only qualified instructors are teaching classes. **FEMS Comments:** (a) Agree. This issue is currently being addressed and a new interpretive guide has already been made and is awaiting a labor and management review. (b) Agree. This is an

ongoing process and a quality improvement of the training academy, which is in line with the three-year strategic plan that we have developed. (Page 56).

Fire and Emergency Medical Services



INTRODUCTION

INTRODUCTION

Background and Perspective

The Inspector General directed the inspection of the District of Columbia (District) Fire and Emergency Medical Services Department (FEMS) in response to public complaints about the length of time it takes Emergency Medical Technicians (EMTs) to respond to calls for pre-hospital emergency medical assistance. These complaints were reflected in a number of news reports in both print and electronic media.

The Department has approximately 1,900 employees, and its fiscal year 2002 budget was $119,330,233. During calendar year 2001, FEMS responded to 75,889 emergency medical care calls.

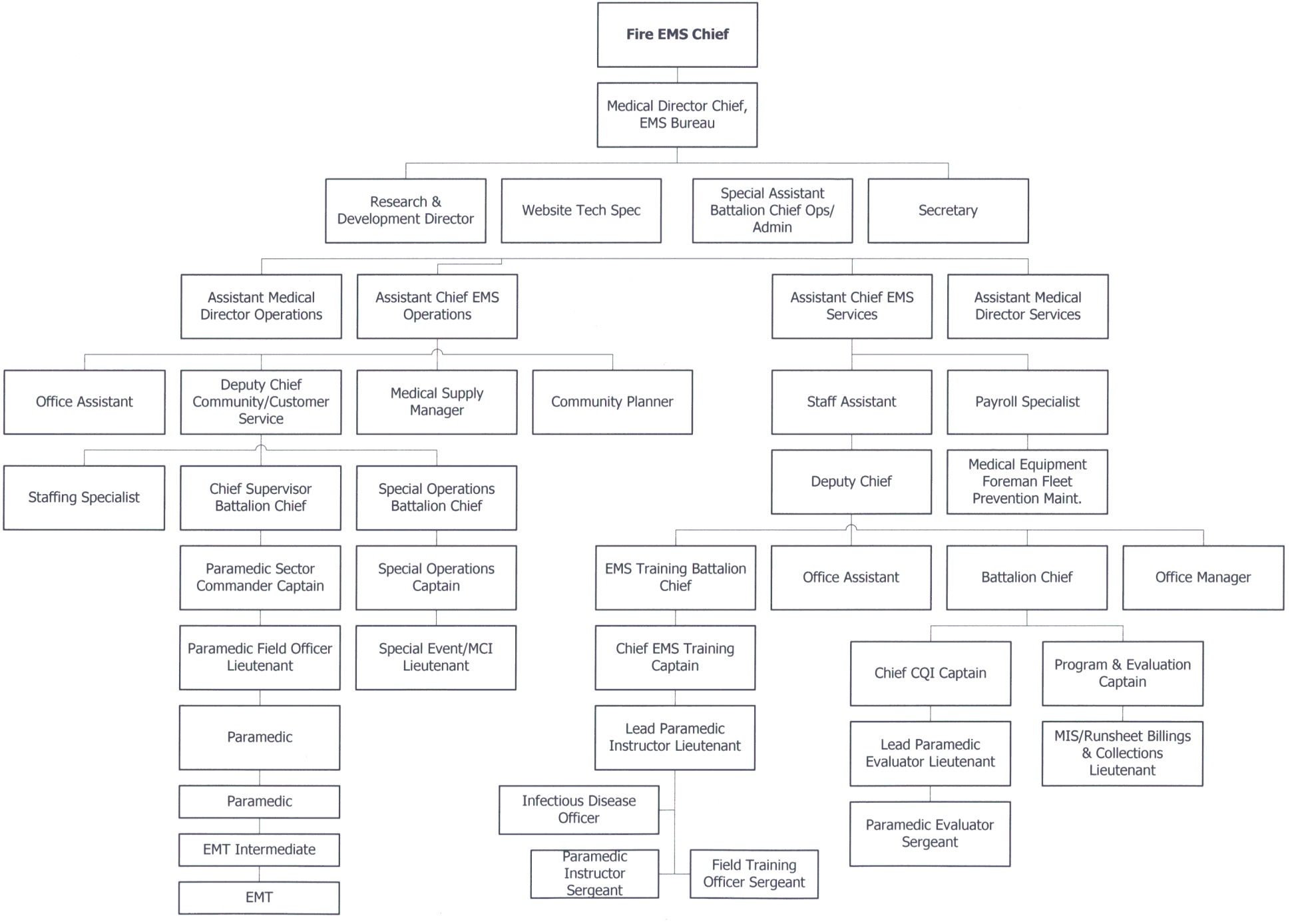
Scope and Methodology

The inspection of FEMS evaluated the efficiency and effectiveness of the emergency medical response process. Inspectors determined adherence to laws, regulations, and policies and compared FEMS operations to other local municipalities and recommended national standards. The team conducted 94 interviews, reviewed numerous documents, directly observed key work processes and inspected selected work areas and facilities. A list of the 16 findings and 30 recommendations is at Appendix 1.

Compliance and Follow-Up

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. A compliance form for each finding that has recommendations will be sent to the Chief of FEMS along with this Report of Inspection. The Inspections and Evaluations Division Compliance Officer will coordinate with FEMS on verifying compliance with the recommendations over an established time period. In some instances, follow-up inspection activities and additional reports may be required.

EMS Bureau Organizational Chart



Findings and Recommendations:

OFFICE OF THE FEMS CHIEF

OFFICE OF THE FEMS CHIEF

The Chief of Fire and Emergency Medical Services (FEMS) directs overall policy, planning and management of the department with the aid of two Assistant Fire Chiefs and a Medical Director.

The Assistant Fire Chief for Operations is responsible for overall supervision and coordination of field activities, including the Firefighting Division, Communications Division, and Special Operations.

The Assistant Fire Chief for Services supervises the support systems of the Fire Prevention Division, Training Division, Fleet Maintenance, Facilities Maintenance, and Health and Safety.

The Medical Director is responsible for the overall management and control of emergency pre-hospital patient care and transportation to appropriate emergency medical facilities by paramedic and emergency medical technician (EMT) field providers.

Within the Office of the FEMS Chief are the offices of Public Information, Financial Operations, Compliance, Management Information Systems, General Counsel, and the Diversity Management Officer.

1. Emergency units do not meet some FEMS management and national standards related to response times.

The National Fire Protection Association (NFPA) *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments Chapter 1710, § 4.1.2.1* (2001) states that:

> **[t]he fire department shall establish the following time objectives:**
>
> *** * ***
>
> **(2) One minute (60 seconds) for turnout time.**[3]

[3] Turnout time is the length of time between an emergency response unit acknowledging notification of the emergency from a FEMS dispatcher until the unit is actually en route to the emergency.

* * *

(4) Eight minutes (480) seconds or less for the arrival of an advance life support unit at an emergency medical incident, where this service is provided by the fire department.

When emergency response units are dispatched to the scene of medical emergencies, FEMS management and nationally recognized standards require the response unit to acknowledge the dispatcher and have the response vehicle in motion and en route[4] to the location within 1 minute. The majority of the FEMS emergency response units who respond to medical emergencies do not leave the stationhouses within the 1 minute requirement. Based on call center data, FEMS emergency response units fail to leave stationhouses in 1 minute, or less, 80% of the time. From July 2001 through December 2001, emergency response employees were taking 1 minute and 58 seconds on average to turnout, as detailed below.

FEMS Average Response Time to Critical Medical Calls		
	Standard	**Actual[5]**
Citizen calls 911	MPD evaluates how long it takes MPD PSAPs to answer the phone. NFPA does not have a standard for this time interval.	FEMS does not evaluate this time period.
MPD PSAPs ask caller a series of questions to determine the nature of the emergency. They transfer all medical calls to FEMS.	NFPA does not have a standard for this time interval.	MPD/FEMS does not evaluate this time interval.

[4] *En route time* is the sum of the time between the receipt of the emergency dispatch by the response unit and the unit's acknowledgement of the dispatch, plus the time between the acknowledgment of the dispatch and the departure of an emergency vehicle to the scene of the emergency.

[5] Numbers highlighted in red indicate that FEMS has not met the standard.

FEMS Average Response Time to Critical Medical Calls		
	Standard	**Actual**[5]
FEMS call takers conduct a patient assessment and prioritize the medical emergency. Call takers then transfer calls to FEMS dispatchers.	1:00 minute or less	1:06 minutes on average (July 2001 through December 2001)
FEMS dispatchers locate a unit to respond to the emergency and alert the unit of the emergency.	1:00 minute or less	1:56 minutes on average (July 2001 through December 2001)
Once notified, the FEMS unit leaves the firehouse.	1:00 minute or less	1:58 minutes on average (July 2001 through December 2001)
Once en route, the FEMS unit has to get to the scene of the emergency.	8:00 minutes or less	6:21 minutes on average (July 2001 through December 2001)

In December 2001, the average turnout times for paramedic engine companies[6] (PECs) was 1 minute and 47 seconds, and the Emergency Medical Services Bureau (EMSB) ALS[7] response units took an average of 1 minute and 49 seconds to leave the stationhouse.

