



Columbia-Richland Fire Department

Standard Operating Guideline OPS – 3.01

Emergency Medical Responder Program

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Issued by: Aubrey D. Jenkins, Fire Chief

Rescinds:

Retain Memos #00-020R (June 14th, 2000); #00-002 (Feb 1st, 2000); #00-022R; #02-0022R; #02-0008R; #02-0001; #02-0013R

Purpose:

In order to provide the community we serve with the best possible medical care and by working in conjunction with Richland County Emergency Services, the Emergency Medical Service (EMS) provider, the Columbia-Richland Fire Department is establishing guidelines for an Emergency Medical First Responder Program. Due to the strategic locations of fire stations, and the training and experience of its firefighters, the Columbia Fire Department, when notified promptly, can often reach, treat, and begin stabilizing patients who are experiencing life-threatening medical emergencies prior to the arrival of Advanced Life Support (ALS) Units.

Scope:

This guideline will be applicable for *all* suppression personnel (Career and Volunteer) in the Columbia Fire Department. Should other affiliated department personnel become certified as an Emergency Medical Responder, all provisions of this guideline pertain.

Guideline:

Emergency Medical First Responder Program

I. Medical Direction and Oversight

- A. Columbia-Richland Fire Department's Emergency Medical Responder Program operates within the scope of South Carolina DHEC Division of EMS First Responder Program; CRFD will operate under the Medical Direction of Dr. William Gerard, who is also currently the Medical Control Physician for RCEMS.
- B. Scope of Practice: Columbia-Richland Fire Department's Scope of Practice is defined as the *skills and duties* a SC DHEC First Responder Agency *is allowed and expected* to perform. (This outlines *What* responders should do.)
 - i. The Columbia-Richland Fire Department uses the National Registry EMT (NREMT) curriculum for Emergency Medical Technician certification and the American Red Cross Emergency Medical Responder (ARC-EMR) curriculum for Emergency Medical Responder certification.

- ii. NREMT and ARC-EMR Certified Personnel shall operate only within their respective Scope of Practice. Personnel shall not operate above their level of training.
 - iii. Columbia-Richland Fire Department personnel registered as an EMT through National Registry shall be considered the higher level of care until more advanced Emergency Medical Personnel take over patient care.
- C. Standard of Care: Columbia-Richland Fire Department's Standard of Care is defined as the criteria of the *extent and quality* of care certified personnel shall perform. (This outlines *How* responders should do it.)
 - i. Certified Personnel shall perform duties consistent with their respective training curricula of either the National Registry EMT or American Red Cross Emergency Medical Responder.
 - ii. National Registry EMT personnel are expected only to perform to the level as outlined by CRFD Standing Orders (EMT Guidelines) and with available DHEC listed equipment on designated First Responder Units.
- D. The Training Bureau's Medical Officer is the point of contact concerning the Emergency Medical Responder Program and extensions within the Department.
- E. Emergency Medical Responder Oversight Group
 - i. This group will be comprised of individuals selected by the Chief of the Department or his designee and the Medical Director or his/her designee; appointees from the local EMS provider. Other members may be added as deemed necessary by the Chief of the Department and/ or the Medical Director.
 - ii. Responsibilities of the group will be to provide direction, leadership, and program assessment in order to continually improve the Emergency Medical First Responder Program and patient care within the Columbia-Richland Fire Department's jurisdiction.
 - iii. For Operating Protocols concerning the Oversight Group, refer to **Section VII. Quality Assurance and Improvement.**
 - iv. Daily management of the Emergency Medical Responder Program shall be under the supervision of on-duty Battalion Chiefs in their respective areas.

II. Response Protocols: All responders shall respond and act in accordance consistent with their training curricula. EMT's will follow procedures outlined in Medical Director's Standing Orders (EMT Guidelines).

A. Arrival On Scene

- i. The first arriving unit shall establish Command according to Operational Guidelines; SOG OPS-001.
- ii. Personnel shall perform a Scene Survey, including, but not limited to the following:
 - 1. Ensuring Scene Safety
 - a. Identify and isolate hazards to responding personnel and by-standers.

