

**OKALOOSA COUNTY
EMERGENCY MEDICAL SERVICES
STANDARD OPERATING PROCEDURE**

Title:	Critical Failures
Policy:	416.00
Purpose:	To ensure that Okaloosa County EMS records and investigates critical failures for the purpose of improving performance and complying with federal/state/local guidelines

Policy:

Definitions

A Critical Failure is defined as any event which occurs that interferes with the response or transport of a patient, involving either a vehicle, piece of equipment, etc. (i.e. flat tire on the way to a call or during a transport. A flat tire on the way back to the station is not.)

Hard equipment (any piece of equipment which is reusable) - Any biomedical device that fails during patient care.

Soft equipment (any medical supply which is one use disposable) - Any item that fails or is found to be defective in some way when attempted to be used on a patient.

Vehicles - Any time a call cannot be completed or increases the transport time for a patient because of a mechanical failure.

Reporting Critical Failures

Verbally notify the on-duty Shift Commander initially, then notify Logistics as soon as practical.

Document the equipment deficit in as much detail as possible with an Incidnet Report (104.00 Conflict Resolution).

Acquiring Replacement

Hard equipment - immediately remove the equipment from service and tag the equipment "OUT OF SERVICE". Contact the On-duty Shift Commander and then contact Logistics to obtain a replacement and to return the out of service device.

Soft equipment - bag the medical supply and tag the bag appropriately. Forward the sealed bag to Logistics for inspection. If a replacement is needed before the usual replacement of soft equipment will occur, contact the On-duty Shift Commander and then contact Logistics to obtain a replacement.

Vehicles - contact the On-Duty Shift Commander to determine what vehicles are available to transfer into.

Equipment Inspection, Evaluation, And/Or Repair

Hard equipment will be inspected and evaluated by Logistics. Any medical device pulled from service for any problem must be cleared through Logistics prior to returning the equipment to service.

If it is determined to be an issue that can be correct by Logistics, it will be corrected and returned to service.

If it is an item that cannot be corrected by the Logistics, or it is a bio-medical device that needs specialized care, it will be sent to an appropriate repair facility.

Vehicles repairs will be sent to an appropriate service location to deal with the suspected problem.

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Specialized Equipment And Circumstances

Cardiac Defibrillators

Okaloosa County EMS will participate in reporting of cardiac defibrillators that fail during patient care, that cause death or patient injury. Report the incident using the normal reporting practice in place (104.00 Conflict Resolution). The monitor, all cables, batteries, and open electrodes, including combo-pad packages used on the patient are to be quarantined and returned to the Logistics as soon as possible. Logistics will contact the monitor manufacturer and arrange for the inspection of the device.

Cardiac Monitors

Will be evaluated and appropriate steps to rectify the issue will be taken, up to and including returning the device to the manufacturer for evaluation and repair.

Ventilators

Will be evaluated and appropriate steps to rectify the issue will be taken, up to and including returning the device to the manufacturer for evaluation and repair.

Suction Units

Will be evaluated and appropriate steps to rectify the issue will be taken, up to and including returning the device to the manufacturer for evaluation and repair.

Team Member Feedback

Team members who submit the required documentation will also be sent the primary details.

Accountability and Compliance:

Record Keeping And Trend Analysis

A spreadsheet will be maintained by the On-duty Shift Commander to track all critical failures to include:

1. Date of the failure
2. Team member reporting the failure
3. Run number in which the failure occurred
4. Item failed
5. Specific model of item
6. Serial number or identifying number on item
7. Type of failure
8. Suspected cause of the failure
9. Final disposition of item
10. Suggestion to prevent similar failures

The results will evaluate the failure to determine patient impact and if indicated will report to the Chief and/or Medical Director the findings.

The Senior Staff will review the results at least quarterly.

The entire record will be submitted and reviewed by the Director of Public Safety at least annually.

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