[6] A fire engine company that has an EMT/P from the EMSB assigned to the company is considered a PEC. In addition to responding to fire calls, these engine companies can respond to ALS emergency calls. A BLS ambulance unit is also dispatched to ALS calls that are responded to by PECs to transport a patient to the hospital if needed.

[7] The National Fire Prevention Association defines ALS as the functional provision of advanced airway management, including intubations, advanced cardiac monitoring, manual defibrillation, establishment and maintenance of intravenous access, and drug therapy. ALS is critical care administered by a paramedic during medical emergencies, e.g. strokes, heart attacks, burn victims.

Some PEC and ALS ambulance response unit employees stated that the employees themselves are partially responsible for slower response times to critical medical calls, because some employees do not exit the stationhouse or respond to calls in a timely manner if they are already on the street, and some are lazy or do not care. In addition, some ALS response unit employees stated that PEC firefighters treat medical calls with less urgency than they treat fire calls. As a result, FEMS is not able to meet national and management performance standards when responding to critical medical emergencies.

Recommendation:

That the Assistant Fire Chief of Fire Operations, the Medical Director and the Assistant Chief for EMSB Operations ensure that emergency medical response units adhere to both national and FEMS management standards for exiting the stationhouse and responding to emergency medical calls.

Agree **X** Disagree _____

2. <u>Once en route, FEMS units arrive at the scene of critical medical emergencies faster than the national standard</u>.

The NFPA *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments Chapter* 1710, § 4.1.2.1 (2001) states that once en route, it should take 8 minutes (480) seconds or less for the arrival of an advance life support unit at an emergency medical incident, where this service is provided by the fire department.

A review of the records that FEMS maintains to monitor en route times showed that once en route, FEMS emergency response employees are doing an excellent job getting to the scenes of emergencies quickly. From July 2001 through December 2001, emergency response employees took only 6 minutes and 21 seconds, on average, to arrive on the scene of an emergency (see chart, page 14).

No Recommendations.

3. <u>FEMS does not measure significant time intervals that may affect overall response time</u>.

MPD operators at the Public Safety Answering Point (PSAP) initially answer all emergency calls placed to the Call Center. Operators assess callers' needs, and if the call is a medical emergency, it is transferred to a call taker in the FEMS Communications Division. If the call is a fire emergency, it is transferred to a FEMS fire lead dispatcher in the Communications Division. According to nationally recognized standards, the initial call taker's response to an alarm should take no more than 60 seconds.

FEMS and MPD management stated that they do not measure the interval from the time the PSAP receives the call to the time that the call is transferred to FEMS. In addition, FEMS managers stated that they do not measure the amount of time it takes the FEMS call taker to answer the call after it is transferred from the PSAP. Because these intervals are not measured, actual response times to emergencies are likely longer than are currently being reported.

An outside consultant recently hired to look at Communications Division operations stated that FEMS management had never attempted to measure these time intervals because they were not aware that the data was available.

Recommendation:

That Chief/FEMS and the Deputy Chief of the Communications Division ensure that data on all time intervals that affect response time is collected and reviewed on a regular basis.

Agree **X** Disagree _____

FEMS Comments: ***Has been implemented and is ongoing.***

4. Some callers abuse 911 system by misrepresenting their medical needs.

According to FEMS employees, some callers abuse emergency medical services and thereby contribute to response time problems. Callers misrepresent the nature of their needs in an effort to get a higher priority for their calls and a faster response from FEMS units. Such tactics prevent a quick response time to more serious calls.

For example, the inspection team witnessed an ALS unit respond to a scene where the caller alleged that a pit bull had severed the leg of a child. After arriving on the scene and assessing the situation, the field providers concluded that the actual victim was an adult male with a less than serious dog bite that could have been handled by a BLS[8] unit. On other occasions, people have called for emergency medical care when what they actually needed were rides to the hospital for scheduled clinic appointments. Field providers stated that District medical protocols prohibit refusing assistance to anyone, even if callers have abused the system because they do not require medical attention. System abuses contribute to increased response times because ALS units that would otherwise be available for critical medical emergencies are often taken out of their service areas to respond to these non-life-threatening calls.

Callers with non-emergencies should dial 311. The Chief/FEMS and the Public Information Officer (PIO) are responsible for ensuring that the public is knowledgeable about the appropriate use of the District's 311 number. According to FEMS management, however, a comprehensive community outreach program to educate the public on using 311 instead of 911 for non-emergency calls has not been developed.

[8] The National Fire Prevention Association defines BLS as the functional provision of patient assessment, including basic airway management; oxygen therapy; stabilization of spinal, muscolo-skeletal, soft tissue, and shock injuries; stabilization of bleeding; and stabilization and intervention of sudden illness, poisoning and heat/cold injuries, childbirth, CPR, and automatic external defibrillator (AED) capability.

Recommendations:

a. That Chief/FEMS and the PIO develop and implement a written community outreach plan to disseminate information to the public on how abusing the emergency medical response system affects the timeliness of emergency medical services in the District.

Agree **X** Disagree _____

b. That Chief/FEMS and the PIO ensure that the public is well-informed about when to use the District's 311 non-emergency number.

Agree **X** Disagree _____

FEMS Comments: ***Community outreach proposal submitted as an attachment.***

5. Despite independent reports citing deficiencies in the critical medical emergency response system, many problems have not been corrected.

FEMS has been inspected and evaluated by several public and private organizations in order to highlight the deficiencies within the emergency response process and to recommend corrections.

In March 1989, the Productivity Management Services Division in the Office of the City Administrator made public a report entitled *Improving Ambulance Operations in Washington: A Blueprint for Change, D.C.*, which highlights deficiencies in such areas as staffing, ambulance unit hours of operation, medical supply availability for ambulances, and the dispatching of emergency medical calls in an efficient manner. In October 1997, two private organizations submitted the first of a series of reports entitled

Development and Implementation of a Management Reform Plan for the District of Columbia: Fire and Emergency Medical Services Department, to the District's Financial Responsibility and Management Assistance Authority.

The 1989 report documented areas within FEMS where changes would help make operations more effective and efficient. The latter reports identified the specific changes needed and ways to develop a plan to implement these changes.

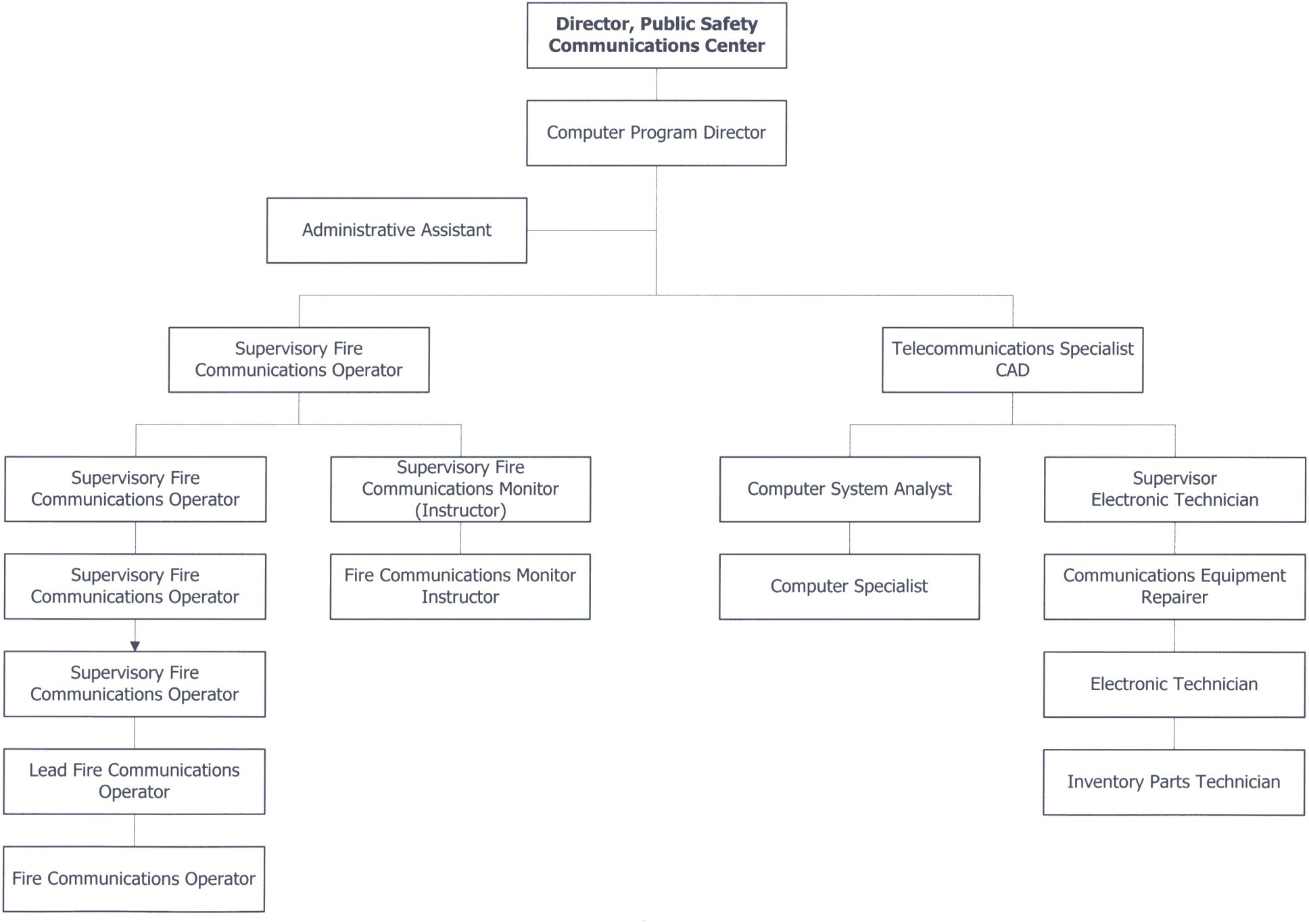
All reports accurately described FEMS deficiencies. However, 13 years after the release of the City Administrator's report, and 5 years after the release of the reports from private consultants, many of the same problems remain. Additionally, the stable leadership and management needed to guide FEMS, an essential public safety organization, into more effective and efficient operations has been sorely lacking.