- b. Proper stabilization of vehicles involved in accidents (overturned/ verses structures) prior to gaining access to the patient.
- c. Identify leaking fuel and/ or Hazardous Materials Present.
 - i. If identified, respond appropriately according to OPS-031 Hazardous Materials Responses/Incidents.
- d. Potentially Violent Scenes: When responding to incidents where there are reports of violence, such as gunshot wounds and domestic disputes, Central shall inform the responding companies. If Central does not provide such information concerning calls of typical suspicion, the first arriving unit should inquire as soon as possible during response. Fire companies should stage at a safe distance until law enforcement confirms that the scene is secure.
 - i. If it is a crime scene, preserve evidence by not disturbing anything unless absolutely necessary.
 - ii. If personnel observe unusual items, document and report to the appropriate authorities; (e.g. drugs, child abuse, weapons, etc.)

B. Patient Contact and Care:

- i. For specific patient assessments, treatments, interventions, and skills, refer to the Operating Protocols as established by the Medical Director and consistent with certified personnel's scope of practice, except where limitations based on local option of the Medical Director are established.
- ii. Upon beginning care, it is recommended to attempt to place a single person in charge of patient care.
- iii. In the case of multiple patients on scene, ensure adequate resources are responding and designate one responder per patient, if and when available, to ensure proper continual care. Each patient that is given care by the CRFD must be properly documented.
- iv. Obviously Deceased Patients as indicated by the Medical Director's criteria, and consistent with those of RCEMS, should not have resuscitative efforts initiated. If there is any doubt as to the condition of the patient, begin resuscitation efforts immediately.
- v. Patients with DHEC EMS Do Not Resuscitate (DNR) orders
 - 1. Responders may stop or not initiate resuscitative efforts if *presented* with the original SC DHEC EMS DNR document signed by the patient's physician.
 - 2. Oral DNR orders are **not** acceptable.
 - 3. Basic airway management and first aid treatment must always be given.
- vi. Pre-hospital care documentation is vitally important in providing written proof of the status and condition a patient was found, the interventions and treatment given, and the condition of the patient prior to transfer of care. For detailed guidelines; see **Section III. Documentation and Reporting.**

- vii. Confidentiality: At no time shall any patient information be released to the public. For details on patient information see **Section VII. Patient Privacy and the Health Insurance Portability and Accountability Act.**
 - viii. In cases of death or serious injury caused by fire and/or smoke inhalation, and/or resulting in the transporting of a patient to a medical facility, a Fire Marshal (F-8) shall be notified in accordance with **Fire Investigations Operational Guidelines OPS-011.**
 - ix. **Under no circumstance shall patient care be abandoned prior to transferring care to more advanced personnel. Exception**; if the scene becomes unsafe and an emergency move cannot be performed to remove them from the hazard or danger; responders may relocate to a safe position. Should a responder become exhausted during resuscitation efforts, they must remain with the patient until additional help arrives.
 - x. Recorded transmissions should support documentation concerning the times and level of care given. In order to properly capture pertinent patient care times the Incident Commander shall contact Central and state all normal benchmarks as well as the following:
 1. Arrival on scene and Establishment of Command
 2. When EMS provider took over primary patient care
 3. Scene Under Control
 4. Termination of Command.
 5. It is unnecessary to announce when major interventions are initiated, how ever they should be documented on the DHEC Long form; i.e. CPR started, patient is being connected to AED; AED shocked; patient regained pulse, etc.
- C. Coordination with EMS provider
- i. **CRFD and EMS responding from the same fire station when dispatched:**
 1. CRFD will not respond to first responder calls when the fire company and the EMS unit are in the same fire station and are dispatched to the same call. **Exception; See #6**
 2. If CRFD is dispatched to a call fitting the above criteria the Captain or Engineer of the fire company dispatched will determine if the EMS unit is responding to the same address and if so the fire company will cancel on the call and not respond.
 3. The Captain or Engineer will confirm with Central over the assigned Ops Channel, (not the Dispatch Channel) the EMS unit number and location they are responding from.
 4. If it is confirmed the unit is responding to the same location, CRFD will request Central to notify the EMS unit and inform them that the fire company will not be responding as both units are responding out of the same location. With both units leaving the same station there is no need for CRFD to respond to the same call. The fire company will remain in available status.

