

Policy and Procedures Manual

Formal Submission for Approval

MEDICAL FIRST RESPONDER (MFR): REQUEST FOR REPLACEMENT OF CONSUMABLE EQUIPMENT AND SOFT SUPPLIES

Health PEI		POLICY & PROCEDURES
Applies To:	Provincial Ground Ambulance Program	
Monitoring:	Director, Emergency Health & Planning Services	
Date:	Effective: May 01, 2017 Next Review: May 01, 2020	

Approving Authority: CAO, Emergency Health Services, Long Term Care & Hospital Services East

Authorized Signature: _____

Record of Decision	Approving Body:	CAO, Emergency Health Services, Long Term Care & Hospital Services East
	Meeting Date:	May 09, 2017

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<p>This is a CONTROLLED document. Any copies of this document appearing in paper form should always be checked against the electronic version prior to use.</p>		

1.0 POLICY

- 1.1 Health PEI shall reimburse Island EMS Inc. for the replacement of equipment and soft supplies, listed in Appendix A. It should be recognized that had an MFR Partnering Agency not been available to respond, Emergency Medical Services (Ground Ambulance) consumables would likely have been used.

2.0 DEFINITIONS

Equipment:	Any item that is non-disposable.
MFR Partnering Agency(ies):	Any Fire Department registered with the PEI Firefighters Association (PEIFFA) to provide community Medical First Responder (MFR) services.
MFR Program:	An optional program, delivered by local Fire Departments, coordinated by the Prince Edward Island Firefighters Association (PEIFFA).
Soft Supplies:	Any item that has a onetime use / is disposable.

3.0 PURPOSE/SCOPE

- 3.1 While each MFR Partnering Agency is ultimately responsible for training and equipment costs in order to safely carry out MFR activities, Health PEI recognizes the importance of ensuring that MFR Partnering Agencies have timely access to the replacement of consumable emergency medical equipment and soft supplies to deliver the level of service defined by the MFR Partnering Agencies.

4.0 APPLICATION

- 4.1 This policy applies only to MFR Participating Agencies that are registered and approved by the PEI Firefighters Association.

5.0 PROCEDURES

- 5.1 All requests must be completed by the MFR Partnering Agency on the “MFR Approved Consumables Order Form” and submitted directly to Island EMS.
- (a) Completed forms may be emailed to Island EMS at: phillip.pollard@islandems.ca

- (b) Orders shall be filled and sent back to the MFR Partnering Agency within ten (10) business days.
 - (c) Large items such as Backboards or Oxygen Tanks may be exchanged on scene if time permits and provided it does not deplete the ambulance's supply. **On-scene exchange of consumables shall not delay transport or compromise care of the patient.**
 - (d) Only consumable equipment and soft supplies that were used for patient related care will be approved (ie. replacement of training related equipment will not be approved).
- 5.2 MFR Partnering Agencies shall maintain a complete and accurate record of consumable equipment and soft supplies used on the Prince Edward Island Medical First Responder Patient Care Report (Appendix B). Records will be made available upon request by Health PEI.
- 5.3 Health PEI, at its sole discretion, reserves the right to request justification be provided by the MFR Partnering Agency for the replacement of consumable equipment and soft supplies. Failure to provide justification or maintain records on the use of consumable equipment and soft supplies may lead to the suspension or denial of an MFR Partnering Agency from receiving replacement consumable equipment and soft supplies under this policy.
- (a) Note, the maintenance of the "MFR Request Replacement of Consumable Equipment and Soft Supplies" policy is dependent on available program budget and prioritized need.
- 5.4 On a monthly basis, Island EMS shall submit an invoice to Health PEI (c/o: Emergency Health & Planning Services) for expenses related to this policy. The invoice must include a copy of each "MFR Approved Consumables Order Form" for the purpose of confirming all related expenses and to maintain statistics on consumables replaced.

6.0 MONITORING

The Director of Emergency Health and Planning Services within the Section of Emergency Health and Planning Services is responsible for ensuring this policy is reviewed every three years as per Health PEI's policy review cycle and standards.

7.0 REFERENCES

Related Documents

Ambulance Services Act, RSPEI 1988, c A-10.01

Prince Edward Island Ground Ambulance Services Agreement

References

N/A

Appendices

Appendix A - MFR Approved Consumables Order Form

Appendix B – Prince Edward Island Medical First Responder Patient Care Report

8.0 STAKEHOLDER REVIEW

Group/Committee	Dates of Review
Island EMS Inc.	January 23, 2017
Office of Public Safety: Fire Marshall’s Office	February 01, 2017
Health PEI – Operations / Planning & Evaluation	March 10, 2017
PEI Firefighters Association	February 22, 2017