Recommendation:

That Chief/FEMS and the FEMS Medical Director organize a committee or Task Force comprised of management and line employees to review the 1989 and 1997 reports, as well as this report, and develop a comprehensive strategic plan to address the issues covered. Chief/FEMS should ensure that a strategic plan is subsequently developed and implemented.

Agree **X** Disagree _____

Fire/EMS Communications Division



Findings and Recommendations:

COMMUNICATIONS DIVISION

COMMUNICATIONS DIVISION

All telephone calls for service, criminal, fire, medical, or general information, come through the Washington, D.C. Public Safety Communications Center (Call Center), including 911, 311, and 1010 calls.[9] The Center is located at 300 McMillan Drive, N.W. The FEMS Communications Division is responsible for processing FEMS emergency calls and dispatching the appropriate response units; coordinating telephone, computer, and radio needs for all fire companies and offices within the agency; working with the Management Information Systems office to purchase, lease, and install telecommunications equipment; and providing a radio repair service for all fire department radio equipment.

MPD operators at the PSAP initially answer *all* emergency calls placed to the Call Center. The operators determine the caller's needs. If the call is a medical emergency, it is transferred to a call taker in the FEMS Communications Division. If the call is a fire emergency, it is transferred to a FEMS fire lead dispatcher in the Communications Division.

Upon receiving a medical call from the PSAP, the FEMS call taker determines the type of medical emergency, prioritizes the call, and types pertinent information into the Computer Aided Dispatch System (CAD)[10]. Once the call taker has recorded all the information about the emergency into the CAD, the information is automatically sent via computer to a FEMS Lead Ambulance Dispatcher (dispatcher) (see flowchart, next page).

The dispatcher is responsible for accepting medical emergency calls, selecting and recommending the closest available unit, twice announcing pertinent information about the emergency over the radio to the selected stationhouse or response unit, and sounding a voice alarm in the stationhouse. The information is then sent via computer to an ambulance radio operator.

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[9] Telephone number 311 is used to contact the Call Center to report non-emergency situations. It is intended to replace the District's previous non-emergency number, 1010. Non-emergency numbers are used throughout the country to reduce the number of non-emergency calls placed to the 911 call system. In some jurisdictions more than 40% of calls to 911 are non-emergency.

[10] The Computer Aided Dispatch (CAD) system is a software package that displays information pertaining to each incoming 911 call on a computer screen. It also has the ability to locate the closest FEMS response unit to the scene of the emergency and then select that unit to respond to the emergency.

Medical Emergency Response Flowchart

Citizen calls "911" for help.

911 call is answered by Metropolitan Police Department (MPD) Public Safety Answering Point (PSAP).

Fire and medical emergency calls are forwarded to a FEMS call taker

On medical calls a call taker conducts a patient assessment and prioritizes the emergency

A FEMS Dispatcher then locates a Unit to respond to the emergency.

FEMS ambulance or fire vehicle is then dispatched.

FEMS then arrives on the scene of the emergency.

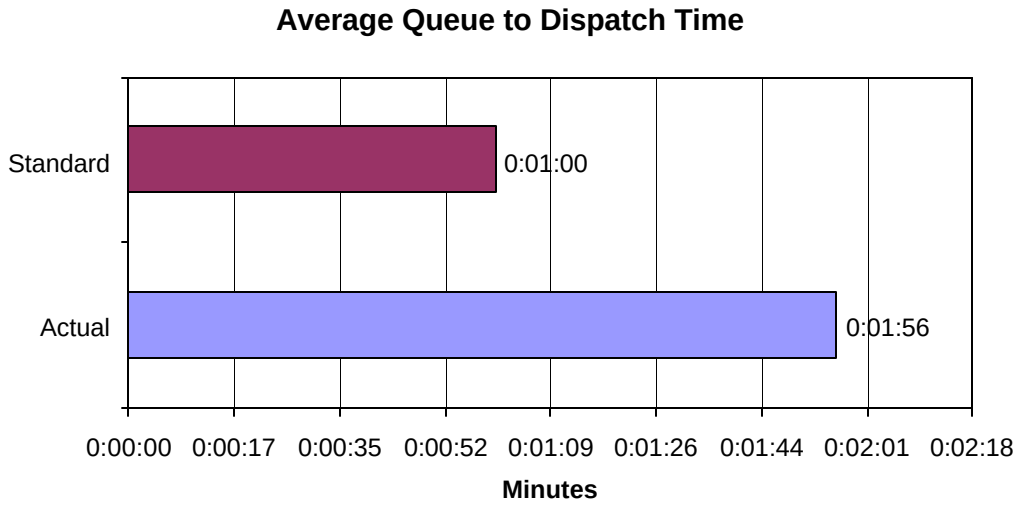
The lead ambulance radio operator is responsible for maintaining communication with response units from the time that they acknowledge the call and are en route to the scene of the emergency to the time that they arrive on the scene.

The ambulance radio operator is also responsible for communicating with the units while they are on the scene and until they have transported patients to the hospital, if necessary.

6. The Communications Division does not meet management and nationally recognized standards for responding to critical medical calls.

According to Communications Division management, each of the two aspects of FEMS calls should be processed within 1 minute or less: call takers should process all 911 calls in 1 minute or less,[11] and dispatchers should dispatch all 911 calls in one minute or less.[12]

Communications Division data, however, indicated that call takers were processing calls in 1 minute or less only 68% of the time. On average, they took 1 minute and 6 seconds to process calls. The data also indicated that dispatchers were dispatching calls in one minute or less only 44% of the time. On average, they took 1 minute and 56 seconds to dispatch calls.[13]



[11] Call taker process time includes the time that a call is placed in queue by the PSAP to when the call taker forwards the call to the FEMS dispatcher.
[12] Dispatch time is the time interval between the forwarding of an emergency call by the call taker and the dispatch of the appropriate response unit by the lead ambulance radio operator
[13] FEMS Communications Division data obtained from July 2001 through December 2001.

a. Communications Division management and employees believe that insufficient staffing has contributed to their failure to meet management and nationally recognized standards.

Communications Division management and staff feel that they do not have an adequate number of Fire Communication Operators[14] to provide quality services to District customers. Currently, there are 46 operators divided into 4 alternating work shifts. Managers stated that there are more positions to fill, and they believe that 52 operators will allow them to operate the FEMS communication system effectively.

According to FEMS management, one of the two radio channels (011)[15] is frequently out of service because they do not have a qualified employee to operate the radio. When the 011 radio channel is not staffed, emergency personnel are asked to use the 012 radio channel[16] for both en route and on-the-scene communications. The dispatcher must then handle en route calls, on-the-scene calls, as well as dispatch new calls. As a result, response time to an emergency may be delayed because an incoming call may be held in queue until the dispatcher/radio operator is finished handling an en route or on-the-scene call. On several occasions, the inspection team observed significant delays between the times that calls were placed in queue by the call takers, and when the dispatchers actually dispatched the call to the stationhouse. Management and employees stated that delays frequently occur.

FEMS management informed the inspection team that call takers are "overworked, frustrated and tired" because of the lack of sufficient staff. They are answering emergency calls back-to-back for extended periods of time without adequate downtime. Most of the time, employees eat lunch at their desks. Emergency calls sometimes go unanswered, are not answered in a timely manner, or are not dispatched properly to emergencies. Overall

[14] This position title includes several positions within the Communications Division, including call taker, dispatcher, radio operator, switchboard operator, and lead operator.
[15] The 011channel is used by fire and EMS to communicate with the Communications Division when they are en route to a medical emergency.
[16] 012 is used by fire and EMS to communicate with the Communications Division when they are on the scene of a medical emergency.

response time increases with each deficiency in receiving and dispatching information.

b. FEMS management and staff note that the new CAD system has problems.