5. *Should there be any question as to who is responding or information about the call warrants a response, the fire company shall respond to the call.*
 6. *Regardless of proximity to the incident, units shall always respond to vehicle accidents, respiratory issues, cardiac arrest, unconscious, near drowning, electrocution and burn injuries.*
- ii. **CRFD in cover response for another fire company on a first responder call**
1. CRFD will not respond as routine to calls for service to first responder calls in “cover response” if the EMS unit is closer to the location than the fire company.
 - a. However, if dispatched to a call in a “cover response,” that company will begin their response and then confirm with Central the EMS unit and the location from which EMS is responding from.
 - b. If the EMS unit is closer than the fire company, have the EMS unit responding to the same call move over to the “Public Safety” channel. Once communication has been established the unit will advise EMS that CRFD is responding for another fire company outside the territory and are further out than the EMS unit, and because **EMS will arrive first**, CRFD is canceling their response.
 2. *Also, regardless of proximity to the incident, the CRFD will always respond to vehicle accidents, respiratory issues, and cardiac arrest, unconscious, near drowning, electrocution and burn injuries.*
- iii. Once dispatched to a call, units must be moving toward the direction of the emergency until we arrive or are cancelled. Units shall not stop or wait for additional information before responding.
- iv. Units should not delay their responses.
- v. Prior to canceling from any medical call, Fire units should prudently ensure no further fire response is needed due to possible on scene hazards, including, but not limited to the following:
1. Entrapments/ overturned vehicles
 2. Fire or Explosions
 3. Unstable structures/ vehicles
 4. Leaking fuel or gas leaks
 5. Electrocutions (lock out/ tag out, downed lines)
 6. Possible Hazmat or Technical Rescue Incidents
- vi. **Communicating with EMS**
1. There is no need to verify with Central if EMS is en route.
 2. All communications with EMS should occur only on the Public Safety Channel.
 3. EMS units should be referred to as “Sierra ___” and identify self by the Incident Command name.

4. Use accepted CRFD clear text terminology. Exceptions listed below:
 - a. Signal 7 shall be used for patients with known or reported communicable diseases when the patient's privacy may be compromised, including when other family members are present, unless strict expressed consent is given otherwise. Central will advise CRFD units of a Signal 7 when applicable.
 - b. 10-60 should be used to notify Central when requesting the Coroner.
5. If the local EMS provider is on scene of a medical incident, they may cancel fire units that are still en route or after they have arrived on scene. However, fire units should prudently ensure no further fire response is needed due to possible on scene hazards, including, but not limited to the following:
 - a. Entrapments/ overturned vehicles
 - b. Explosions
 - c. Unstable structures
 - d. Leaking fuel/ Hazmat
 - e. Electrocutions (lock out/ tag out, downed lines)
- vii. Requesting Additional resources
 1. Air Medical Transport
 - a. Columbia-Richland Fire Department may request Air Medical Transport.
 - b. CRFD should coordinate LZ set-up with EMS.
 - c. Conditions for activation should be consistent with RCEMS activation criteria. An attempt to contact the RCEMS Supervisor should be made prior to launching Air Medical Transport.
 2. Multi-casualty incidents: For any incident involving 3 or more critical patients, based on level of injuries; or 5 or more total injured patients; the scene Incident Commander will contact the responding EMS agency. The following information should be communicated:
 - a. Number of patients.
 - b. Estimate of Priority for each patient.
 - c. Implementing the START system.
 - d. Additional Alarms or Apparatus
 3. For Hazmat Incidents and those involving WMD, refer to **Operational Guidelines SOG OPS-031**.
- viii. Patient hand-off: When EMS arrives; responders working on the victim should turn over primary patient care and communicate important information to the EMS providers following the SBAR principal: Situation, Background, Assessment, and Recommendations of current

and continuing care. During patient transfer with EMS ensure that all patient information is given discretely.

1. Situation
 - a. Condition of Patient
 - b. Current treatment and interventions
 - i. Oxygen
 - ii. Hemorrhage control
 - iii. Spinal precautions
 - iv. Immobilization of extremities
 - v. Patient reassurance
 - vi. Changes in patient's status
2. Background
 - a. Age
 - b. Sex
3. Assessment
 - a. C-ABC's
 - i. Level of Consciousness
 - ii. Airway Status
 - iii. Breathing Status
 - iv. Pulse Status
 - b. Vitals
 - i. Pulse Rate
 - ii. Respiration Rate
 - iii. Skin color
 - iv. Overall appearance
 - v. Signs of distress
 - c. SAMPLE History
 - d. Physical Exam findings
 - e. Ongoing /Trending Vitals
4. Recommendations