9.0 REVIEW HISTORY

Review Dates: March 2017 _____

Appendix A



MFR APPROVED CONSUMABLES ORDER FORM

Name of MFR		
Partnering Agency:		
Contact Person:		
Telephone:		
Shipping Address: (Include Postal Code)		
Item Description	Units Of Measurement	Quantity Requested
Adhesive Bandages	100 / Box	
Adhesive Tape	12 / Box	
Alcohol Wipes	200 / Box	
Backboard (Used)	Each	
Bag-Valve-Mask (BVM – Adult)	Each	
Bag-Valve-Mask (BVM – Pediatric)	Each	
Cold Packs	Each	
Defibrillator Pads	Each	
Hot Packs	Each	
Nasal Cannula (Adult)	Each	
Nasal Cannula (Pediatric)	Each	
Non-Sterile Gloves (Small)	100 / Box	
Non-Sterile Gloves (Medium)	100 / Box	
Non-Sterile Gloves (Large)	100 / Box	
Non-Sterile Gloves (X-Large)	100 / Box	
Non-Sterile Gauze - 4"x4"	20 / Box	
Oropharyngeal Airway (40mm)	Each	
Oropharyngeal Airway (50mm)	Each	
Oropharyngeal Airway (60mm)	Each	
Oropharyngeal Airway (70mm)	Each	
Oropharyngeal Airway (80mm)	Each	
Oropharyngeal Airway (90mm)	Each	
Oropharyngeal Airway (100mm)	Each	
Oxygen Mask (Adult) – Simple Face Mask	Each	
Oxygen Mask (Pediatric) – Simple Face Mask	Each	
Oxygen Tank (D Portable Tanks) ** Only Supplier: VitalAire	Each	
Stabilization Collar (Adult)	Each	
Stabilization Collar (Pediatric)	Each	

Complete Form and Submit to:

Phillip Pollard - Central Operations Manager

Email: phillip.pollard@islandems.ca

Tel: (902) 892-9905 Fax: (902) 892-9993

ISLAND EMS OFFICE USE ONLY			
Date Filled / Sent:		Sent By:	
Date Received:		IEMS Management Approval:	

Appendix B



Prince Edward Island Medical First Responder Patient Care Report



Department/Agency Name (Do not abbreviate or use station number)

Department of Health

Incident Location	Date	M /	D /	Y	Time Call Received	Time of Arrival	Time Cleared
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Patient Information	Chief Complaint						
Patient Name					DOB		Age
What Happened? (Mechanism of Injury)					Ambulance on scene prior to MFR arrival? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, patient info is NOT required)		
When Did it Happen/Start?					Did you see at the medicals? Yes <input type="checkbox"/> No <input type="checkbox"/>		
					Ambulance on scene Time _____ Unit# _____		

Medical Conditions	None <input type="checkbox"/> Lung Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____						
	Heart Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> High BP <input type="checkbox"/> Infectious Disease <input type="checkbox"/>						

Allergies	None Known <input type="checkbox"/> Unknown <input type="checkbox"/> ASA <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____						
	Penicillin <input type="checkbox"/> Bee Sting <input type="checkbox"/> Foods <input type="checkbox"/>						

Have family gather meds and Personal Health Card

Assessment				Vitals				Level of Pain				
Level of Consciousness		Colour	Temp	Condition	Time	Resp Rate	Pulse	BP				
Alert <input type="checkbox"/>		Pink <input type="checkbox"/>	Hot <input type="checkbox"/>	Dry <input type="checkbox"/>					1 2 3 4 5 6 7 8 9 10			
Responds to Voice <input type="checkbox"/>		Pale <input type="checkbox"/>	Cool <input type="checkbox"/>	Moist <input type="checkbox"/>					Mild ----- Severe			
Responds to Pain <input type="checkbox"/>		Blue <input type="checkbox"/>	Warm <input type="checkbox"/>	Sweaty <input type="checkbox"/>								
Unresponsive <input type="checkbox"/>		Flushed <input type="checkbox"/>										

Cardiac Arrest	Time of collapse or last seen: _____			Time CPR Started: _____		
Was the arrest witnessed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, by whom? Family <input type="checkbox"/> Bystander <input type="checkbox"/> MFR Dept. <input type="checkbox"/> Other _____						
CPR on arrival of MFR: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, by whom? Family <input type="checkbox"/> Bystander <input type="checkbox"/> Police <input type="checkbox"/> Other _____						
Initial Analysis: No Shock Advised <input type="checkbox"/> Shock Advised <input type="checkbox"/> Time of First Shock _____ Total No. of Shocks by MFR _____						

Treatment				
Airway	Breathing	Circulation	Trauma / Burn	Protective Equipment
OFA <input type="checkbox"/> NPA <input type="checkbox"/>	BVM Yes <input type="checkbox"/> No <input type="checkbox"/>	CPR Yes <input type="checkbox"/> No <input type="checkbox"/>	Bandage Applied Yes <input type="checkbox"/> No <input type="checkbox"/>	Seal Del. Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> Helmet Worn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> Airbag Deployed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> Car Seat <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/>
Recovery Position <input type="checkbox"/>	D ² Admin Yes <input type="checkbox"/> No <input type="checkbox"/>		Wet <input type="checkbox"/> Dry <input type="checkbox"/>	
Jaw Thrust <input type="checkbox"/>	LPM _____		Controlled Bleeding Yes <input type="checkbox"/> No <input type="checkbox"/>	
Head Tilt <input type="checkbox"/>			C-Collar <input type="checkbox"/> K&B <input type="checkbox"/> Backboard <input type="checkbox"/>	
Suction <input type="checkbox"/>			Splint <input type="checkbox"/>	
Abdominal Thrusts <input type="checkbox"/>			Circulation OK Post Splinting Yes <input type="checkbox"/> No <input type="checkbox"/>	

Notes								

Provider Information			
Documented by	Name-Please Print _____	Signature _____	MFR Tag No. _____
Provider No. 1	Name-Please Print _____	Signature _____	MFR Tag No. _____
Provider No. 2	Name-Please Print _____	Signature _____	MFR Tag No. _____

OK-12-10544

White - Island EMS Canary - Fire Service