In June of 2001, the District opened a unified Call Center to receive all telephone calls for criminal, fire, and medical emergencies, and requests for general information. Call Center employees use a new CAD system to answer all emergency calls.

The new CAD system has problems that may affect response time. A key problem is that administrative telephone numbers for Call Center management and employees were erroneously programmed into the CAD system. The system does not distinguish between administrative calls and emergency calls, which causes non-emergency administrative calls to be routed to FEMS call takers who must answer and then re-route administrative calls. Call takers may not be able to answer and process emergency calls quickly because they must also handle administrative calls. Consequently, the response to critical medical emergency calls may be delayed.

Division management and staff believe that the primary reason for the administrative numbers being programmed into the system is that employees who operate it were excluded from the planning process. Management stated that the administrative numbers have not yet been removed from the system, and they are unaware of anything the vendor is doing to address this problem.

Another problem with the new system is that because of different keyboard functions, it requires more steps than the previous system to complete some tasks. For example, it now takes seven steps to place an emergency unit out of service, whereas, on the old system, it took only two steps. Division management and staff believe that such inefficiencies in the new system contribute to the division's failure to meet response time standards.

Recommendations:

a. That Chief/FEMS ensure that there is adequate staff for the Communications Division and that key positions are filled as soon as possible.

Agree **X** Disagree _____

b. That Chief/FEMS and the Assistant Fire Chief of Fire Operations explore the possibility that the emergency response system could be reprogrammed so that it distinguishes between an administrative and emergency calls to ensure that only emergency calls are routed to call takers.

Agree **X** Disagree _____

7. <u>The Communications Division has no written policies and standard operating procedures that govern its daily operations</u>.

The Communications Division has no written procedures that govern the current methods used to carry out major functions. Management informed the inspection team that there was a complete policies and procedures manual for the previous CAD system. An operating manual, dated 1995, was provided to the team. There are, however, no written policies and standard operating procedures describing how the division should function using the new CAD system.

Recommendation:

That Chief/FEMS ensure that division management creates and promulgates comprehensive written policies and standard operating procedures for current operations and systems.

Agree **X** Disagree _____

FEMS Comments: ***Ongoing.***

Findings and Recommendations:

EMERGENCY MEDICAL SERVICES BUREAU

EMERGENCY MEDICAL SERVICES BUREAU

The Emergency Medical Services Bureau (EMSB) is responsible for providing 24-hour pre-hospital emergency medical care in the District. Advanced life support (ALS) ambulance units and paramedic engine companies[17] PECs respond to life-threatening emergency medical calls. Two paramedics staff ALS ambulance units, and four firefighters and one paramedic staff PECs. Basic life support (BLS) units, staffed by basic emergency medical technicians (EMTs), respond to non-life-threatening emergency medical calls.

Each day, EMSB uses approximately 27 ambulances, 13 BLS units for non-life threatening incidents and 14 ALS units for incidents that appear to be life-threatening.

Continuing Quality Improvement Unit

The Continuing Quality Improvement (CQI) Unit is the quality assurance arm within the EMSB. This 24-hour, 7-day a week operation is under the supervision of the DC Fire and Emergency Medical Services Medical Director and is staffed by one manager, one supervisory evaluator and nine evaluators. The unit is responsible for monitoring the quality of pre-hospital emergency medical care administered by FEMS paramedics; preparing and submitting EMT certification and recertification documentation to the Department of Health (DOH) Office of Emergency Health and Medical Services; evaluating trends, suggesting quality improvement processes and procedures to eliminate or effectively manage trends and sometimes initiate, monitor or evaluate pilot programs, i.e., PEC and en route time of ambulances and PECS. The unit also investigates alleged breaches of medical protocols; and ensures that quality care was given to patients treated by FEMS field paramedics.

[17] Paramedic engine companies consist of four firefighters and a paramedic. These units can serve as a firefighting unit or an ALS unit.

EMS Field Operations Division

8. The Field Operations Division does not have an adequate number of paramedics to provide timely responses to critical medical emergencies.

ALS units are required to be staffed by at least two paramedics and are responsible for responding to critical medical emergencies.[18] BLS units are staffed by basic EMTs and are responsible for responding to non-critical medical emergencies. If needed, paramedics can respond to non-critical medical emergencies because they are trained for both ALS and BLS emergencies. Basic EMTs, however, only respond to non-critical medical emergencies.

EMSB management often has to place ALS units out of service or downgrade them to BLS units because they do not have an adequate number of paramedics to keep the units in operation. Unfortunately, placing ALS units out of service is becoming a routine occurrence rather than the exception. If management can only staff an ALS unit with one paramedic and one basic EMT, the unit is downgraded to a BLS unit. Taking units out of service or downgrading them to a BLS unit creates the potential for significant delays in response to medical emergencies in the District.

According to documentation provided to the inspection team, on average, there should be at least 14 ALS response units available during each shift, but that does not always happen. Our analysis of the data provided determined that between September and November 2001 (a 91-day period), 21% of all ALS response units were not in service for 62 days. During this same period, all scheduled ALS units were operating on only 4 days of the 91-day period.

[18] Critical medical emergencies are trauma-based and require the assistance of a paramedic.

The lack of available units negatively impacts response time because this deficiency creates a number of problems:

1. EMSB does not have a sufficient number of field paramedics to allow ALS units to operate at full strength for a regular 12-hour shift, resulting in routine overtime.

2. When there are fewer units operating, they often have to respond to calls well outside of their normally assigned areas, which delays response to medical emergencies.

3. FEMS has 211 paramedics. However, almost 23% are field supervisors, evaluators, or Training Academy instructors. Although field supervisors can assist on critical medicals emergencies, their main responsibilities are to supervise and manage field operations. The remaining 163 paramedics work on ALS ambulance units, PECs, and rapid response units.

4. EMSB supervisors stated that some paramedics abuse sick leave while others are overworked and burned out. With an already insufficient number of paramedics available, any abuse of sick leave negatively impacts the ability to conduct timely and efficient field operations.

EMSB management can work paramedics up to three additional hours at the end of their regular 12-hour shift. This gives the supervisors an opportunity to keep units operating and find replacement paramedics for the units if one or both of the paramedics on the next shift are on unscheduled leave or late for work. However, if the ALS unit cannot be staffed at all, the unit is placed out of service for all or part of the shift.

Recommendations:

a. That Chief/FEMS, the FEMS Medical Director and the Assistant Chief of EMSB Operations assess the staffing shortages within EMSB to determine how many additional paramedics should be hired.

Agree **X** Disagree _____

b. That Chief/FEMS coordinate with all senior level managers to address and take appropriate action with employees who have patterns of abusing leave.

Agree **X** Disagree _____

9. Some paramedics provide emergency medical assistance in violation of District regulations requiring biennial re-certification.

Title 29 DCMR § 504.6 (1987) states that "**[n]o emergency medical technician's certificate shall be granted for more than two (2) years**." In addition, Department of Health (DOH), Office of Emergency Health and Medical Services (OEHMS) recertification requirements state that the EMT/P certification period is 2 years.

Some FEMS paramedics, however, with the approval of FEMS and OEHMS management, continue to provide emergency medical services to District patients after their EMT/P certifications have expired.

The FEMS CQI Unit is responsible for conducting field evaluations[19] on the 211 FEMS paramedics. These evaluations are required to ensure that paramedics are administering proper ALS care, complying with standard DOH paramedic policies, and adhering to the EMS Bureau's medical protocols. The evaluations also serve as part of the requirement to qualify paramedics for recertification. FEMS requires a minimum of six favorable

[19] These evaluations are conducted to ensure that paramedics comply with EMS Bureau Medical Protocols. Paramedics are evaluated at the scene as they provide patient care.

field evaluations within the 2-year period prior to the expiration date of a paramedic's certification.[20]

The CQI evaluations are forwarded to OEHMS along with other documentation needed for recertification. OEHMS presents the recertification information to the Paramedic Review Board.[21] The Paramedic Review Board then approves or denies requests for recertification. OEHMS recertifies paramedics based on the Paramedic Review Board's recommendation.

During a December 2001 session of the Paramedic Review Board, the inspection team observed an FEMS representative requesting extensions for several paramedics whose certifications had expired. Most of those paramedics were not able to meet recertification requirements because the CQI Unit had been unable to conduct the required number of field evaluations in a timely manner. According to CQI Unit management, they routinely request extensions from OEHMS for paramedics approaching the expiration date of their paramedic certifications when the evaluators are unable to conduct six favorable evaluations within the 2-year period.

a. Assignment of CQI Unit employees to other significant duties prevents timely evaluations and recertification of some paramedics.