D. Dispatch Protocols

- i. Every effort must be made to respond immediately to medical incidents, including diverting companies from other incidents when possible, but potentially life-threatening fire incidents may require response adjustments based on risk management models. **In no case, however, will a call for service and/or a patient be abandoned.** In a severe situation, it may be possible to leave a firefighter with a patient until EMS arrives and respond the rest of the company to another incident.
- ii. When multiple incidents or major incidents limit the availability of CRFD resources, the Division Chief or his designee shall move into Central and assist the fire dispatcher with dispatching medical calls for service by determining the location of the responding EMS unit and the fire unit and the life risk based on call information and make adjustments as necessary. However, first responder service will not be temporarily suspended unless approved by a member of the Command Staff (Assistant Chief or higher in rank).

- iii. Normal First Responder Dispatch Procedures
 - 1. Most medical incidents shall only consist of single apparatus responses, unless where it is necessary to respond a second unit for back up or on roadway incidents requiring the use of additional units. Secondary units should be released whenever the Incident Commander can place the incident safely under control.
 - 2. Stations with two or more assigned personnel shall respond together only on one apparatus.
- iv. Incident Types that CRFD will respond to are as follows:
 - 1. Airway obstruction/Choking
 - 2. Altered Mental Status/Unconscious
 - 3. Amputation/Avulsions
 - 4. Anaphylaxis
 - 5. Animal bite
 - 6. Apnea
 - 7. Burn
 - 8. Cardiac arrest
 - 9. Coronary
 - 10. Crushing injury
 - 11. Electrocution
 - 12. Entrapment
 - 13. Fainting/Hypotension
 - 14. Laceration/punctures/stabbings/gunshot wounds
 - 15. Multi trauma/shock
 - 16. Near drowning
 - 17. Patient Trapped/ Patient Down
 - 21. Poisoning/Overdose
 - 18. Snake Bite
 - 19. Seizure
 - 20. Respiratory Distress/Arrest
 - 21. Spinal injury/Paralysis
 - 22. Stroke
 - 23. Vehicle accidents With injuries, including pedestrians
 - 24. Accidents with Special Considerations
 - 25. Significant Delays by EMS Provider (Code 4)
 - 26. As Requested by EMS Provider
- v. Currently the following are Excluded Call Types
 - 1. Abrasion/contusion
 - 2. Eye-injury
 - 3. Hypertension
 - 4. Medical (Life)Alarm
 - 5. Lifting Assistance
 - 6. Request for EMS with No Further Information
 - 7. Incidents at Licensed Medical Facilities

- vi. Special Consideration Incidents with medical patients should receive normal fire responses. Special Consideration Incidents include but are not limited to:
 - 1. Environmental Hazards/ Natural Disaster
 - 2. Technical Rescues
 - 3. Hazard Material Spills and Releases
 - 4. Rescue / Patient Trapped
 - 5. Water Rescues
 - 6. Below Grade
 - 7. Excavation Trench
 - 8. Confined Space
 - 9. High Angle/ Tower
 - 10. Collapsed Structures

E. Equipment

- i. Inventory of medical equipment should be taken every day for each unit, this includes both EMT and EMR units. For replacing equipment, contact Logistics or your Battalion Chief.
- ii. SC DHEC Designated response units shall carry all items as required by SCDHEC for the appropriate treatment level.
 - 1. EMT units are NOT to go out of service to wait on equipment to be released from the hospital (i.e. backboards, splints, etc.)
 - 2. Spare equipment shall be placed at EMT designated stations to return units back in service promptly. Notify the Battalion Chief and logistics to restock spare EMT equipment.
 - 3. It shall be the responsibility of each EMT unit to follow up and or make arrangements to retrieve EMT equipment used in the process of patient packaging and transport.
 - 4. Incidentals and single use EMT equipment shall be replaced via normal means.
- iii. At no time should any medical equipment on any apparatus be stored with fuel, oil or hydraulic oils or solutions.
- iv. Cleaning of contaminated equipment should follow the guidelines according to OPS-022 Infection Control.
- v. Automated External Defibrillators
 - 1. For details on the operation, use, and inspection of the Columbia-Richland Fire Department's automated external defibrillators, refer to Operational Guidelines on Automated External Defibrillators.
- vi. PPE
 - 1. All personnel must follow Operational Guidelines OPS-22; Infection Control when providing patient care or performing duties that have a reasonable expectation of coming in contact with blood or body fluids (Other Potentially Infectious Material.)

