

After Action Review

“What is not defined cannot be measured. What is not measured, cannot be improved.

What is not improved, is always degraded” - William Thomson Kelvin

With the increase of new and younger EMS providers and firefighters it is important as a department to find ways to improve and grow regardless of call volume. The best way of doing that is owning our/your mistakes and learning from them. We should take every call and opportunity to grow from our success and failure. We should also take these opportunities to grow from the success and failure of others. Just as we study line of duty deaths and near miss events, we need to learn from every call we can. We need to learn from the big calls as a platoon and department and learn from the smaller calls as a partnership and crew.

There is also an added benefit by having an after-action review with a built-in quality assurance program. This helps us ensure we are operating appropriately according to protocols, policies and procedures as our standard. We can also use this as a way to see if protocols, policies and procedures should be altered. As we look to improve ourselves we can also evaluate and test our standards and look to improve them as well.

To have the greatest success in improving and learning we need to dissect the calls to see what we have done wrong, what can we improve and what we can continue to do well. The way we do that is through the After Action Review. This gives us the format to take ownership of your actions and learn from the actions of others all with the goal of being better on the next call.

To be the most successful with this program you need a facilitator. This role is extremely important.

Fire & Rescue

What actually occurred? What did you intend to accomplish?

- Was leader's intent communicated?
 - Task
 - Purpose
 - End State

What was the expected plan?

What obstacles were encountered?

What can be improved?

- How?


What went well?

What lessons are you taking to the next call?

What If...?

Cardiac Arrest

What actually occurred? Was leader's intent communicated?

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- The background features a large, semi-transparent watermark of the Lehi Fire Department logo. The logo is a shield-shaped emblem with a red border. At the top, the words "LEHI FIRE" are written in large, white, bold, sans-serif capital letters. Below this, a white banner with a scalloped edge contains the text "EST 1901". The central part of the logo depicts a fire scene with a fire hydrant, a fire truck, and a firehouse. To the right of the central scene is a blue Star of Life, a symbol for emergency medical services. At the bottom of the shield, another white banner contains the word "UTAH".
- Task
 - Purpose
 - End State
 - CPR Depth (2.00 to 2.40 in)
 - Rate (100-120 cpm)
 - Release Velocity (400+ mm/s)
 - CPR Pause (<5 sec pre & Post shock)
 - Rhythm recognition Defib/Pace/Sync Cardiovert

What did you intend to accomplish? What was the expected plan?

- CPR Depth
- Rate
- Release Velocity

- CPR Pause
- Rhythm recognition Defib/Pace/Sync Cardiovert

What obstacles were encountered?

What can be improved?

- How?

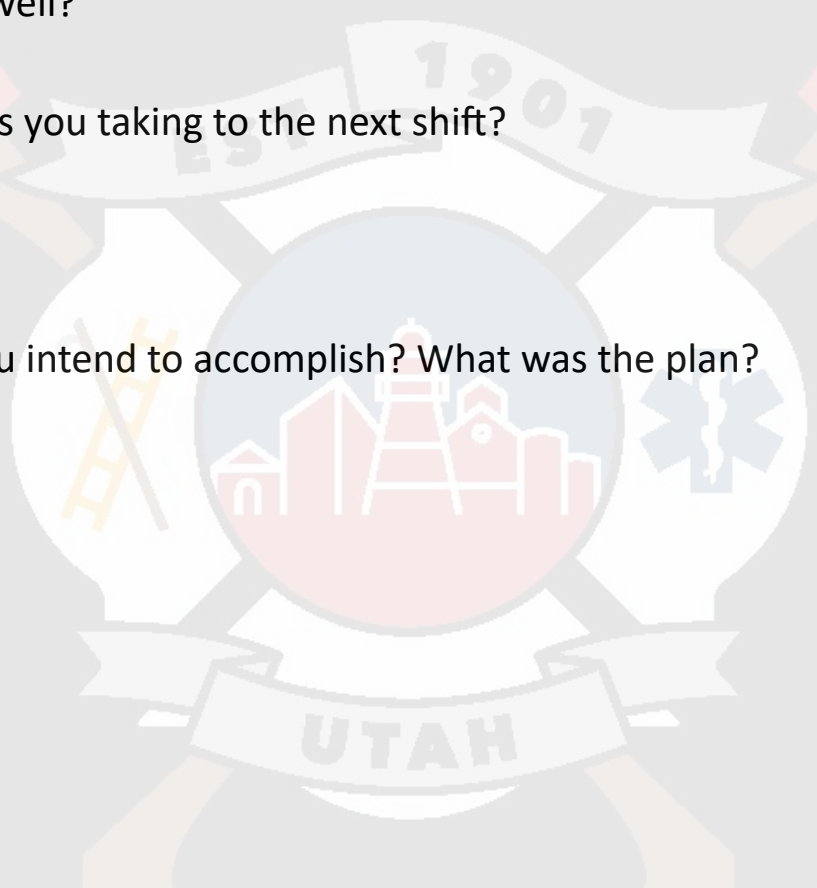
What went well?

What lessons you taking to the next shift?

What If...?

What did you intend to accomplish? What was the plan?

LEHI FIRE



EKG Reference

- PRI: 120 – 200ms
- QRS Duration: 70-110ms
- QT Interval: 400 to 440ms
- QTc: Prolonged if > 440ms in men or > 460ms in women
- P axis: Between 0° and +75°
- QRS axis: -30° and +90°
- T axis: 15° to 75°
- STJ (mm) on the case review 0.06mm will be seen as 6
- V2, V3
 - Men < 40: 2.5 mm ST-elevation
 - Men > 40: 2.0 mm ST-elevation
 - Women: >1.5 mm ST-elevation
- All other leads: >1 mm ST-elevation