Not all CQI Unit employees are assigned full-time to conduct field evaluations of paramedics. Of the unit's 11 employees, 9 are field evaluators and 2 are managers. Five evaluators split their time between conducting field evaluations of paramedics and performing other significant duties such as monitoring databases, investigating alleged breaches of medical protocols, and organizing certification documents within the CQI office. One evaluator has been detailed to the Office of the Fire Chief, and one is on extended sick leave. The two remaining evaluators either conduct

[20] Although OEHMS requires five evaluations, FEMS policy requires each paramedic to have six evaluations during this period.

[21] The Paramedic Review Board is a seven member board consisting of two paramedics, two registered nurses, and three emergency medical physicians who have the authority to approve and deny recertification and certification applications for District of Columbia paramedics. The Executive Director of OEHMS appoints all members.

field evaluations or are periodically assigned to the former D.C. General Hospital as a mobile transport unit, in addition to conducting field evaluations. Consequently, employees are unable to complete the required six evaluations on some paramedics prior to the expiration of their certifications.

The lack of a full-time effort by the CQI unit to conduct timely evaluations of paramedics creates potential health risks to those who live and work in the District, as well as those who visit the city. Paramedics who have not been evaluated or who have not passed all evaluations are allowed to continue providing critical emergency care once they are granted extensions to their expired certifications. According to CQI division management, there should be a minimum of two evaluators to monitor the field performance of paramedics for each of the four EMS platoons.[22] Division management also stated that additional evaluators support staff should be assigned to the unit to assist with other operational duties.

b. The CQI unit does not have an adequate pool of emergency response vehicles to conduct field evaluations in a timely manner.

Field evaluators conduct evaluations by following ALS response units in an assigned emergency response vehicle, by riding along with the ALS response unit on the ambulance, or by driving their privately owned vehicles. The CQI Unit has only one vehicle that is shared by all evaluators. More vehicles assigned to the CQI Unit will allow the evaluators to travel independently behind several ALS units in a day and increase the number of evaluations completed by the unit.

c. Extensions are routinely granted to FEMS paramedics whose certifications have expired. However, there is no regulatory provision for such extensions.

Paramedics are granted extensions to their expired paramedic certifications by OEHMS although there are no written regulations or policies that allow for such extensions. Currently, there are 12 paramedics

[22] The EMSB has four platoons that operate on rotating 12-hour shifts.

who have received extensions from OEHMS and are providing emergency medical services.

According to FEMS employees, up to two extensions can be granted to FEMS paramedics. However, the understanding of what the correct length of time is for each extension varied among CQI Unit employees. Some stated both extensions are for no more than 6 months each, while others stated that the first extension is for 6 months and the second extension is for 90 days. OEHMS employees have equally confusing interpretations. Some employees stated that there was only one extension for no more than a 1-year period. The lack of policies or regulations regarding certification extensions allows them to be granted on a case-by-case basis without any uniform standards.

The FEMS Medical Director is responsible for ensuring that FEMS employees comply with District and FEMS medical protocols. The CQI Unit manager is responsible for preparing recertification documents for FEMS paramedics and submitting the information to OEHMS prior to the certification expiration date.

d. CQI Unit and OEHMS employees use an outdated District regulation as a recertification guideline for FEMS paramedics.

Both OEHMS and FEMS employees provided the OIG inspection team with conflicting and outdated standards governing paramedic recertifications.

OEHMS and CQI Unit employees are using District of Columbia Regulation #72-29 (1972), "*A Regulation to Establish Standards for Ambulances and Medical Personnel and to Provide for their Certification*," to govern the certification and recertification requirements of District paramedics. Regulation 72-29 § 6(f) states that "**[n]o Emergency Medical Technician's license shall be granted for more than 3 years . . . .**" The licensing period in this regulation conflicts with Title 29 DCMR § 504, which provides for a 2-year period. Neither DOH nor FEMS personnel referred to the DCMR when discussing certification and recertification guidelines.

Recommendations:

a. That Chief/FEMS and the FEMS Medical Director ensure that additional evaluators are hired for the CQI Unit so that the mission, goals and objectives of the unit can be fulfilled in a timely manner.

Agree **X** Disagree _____

FEMS Comment: ***The current Medical Director has requested additional positions for some time now. See CQI 2000 Strategic Plan.***

This is being investigated now and we are awaiting DCOP to post multiple position announcements.

b. That the FEMS Medical Director take steps to ensure that the CQI Unit has the necessary staff and resources to complete field evaluations on paramedics within the 2-year certification period.

Agree **X** Disagree _____

FEMS Comment: ***Same as a. This is a labor management issue, which we are investigating at the present time.***

A car has been identified that is currently being outfitted for the CQI staff.

c. That Chief/FEMS consider reassigning all detailed CQI Unit evaluators back to the CQI office.

Agree **X** Disagree _____

FEMS Comment: ***Agree. Accomplished July 1, 2002.***

A detailed supervisor, who assists the CQI Unit in conducting Investigations, is on extended sick leave. This member returned to duty in the CQI Unit February 1, 2002. To date he is awaiting clearance from the DC Fire and Emergency Medical Services Clinic to return to his original position.

d. That Chief/FEMS coordinate with Director/DOH and the Paramedic Review Board to develop a policy on certification extensions.

Agree **X** Disagree _____

FEMS Comment: ***Agree. DC Fire and Emergency Medical Services Department has requested this be accomplished for over 3 years.***

Even though Title 29 DCMR section 504 was not mentioned from the example provided on extensions, in this report, you can see that the Department of Health and DC Fire and Emergency Medical Services is complying with the law.

The CQI Unit does not allow a paramedic to operate with an expired Department of Health Paramedic Card. However, the CQI Unit does allow paramedics to serve the public while on extensions granted by the DC Department of Health.

Extensions are sometimes needed, especially in the case of new paramedics who are placed on "provisional status". This means that they can only perform their duties on an Advance Life Support (ALS) unit that is fully staffed. During this time they receive valuable hands on training that enables them to become fully certified paramedics. Some provisional paramedics learn faster that others and sometimes with the staffing shortage some provisional paramedics are pulled from ALS units to man Basic Life Support (BLS) units. This practice causes breaks in continuity and causes training delays for provisional paramedics. The Department of Health recognizes the fact that things happen beyond our control and therefore grants extensions.

When a paramedic is granted an extension their certification is still legal under the rules of the Paramedic Review Board and the DC Department of Health, which is the certifying body for all paramedics. The paramedic's certification does not expire until the end of the extension period.

First, once an extension is granted the certification does not expire until the end of the extension.

Second, The CQI Unit grades critical and non –critical areas. If a paramedic fails a critical area they are immediately down graded and placed in a training status. Training may take many forms. The person could be placed in a supervised status with the evaluator for the end of the tour of duty. If this training is not sufficient the paramedic may be administratively down graded and not allowed to ride on an ALS unit with out supervision i.e. evaluator or field training officer. In these severe cases, the evaluator makes the recommendation for the paramedic to report to training. A complete assessment is done by the evaluator or training depending on time and necessary resources. EMS Training handles all training until the paramedic is ready to be evaluated and upgraded to his previous status. This process is in place to make sure that there is no degradation in the quality of care that we render to the patients.

Finally, in order that the Department of Health and the Paramedic Review Board comply with the 2-year certification period all extension time is charged to the new certification card. For example, if a paramedics card was set to expire in June 2000 and he/she receives a 6-month extension and successfully completes his/her evaluations, his/her new certification will still expire in June 2002.

While it is true that extensions are granted on a case-by-case basis. The correct information is the Paramedic Review Board in conjunction with the DC Department of Health allows extensions for the purpose of evaluation. The lengths of extensions are 6 months for the first extension and 90 days for the second extension.

It is important to note the Department of Health and the Paramedic Review Board complies with the 2-year certification period, because all extension time is charged to their new certification period. For example, if a paramedics' card was set to expire in June 2000, and he/she receives an extension, (first one for 6 months), but successfully completes his/her evaluations and is presented in November, his/her new certification will expire in June 2002 (not November 2002).

The CQI Unit refers the issue of extensions to the Department of Health and The Paramedic Review Board.

Our records indicate that there were only 3 paramedic extensions and 3 Intermediate Provisional extension requested at the Paramedic Review Board in December. In percentages this represents only 12% for full paramedics. This figure is acceptable with the consideration of the scaling back of CQI Unit operations to support the contingency plan surrounding the closing of DC General.

As mentioned earlier, Provisional are new paramedics. In this case we have 3 Intermediate Provisional Paramedics [23] who just completed training. Their training was severely affected by the closing of DC General Hospital and the contingency plans that forced other units in service practically over night to manage response times with no degradation to patient care. The natural delay in the recruiting and hiring process lengthened the time the provisional Intermediate paramedics spent on BLS Units.

It should be noted since the hiring of the new Medical Director extensions have gradually decreased over the years. Since we have rebounded over the DC General closing extensions should be reduced to only the members who are out on extended leave or for extenuating circumstances.

[23] There are three levels of EMTs recognized by the National Registry of Emergency Medical Technicians. From BLS to ALS they are; EMT, EMT-Intermediate, and EMT-Paramedic.