III. Documentation and Reporting

A. General Guidelines about Documentation

- i. Documentation provides a legal record of care provided on the incident scene.

- ii. Because a patient's condition may change before the patient arrives at the hospital, a record of conditions immediately after patient contact and when transferring to the EMS provider can provide useful information to EMS and the hospital.

B. Patient Care Forms

- i. SCDHEC requires careful documentation of pre-hospital care including the status and condition in which a patient was found, the interventions and treatment given, and the condition of the patient prior to transfer of care.
- ii. CRFD requires the use of the SC DHEC Long Form to capture all the required patient care information.
- iii. At no time should completing paperwork take priority over providing care to life threatening conditions, but every attempt to gather pertinent information should be attempted.
- iv. The only exception is when absolutely no patient contact was made. Any assistance provided such as patient packaging, lifting assistance, and calls where EMS arrives at the same time as fire units *require* documentation.

C. Medical Incident Reporting:

- i. SCDHEC requires all reportable medical incidents to be directly entered or uploaded to the EMS Improvement Center's PREMIS site within 72 hours for Quality Assurance measures.
- ii. Designated CRFD EMTs are required by SC DHEC to complete all patient reporting requirements as mandated by the state.
 - 1. Certified NR-EMTs that responded to an incident on designated EMT units shall be responsible for completing associated DHEC reports where patient contact was performed.
 - a. *Each* patient contact requires its own patient care report, such as in the case of a vehicular accident with multiple passengers.
 - b. Fire, Rescue or other emergency related incidents where EMTs provide patient care, shall also be subject to these provisions.
 - 2. Reports shall be completed before the conclusion of each shift, unless with the sole approval of the on-duty Division Chief. Refer to **ADM-033 Disciplinary Action Plans** for failure to complete incident reports.
- iii. **It is Mandatory to report ALL incidents with patients that are in cardiac arrest to the Training Bureau's Medical Training Officer by email for cardiac incident reviews, Quality Assurance and Improvement Measures.**
- iv. Normal Firehouse Reporting still pertains for all department incident reporting, even when PREMIS is used.
 - 1. Patient Care shall not be recorded in the general section of the Firehouse report, but under the EMS treatment section.

- v. **The primary or secondary on-scene caregiver shall be responsible for entering patient information into Firehouse and/or PREMIS. CRFD does not authorize any other individuals to enter patient health information data into the reporting system due to DHEC document retention requirements.**

IV. Personnel Certification and Training

- A. All recognized certification for the Emergency Responder Program shall be coordinated through the Columbia-Richland Fire Department's training Bureau and/ or their designees. Complete oversight of record keeping and documentation of personnel training records shall be maintained by the Bureau.
- B. It is a job requirement for suppression personnel and those deemed as essential personnel to maintain at a minimum an ARC-EMR certification at all times, unless expressed written consent is given by the Chief of the Department excluding those individuals from maintaining current certifications of the courses listed below.
- C. ARC-EMR Certification shall be met by successfully completing **all** components of the ARC Emergency Medical Response Course components.
 - i. Professional Rescuer Cardiopulmonary Resuscitation, renewed at least bi-annually.
 - ii. Automated External Defibrillator, renewed at least bi-annually.
 - iii. Oxygen Delivery, renewed at least bi-annually.
 - iv. Emergency Medical Responder, renewed at least every 3 years.
- D. Suppression and essential personnel failing to fully meet the minimum ARC-EMR certification standard do not meet suppression or essential personnel job requirements, and therefore can be removed from their position and placed on suspension **without** compensation until certification requirements are satisfied fully.
- E. Individuals failing to attain ARC-EMR within 45 days will be terminated.
 - i. **Exception:** Fire Recruits must pass all portions of the accepted recruit medical certification training course while attending the recruit program. Failure to attain certification will result in **immediate** dismissal from the Recruit program, thereby terminating their employment.
 - ii. **Exception:** Volunteer Personnel must follow the Guidelines as set forth in **Operating Guideline VOL-020; Training/Response Guideline for Volunteer Firefighters**
- F. Discovery of improper or unethical behavior prior to, during, or after any certification testing shall have the certifications of all individuals involved removed immediately, and the offense reported to the Chief of Training and the Chief of Professional Services, the Medical Director, and City of Columbia-Richland Human Resources. Personnel shall then be responsible for attaining verified certification on their own, **without** compensation, through a third party, as well as face internal disciplinary procedures.
- G. NREMT Certification shall be met by successfully completing all components of a recognized National Registry EMT Course.
 - i. Recertification of NREMT's shall be conducted in accordance with SC DHEC Division of EMS and NREMT standards.