OIG Response: ***Although the comments from FEMS state that this report did not reference DCMR 29 § 504 when discussing the recertification extensions, it was referenced in the finding (See pages 33 and 36). This regulation does not have language governing the issuance of extensions. Additionally, the Department of Health informed the OIG inspection team that while standard operating policy and procedures governing extensions were in draft form, no official policies had been approved.***

While it is accurate that only six paramedics were granted extensions during the December 2001 Paramedic Review Board meeting, the main issues are what regulations govern the issuance of extensions as well as how the quality of care provided by the paramedics is impacted by those individuals who do not meet the recertification requirements in a timely manner.

As a point of clarification, of the six paramedics granted extensions during this meeting, four were placed on the first extension period for 6 months and the remaining two were placed on the second extension for an additional 90 days.

It should also be noted that at this same meeting, the recertification packages of an additional 15 FEMS paramedics were presented to the Paramedic Review Board. Of this number, 13 were already on either their first or second extensions. Only two paramedics presented met the recertification requirements by the end of their recertification periods.

e. That the FEMS Medical Director coordinate with Chief/FEMS to ensure that the most recent version of District regulations governing paramedic certification and recertification is followed.

Agree **X** Disagree _____

FEMS Comment: ***Agree. The CQI Unit will request help from the Departments Legal Section in complying with this request.***

10. <u>The CQI Unit does not evaluate and monitor the field performance of basic level emergency medical technicians</u>.

DOH OEHMS requires paramedics to have at least five favorable field performance evaluations in order to be recertified. Evaluators review the work practices of paramedics to ensure that they are providing the best quality care to patients. These evaluations can also serve as an official document to address any deficiencies paramedics might have.

There is no similar evaluation process, however, for the field performance of basic EMTs because that is not an OEHMS requirement for recertification. Field supervisors monitor the field performance of basic EMTs and, on occasion, a CQI evaluator may conduct an evaluation if he or she is at the scene of an emergency with a BLS response unit. However, these occasional evaluations are not a priority.

A similar evaluation process during their 2-year certification period would help to ensure that they are complying with District medical protocols and EMSB policies. Routine evaluation of basic EMTs can help to prevent any violations in District medical protocols.

Recommendations:

a. That the FEMS Medical Director develop a field evaluation process for basic EMTs similar to that used for paramedics.

Agree **X** Disagree _____

FEMS Comment: ***Agree. A Draft of such project has been developed. The current Medical Director recognized this problem and ordered the CQI Unit to evaluate all EMTs in the year 2000. That was the first year that the CQI Unit successfully evaluated all EMTs assigned to BLS units. The next phase called for CQI Evaluator to evaluate all field providers assigned to the department. This did not come to fruition because of the lack of resources. Between that time and now the CQI Unit lost 2 evaluators while the number of new paramedics increased at a feverish pace.***

b. That Chief/FEMS and the FEMS Medical Director hire sufficient staff to perform field evaluations on basic EMTs when feasible.

Agree **X** Disagree _____

FEMS Comment: ***Agree. The Medical Director has made request for additional staffing. See CQI 2000 Strategic Plan. With the addition of resources the CQI Unit plans to complete this initiative and make it standard practice. The department is currently awaiting the certification list for evaluators at this time. It is important to note that there have been administrative problems selecting candidates from the list in the past. Those administrative problems within the personnel section have drastically slowed this department's ability to quickly hire the best-qualified candidates.***

11. <u>The CQI Unit's method of monitoring the en route time of ambulances and PECs is insufficient</u>.

One of the many tools FEMS management uses to determine how efficiently field staff responds to emergency medical calls is to monitor the en route time of all units. According to FEMS management and NFPA standards, it should not take a response unit more than 1 minute to leave the stationhouse and begin responding to a call once they acknowledge receipt of the call.

The CQI Unit has developed a manual process for capturing the en route times for ambulances and PECs. EMSB field supervisors and CQI evaluators use stopwatches to document the time it takes for a PEC or an ambulance to leave a stationhouse once a vocal dispatch over the loudspeaker is issued signaling an emergency call.[24]

[24] The Communications Division transmits a vocal dispatch to the assigned unit describing the type of emergency and its location.

To monitor en route time, CQI evaluators and EMSB field supervisors sit outside of randomly selected stationhouses. When a call is dispatched over the vocal alarm system, the evaluators and/or field supervisors start the stopwatch. Once the ambulance or PEC leaves the stationhouse, the stopwatch is stopped and the time is logged. The information is then forwarded to the CQI Unit to be entered into a CQI database.

The CQI Unit's method of monitoring the en route time is not done in conjunction with data collected by the CAD system,[25] nor is a systematic or scientific method used to select which stationhouses will be monitored. Supervisors and evaluators select the stationhouses to be monitored by using personal criteria, which can vary and may include biases, rather than analyzing data collected by the CAD system in order to determine which PECs or ambulances have en route times of more than 1 minute before deciding which stationhouses to monitor. Using data from the CAD will allow the CQI Unit to use their resources more efficiently by ensuring that they Unit monitors only those employees who are not complying with the en route time standard.

Recommendation:

That the FEMS Medical Director instruct the Office of Program Evaluation to compile the en route times for all ambulances and PECs from the CAD system on a monthly basis, and disseminate it to the CQI unit for use in determining which stationhouses need to be monitored.

Agree **X** Disagree _____

FEMS Comment: ***Agree. This time will be accurately monitored with the new technological advances that the department is putting in place i.e. Automatic Vehicle Locating Systems (AVLS), Mobile Data Terminals (MDTs), which will be installed on all response vehicles. This will enable the department to get response time data from***

[25] ALS and BLS response unit employees press a button once they acknowledge receipt of the call and when they are en route to the emergency. This information is captured in the CAD system.

Communications Division Computer Aided Dispatch (CAD) System. All pertinent response time data will be recorded and available as they occur.

While we agree the actual methods were crude in this age of technology this was merely a pilot program designed to examine a potential problem. It has served its purpose and the CQI Unit is no longer monitoring en route times.

Medical Equipment Repair Unit

The Medical Equipment Repair Unit is responsible for repairing and replacing medical equipment on ambulances, transporting ambulances to the Fleet Division for preventive maintenance, transporting new ambulances from the dealers, cleaning and stocking reserve ambulances, and ensuring that equipment and ambulances are available for EMSB field providers as needed.[26] This unit is staffed by three employees and operates 7 days a week.

12. Equipment stored in the Medical Repair Unit lacks accountability and is vulnerable to theft.

The Medical Equipment Repair Unit is located at the Engine 6 stationhouse at 2900 New Jersey Avenue, N.E. The unit has a small office with one computer that employees share. A second, larger room is used to store small pieces of medical equipment. Reserve ambulances are kept in a locked parking area on the side of the building. New stretchers are kept outside in a locked area because there is not enough space inside.

According to unit employees, because the facilities are accessible to other FEMS employees, they often have problems accounting for inventory. When the Unit is closed, EMSB field supervisors require access to the storage facilities so that they can get replacement equipment, stretchers, and ambulances for the field providers. However, they do not always sign for these items as required. The unit does not have a way of tracking equipment that is removed during off hours if the supervisors forget to sign it out. Additionally, the Unit does not have an inventory system to verify what equipment should be available.

[26] Field providers are paramedics and Emergency Medical Technicians.

Recommendations:

a. That the FEMS Medical Director limit access to all areas used by the Medical Equipment Repair Unit to Unit employees during service hours.

Agree **X** Disagree _____

FEMS Comment: ***We currently do not have the designated FTE's to fill this request.***

b. That the FEMS Medical Director hire additional staff, when possible, to ensure that at least two Medical Repair Unit employees are available at all times. Once adequate staff has been hired, the hours of operation for the unit should be changed from 16 hours a day to 24 hours a day.

Agree **X** Disagree _____

FEMS Comment: ***We currently do not have the designated FTE's to fill this request.***

c. That the FEMS Medical Director and EMSB Administrative Services management Medical Equipment Repair Unit employees conduct an inventory of all equipment on a regular basis and report any discrepancies to division management.

Agree **X** Disagree _____

FEMS Comment: ***The automation of the department as well as the inventory tracking system will assist in solving some of this problem. The current form one and the accountability system will be enforced. We are looking at alternative sites and ways to secure the equipment in our house renovation plans.***

13. <u>Medical Equipment Repair Unit employees lack the training and resources to properly repair medical equipment used by EMSB field providers</u>.

The Medical Equipment Repair Unit ensures that all replacement medical equipment and reserve ambulances are available for field providers within minutes of receiving a call from EMSB management. This is essential so that field providers are not out of service for long periods of time while they wait for replacement equipment or ambulances. When field providers have to go out of service, the number of available response units decreases, which could have a negative impact on response time.

Since the unit is small, meeting the needs of the field providers takes some creative effort. Unit employees do not receive training from vendors or from outside workshops on how to repair essential ambulance equipment such as stretchers and gauges on oxygen bottles. Equipment is usually repaired by trial and error, and without the required tools.