1. Personnel failing to meet the SC DHEC Division of EMS / NREMT standard must ensure they have a minimum certification level of ARC-EMR within 45 days, or fall subject to Section I; Paragraphs D and E.

H. NREMT In-Service Training (IST)

- i. In an effort to enhance EMT skill retention and knowledge enhancement, “In-service” training shall be conducted for certified EMT’s by a SC DHEC approved IST program.
- ii. Training documentation and record keeping shall be coordinated through the Training Bureau with RCEMS and documented accordingly.

I. Remedial/ Quality Improvement Sessions

- i. If during incident event reviews or Quality Improvement processes, deficiencies are learned, the Department and/or Medical Director, at its discretion shall institute remedial training to correct noted deficiencies.

V. **Infection Control** guidelines are outlined in **Operational SOG Ops-022.**

VI. **Exposure Reporting:** Anytime it is suspected that a responder or an employee has been exposed to either airborne or bloodborne pathogens, it is required for that employee to immediately begin the process according to **Operational Guidelines SOG Ops-022 on Infection Control.**

VII. **Patient Privacy and the Health Insurance Portability and Accountability Act (HIPAA):**

- A. Any Patient Documentation or supporting forms used to complete incident and medical reporting must be properly discarded or shredded so that no identifying information may be obtained from the documents. These forms must not be left unsecured, as it is a violation of the Federal HIPAA act.
- B. The HIPAA Privacy Rule **is not** intended to impede customary and essential communications and practices and, thus, does not require that all risk of incidental use or disclosure be eliminated to satisfy its standards. Rather, the Privacy Rule permits certain incidental uses and disclosures of protected health information to occur when the covered entity has in place reasonable safeguards and minimum necessary policies and procedures to protect an individual’s privacy.
 - i. The Department shall remind employees to protect patient confidentiality; and provide annual training as a part its Emergency Medical Responder Program
 - ii. Personnel should be fully aware of the legal implications of using any and all forms of electronic and/or social media.
- C. Personnel shall not access patient records or documentation outside their scope of responsibility without expressed approval from the Deputy Fire Chief or his designee.
- D. See Standard Operating Guidelines concerning Patient Privacy and releasing Private Health information (PHI).

VIII. **Quality Assessment and Improvement**

- A. The Emergency Responder Program Oversight Group shall be responsible for reviewing and auditing the program in its entirety to ensure that acceptable patient care is being consistently provided to the public, as required by SC DHEC Division of EMS. Additionally adherence to all guidelines and protocols will be periodically reviewed.
- B. Additional internal Quality Assurance and Improvement will be performed by instituting processes to systematically review the following:
 - i. Reviewing Patient Care Reports for Quality Control (QC)
 - 1. Pre-hospital response time comparisons with fire incidents and local EMS response times
 - 2. Personnel compliance to program protocols
 - 3. Uniformity/ standardization of treatment
 - 4. Frequency of omissions and/or opportunities for improvement
 - 5. Timeliness of completion
 - 6. Are reports complete?
 - ii. Identifying program concerns, successes and deficiencies
 - iii. Implement processes to measure program success
 - iv. Implementing and evaluating improvements
 - v. Overall progress and direction of program
- C. The Quality Improvement (QI) Program shall identify areas of critical performance deficiencies and institute necessary changes or improvements.
 - i. Remedial and In-service training may be instituted as part of the improvement process.
 - ii. Evaluations of QI measures must be performed to ensure their success
 - iii. Program performance shall be benchmarked against other emergency responder agencies
 - iv. Patient care enhancements shall be made through researching new technology, patient care evaluations, reviews, and instructor and student development including:
 - 1. Mandatory SCA post-event review and improvements
 - 2. Continued program evaluation and improvement
 - v. Reviewing dispatch and response protocols
 - vi. Tracking and reporting SCA survival rates through National Databases, such as the Resuscitation Outcome Consortium
- D. Internal and External Relations: Success of the Medical First Responder Program can be improved through solicitation and review of internal and external feedback including, but not limited to:
 - i. Citizen and customer satisfaction surveys
 - ii. Internal audits and program feedback forums
 - iii. National “Life Saver” Awards