Although the Unit does not provide services directly to the public, the lack of training and resources needed to operate the unit efficiently could impact the field providers' ability to respond to medical emergencies within the target response time because the reserve equipment may not be available.

Recommendations:

a. That the FEMS Medical Director and the Assistant Chief of Administrative Services coordinate with the Training Academy to identify training for Medical Equipment Repair Unit employees.

Agree **X** Disagree _____

FEMS Comment: ***This process has commenced and we have had multiple vendors in via the training academy to train and instruct the staff and providers. They have also in-serviced the field providers on various new equipment.***

b. That the FEMS Medical Director and the Assistant Chief of EMS Administrative Services ensure that the Medical Equipment Repair Unit employees have the necessary tools to adequately repair the agency's existing medical equipment.

Agree **X** Disagree _____

c. That Chief/FEMS coordinate with the FEMS Procurement Officer to ensure that all contracts for the purchase of equipment and the tools for repairing that equipment contain provisions for training unit employees on how to make repairs.

Agree **X** Disagree _____

Findings and Recommendations:

EMERGENCY MEDICAL SERVICES TRAINING ACADEMY

EMERGENCY MEDICAL SERVICES TRAINING ACADEMY

The FEMS Training Academy provides training to all emergency medical technicians in the Firefighting Division and the Emergency Medical Services Bureau. Although FEMS instructors conduct most of the training, some is conducted by private contractors.

14. <u>The Training Academy does not receive information on new streets and subdivisions in the District, which can affect EMSB field providers' ability to respond to emergency medical calls in a timely manner</u>.

FEMS field providers and Training Academy instructors stated that FEMS does not receive information on the location of new streets and housing developments in the District. Without such knowledge, field providers cannot respond to emergencies within those areas in a timely manner because they have to search for an address. This can have a negative impact on response time. According to FEMS supervisors, they encourage on-duty paramedics and basic EMTs to drive through District neighborhoods to become familiar with new housing subdivisions and streets when they are not responding to emergencies.

Recommendations:

a. That Chief/FEMS ensure that the locations of new areas and streets within the District are disseminated to all FEMS employees.

Agree **X** Disagree _____

FEMS Comment: ***Agree the Chief of EMS training will ensure that the location of new areas and streets within the District are disseminated to all FEMS employees.***

The Medical Director, Chief, EMS Training and Communications Director will meet to ensure that the location of new areas and streets within the District are incorporated into the geography and navigation training classes. With the Mobile Data Computers being installed on the

department's apparatus next year this information dissemination will be a lot easier. Especially since we will be receiving this information via an electronic bridge from DPW.

b. That the Chief of the Training Academy and the Director of the Communications Center ensure that the locations of new areas and streets within the District are incorporated into all geography and training classes.

Agree **X** Disagree _____

FEMS Comment: ***Agree the Chief of EMS Training Academy and the Director of Communications Center will ensure that the locations of new areas and streets within the District are incorporated into the geography and navigation training classes.***

15. <u>FEMS field providers believe that the FEMS Training Academy does not provide the training they need to ensure high quality emergency medical care for District patients</u>.

FEMS paramedic and basic EMT training classes are mostly taught by EMS instructors at the Training Academy. These classes include preparatory instruction for paramedic and basic EMT certification and recertification examinations as well as continuing medical education classes. The duration of these classes can vary from a day to several months, depending on the nature of the training.

FEMS field providers believe they do not receive adequate training from the Training Academy. They stated that instructors often come to class late, are not prepared, and allow students to leave early. FEMS management informed the inspection team that instructor accountability has been an issue in the past, but instructors are not being held accountable if EMS training is not conducted properly.

According to EMS Training Academy employees and field providers, some instructors are not qualified to teach training classes. The inspection team was informed by division management and employees that there is not

an adequate selection process for instructors. Some employees are detailed to the Training Academy because they have been injured in the field or because management asks them to teach a course. Many have never taught or been trained as instructors.

Another issue that negatively impacts the quality of instruction available for EMS training is the lack of resources and space available in the Training Academy. OEHMS and FEMS employees stated that EMS training has been shifted to several locations over the past few years. Training has been conducted in trailers, on the campuses of D.C. General Hospital and St. Elizabeths Hospital, and in the basement of the old communications center.[27] On occasion, instructors and class participants have arrived at a location for training only to be told that the training would be conducted at another location. In addition, some EMS instructors stated that they do not have access to audiovisual equipment, computer hardware and software, and other instructional supplies necessary to facilitate effective training classes. Further, some field providers stated that the medical techniques training that is provided may violate the District's medical protocols. As a result, the field providers stated that they attend outside training on their own in order to get quality instruction.

The lack of adequate space, training materials and qualified instructors can have a negative impact on FEMS response to critical medical calls. If candidates are not able to pass paramedic certification and recertification exams because they have not received the required level of training, there may not be an adequate number of paramedics available to assist the public and respond to critical medical calls.

[27] Management told the inspection team that the new Training Academy building, located at 4600 Shepherd Parkway, Southwest, will be finished by June 2002. All of the EMS training will then be held at this central location.

Recommendations:

a. That the FEMS Medical Director establish qualifications and create a hiring policy for EMS training instructors.

Agree **X** Disagree _____

FEMS Comment: ***Agree that the FEMS Medical Director establish qualifications and create a hiring policy for EMS training instructors. This issue is currently being addressed and a new interpretive guide has already been made and is awaiting a labor and management review.***

b. That the FEMS Medical Director assess the qualifications of all EMS training managers and instructors to ensure that only qualified instructors are teaching classes.

Agree **X** Disagree _____

FEMS Comment: ***Agree that the FEMS Medical Director assess the qualifications of all EMS training managers and instructors to ensure that only qualified instructors are teaching classes. This is an ongoing process and a quality improvement of the training academy, which is in line with the three-year strategic plan that we have developed.***

The entire EMS Training Education program has been revised and updated since January 2002. The EMS Training staff has also been restructured. All EMS Instructors have received new promotional/qualification requirements, which include an oral and practicum review and Instructor Workshops. There are still members of the Instructor staff that are in temporary detail positions. However, appropriate personnel action has been initiated by the Chief of EMS Training to establish a dedicated Instructor staff. The EMS Instructors are well-qualified, competent and properly trained. Instructors are held to a high standard of teaching and are required to utilize PowerPoint presentations and state-of-the-art training adjuncts. Space availability in the Training Education program is still a critical issue until the new training academy building is completed and opened. It is our goal to have

all of our instructors certified and this is currently being achieved. We now strongly refrain from sending non-qualified personnel to the training academy, which used to be a common practice.

c. That the FEMS Medical Director ensure the instructors are facilitating course instruction in compliance with District medical protocols.

Agree **X** Disagree _____

FEMS Comment: ***Agree that the FEMS Medical Director ensures the instructors are facilitating course instruction in compliance with the district medical protocols. This has been accomplished and DC FEMS has met with DOH and requested in writing that their EMT-B and EMT-P examinations reflect the newly approved Adult and Pediatric Protocols, which have not been revised since 1992.***

The Paramedic Education Program has also been revamped and upgraded to meet the requirements of the U.S. DOT National Paramedic Standard curriculum. Of note, from the first intra-department paramedic class that only four providers out of nineteen passed the paramedic national certification exam, twelve out of the nineteen have now passed the examination because of the aforementioned changes made at the academy. Also, over the past few weeks we are in the process of developing a medical Spanish Program that will assist our providers in rendering care to the districts large Hispanic/ Latino patient population.

d. That EMS Training Academy managers and employees provide a list of training materials and equipment needed to FEMS senior management, and that these materials and equipment be provided as needed.

Agree **X** Disagree _____

Agree that EMS Training Academy managers and employees provide a list of training materials and equipment needed to FEMS senior management, and that these materials and equipment be provided as needed

EMS Training has purchased during fiscal year 2002 over $80,000.00 of new medical equipment and training equipment to enhance its training programs under the guidance of the Medical Director. Over the last three weeks we have purchase orders for two Laerdal SIMMAN Patient Stimulators to develop our patient simulation laboratory and to set up in-house medical scenario testing from funds identified by Interim Chief Thompson. We are also procuring an ACLS Self Learning Course (interactive software program) – for ACLS Recertification approved by the American Heart Association.

16. <u>Although the FEMS curriculum is designed for 5 days, the Geographical and Navigation training class is taught in 2 days</u>.

The training for new field providers in the District is comprehensive and the curriculum standards are set by the United States Department of Transportation and enforced by OEHMS. New field providers must successfully attend lectures, participate in on-the-job training and take certification examinations administered by OEHMS in order to obtain certification as a paramedic or basic EMT in the District.

One of the many training programs includes a 2-day Geographical and Navigation training class. During these classes, students learn the layout of the city, the locations of hospitals and other information necessary to navigate quickly around the District. This training is vital because it develops students' ability to respond to requests for emergency medical assistance within minutes of receiving a call from FEMS dispatchers who may have few or no directions to the address of the emergency.

Until 4 years ago, the curriculum for the Geographical and Navigation training classes was taught over a 5-day period. Due to budget constraints, FEMS shortened the training time allotted to new paramedics and basic EMT employees, reducing the course from 5 days to 2 days. In the past,

students were given 40 hours of classroom training in this subject, but now receive only 16 hours within which to learn the layout of the District and how to reach a destination as quickly as possible. However, the amount of course material to be covered is still the same. According to some academy instructors, students need more time in the classroom to learn about the layout of the District.

Classroom training, however, can only give students the background information needed to understand the layout of the city and the location of hospitals and other important buildings. Students do not get an opportunity to apply their knowledge until they are in the field responding to emergencies. Condensing the training into 2 days, without reducing some of the topics in the curriculum, is unfair to students as well as District stakeholders. Response time can be negatively affected if the field providers do not have proper knowledge about the geography of the District and how to navigate the city quickly.

Recommendation:

That the FEMS Medical Director ensure that paramedics and EMTs are allotted sufficient training time so that the 40-hour curriculum is not condensed into 16-hours.

Agree **X** Disagree _____

FEMS Comment: ***The Department of Health is the regulatory body and they make the rulings on how many hours a course can be taught. We will continue to work with them to ensure that all medically related courses are taught over the appropriate time frame.***

The D.C. Fire and EMS Training Academy updated, revised and reorganized the EMS education-training curriculum for all its programs starting in January 2002.

The Geography and Navigation program is currently 40- hours. During a portion of (January – May) fiscal year 2002, the Geography and Navigation course was reduced to 16 hours to accommodate the fire

recruit accelerated class and cut to 32 hours to accommodate the EMS recruit reciprocity class. This was done due to budget constraints imposed upon EMS training. However, in May 2002 the hours of Geography and Navigation Training was restored to 40 hours. All FEMS students are provided a tour of the metro system and ride along program through the streets of D.C.

APPENDICES

APPENDICES

LIST OF FINDINGS AND RECOMMENDATIONS

OFFICE OF THE FEMS FIRE CHIEF

1. Emergency units do not meet FEMS management and national response time standards.

Recommendation:

That the Assistant Fire Chief of Fire Operations, the Medical Director and the Assistant Chief for EMSB Operations ensure that emergency medical response units adhere to both national and FEMS management standards for exiting the stationhouse and responding to emergency medical calls.

2. Once en route, FEMS units arrive at the scene of critical medical emergencies faster than the national standard.

No Recommendations.

3. FEMS does not measure significant time intervals that may affect overall response time.

Recommendation:

That Chief/FEMS and the Deputy Chief of the Communications Division ensure that data on all time intervals that affect response time is collected and reviewed on a regular basis.

4. FEMS needs a community outreach plan to educate the public on when to dial 911 for medical emergencies and to help eliminate abuse of the 911 system.

Recommendations:

a. That Chief/FEMS and the PIO develop and implement a written community outreach plan to disseminate information to the public on how abusing the emergency medical response system affects the timeliness of emergency medical services in the District.

b. That Chief/FEMS and the PIO ensure that the public is well-informed about when to use the District's 311 non-emergency number.

5. Despite independent reports citing deficiencies in the critical medical emergency response system, many problems have not been corrected.

Recommendation:

That Chief/FEMS and the FEMS Medical Director organize a committee or Task Force comprised of management and line employees to review the 1989 and 1997 reports, as well as this report, and develop a comprehensive strategic plan to address the issues covered. Chief/FEMS should ensure that a strategic plan is subsequently developed and implemented.

COMMUNICATIONS DIVISION

6. The Communications Division does not meet management and nationally recognized standards for responding to critical medical calls.

Recommendations:

a. That Chief/FEMS ensure that there is adequate staff for the Communications Division and that key positions are filled as soon as possible.

b. That Chief/FEMS and the Assistant Fire Chief of Fire Operations explore the possibility that the emergency response system could be reprogrammed so that it distinguishes between an administrative and emergency calls to ensure that only emergency calls are routed to call takers.

7. <u>The Communications Division has no written policies and standard operating procedures that govern its daily operations</u>.

Recommendation:

That Chief/FEMS ensure that division management creates and promulgates comprehensive written policies and standard operating procedures for current operations and systems.

EMERGENCY MEDICAL SERVICES BUREAU

8. <u>The Field Operations Division does not have an adequate number of paramedics to provide timely responses to critical medical emergencies</u>.

Recommendations:

a. That Chief/FEMS, the FEMS Medical Director and the Assistant Chief of EMSB Operations assess the staffing shortages within EMSB to determine how many additional paramedics should be hired.

b. That Chief/FEMS coordinate with all senior level managers to address and take appropriate action with employees who have patterns of abusing leave.

9. <u>Some paramedics provide emergency medical assistance in violation of District regulations requiring biennial recertification</u>.

Recommendations:

a. That Chief/FEMS and the FEMS Medical Director ensure that additional evaluators are hired for the CQI Unit so that the mission, goals and objectives of the unit can be fulfilled in a timely manner.

b. That the FEMS Medical Director take steps to ensure that the CQI Unit has the necessary staff and resources to complete field evaluations on paramedics within the 2-year certification period.

c. That Chief/FEMS consider reassigning all detailed CQI Unit evaluators back to the CQI office.

d. That Chief/FEMS coordinate with Director/DOH and the Paramedic Review Board to develop a policy on certification extensions.

e. That the FEMS Medical Director coordinate with Chief/FEMS to ensure that the most recent version of District regulations governing paramedic certification and recertification is followed.

10. <u>The CQI Unit does not evaluate and monitor the field performance of basic level emergency medical technicians</u>.

Recommendations:

a. That the FEMS Medical Director develop a field evaluation process for basic EMTs similar to that used for paramedics.

b. That Chief/FEMS and the FEMS Medical Director hire sufficient staff to perform field evaluations on basic EMTs when feasible.

11. <u>The CQI Unit's method of monitoring the en route time of ambulances and PECs is insufficient</u>.

Recommendation:

That the FEMS Medical Director instruct the Office of Program Evaluation to compile the en route times for all ambulances and PECs from the CAD system on a monthly basis, and disseminate it to the CQI unit for use in determining which stationhouses need to be monitored.

12. Equipment stored in the Medical Repair Unit lacks accountability and is vulnerable to theft.

Recommendations:

a. That the FEMS Medical Director limit access to all areas used by the Medical Equipment Repair Unit to Unit employees during service hours.

b. That the FEMS Medical Director hire additional staff, when possible, to ensure that at least two Medical Repair Unit employees are available at all times. Once adequate staff has been hired, the hours of operation for the unit should be changed from 16 hours a day to 24 hours a day.

c. That the FEMS Medical Director and EMSB Administrative Services management Medical Equipment Repair Unit employees conduct an inventory of all equipment on a regular basis and report any discrepancies to division management.

13. Medical Equipment Repair Unit employees lack the training and resources to properly repair medical equipment used by EMSB field providers.

Recommendations:

a. That the FEMS Medical Director and the Assistant Chief of Administrative Services coordinate with the Training Academy to identify training for Medical Equipment Repair Unit employees.

b. That the FEMS Medical Director and the Assistant Chief of EMS Administrative Services ensure that the Medical Equipment Repair Unit employees have the necessary tools to adequately repair the agency's existing medical equipment.

c. That Chief/FEMS coordinate with the FEMS Procurement Officer to ensure that all contracts for the purchase of equipment and the tools for repairing that equipment contain provisions for training unit employees on how to make repairs.

EMERGENCY MEDICAL SERVICES TRAINING ACADEMY

14. The Training Academy does not receive information on new streets and subdivisions in the District, which can affect EMSB field providers' ability to respond to emergency medical calls in a timely manner.

Recommendations:

a. That Chief/FEMS ensure that the locations of new areas and streets within the District are disseminated to all FEMS employees.

b. That the Chief of the Training Academy and the Director of the Communications Center ensure that the locations of new areas and streets within the District are incorporated into all geography and training classes.

15. FEMS field providers believe that the FEMS Training Academy does not provide the training they need to ensure high quality emergency medical care for District patients.

Recommendations:

a. That the FEMS Medical Director establish qualifications and create a hiring policy for EMS training instructors.

b. That the FEMS Medical Director assess the qualifications of all EMS training managers and instructors to ensure that only qualified instructors are teaching classes.

c. That the FEMS Medical Director ensure the instructors are facilitating course instruction in compliance with District medical protocols.

d. That EMS Training Academy managers and employees provide a list of training materials and equipment needed to FEMS senior management, and that these materials and equipment be provided as needed.

16. <u>Although the FEMS curriculum is designed for 5 days, the Geographical and Navigation training class is taught in 2 days</u>.

Recommendation:

That the FEMS Medical Director ensure that paramedics and EMTs are allotted sufficient training time so that the 40-hour curriculum is not condensed into 16-hours.

LIST OF FINDINGS AND RECOMMENDATIONS