

Kansas Board of Emergency Medical Services

900 S.W Jackson, LSOB, Room 1031

Topeka, KS 66601

785-296-7296

Ground Ambulance Inspection Form



Name of Service _____ Service Number _____

Inspection Address _____ Date _____

VIN _____ Unit# _____

Mileage _____ License Tag _____

Type II Type IIA Type I Type V

Ambulance Inspections are conducted Pursuant to **KSA 65-6130**

General Vehicle Standards

- | Yes | No | Corrected | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exterior appearance |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Body integrity |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Identification/markings |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | loading lights |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emergency lighting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Siren |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Batteries |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tires |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Flashlights/Spotlight |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2-5 # fire extinguishers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cab Climate Control |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cab "No Smoking" sign |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Two/way com |

Patient Compartment

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Interior clean |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ambulance license |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "No Smoking" sign |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Climate control |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Interior lighting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | All equipment secured |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ventilation fan |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Elevating cot |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Waterproof cot cover |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2 blankets |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Linen change |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pillow |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed pan and urinal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emesis basin/bag |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Disaster tags |

Body Substance Isolation

- | Yes | No | Corrected | |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gloves, latex or vinyl |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye protection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Filtering mask |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Protective gowns |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sharps container |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Leak-Proof container |

Airway

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | In line oxygen system _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Portable oxygen unit _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adult nasal cannulas |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pediatric nasal cannulas |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adult oxygen masks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pediatric oxygen masks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oropharyngeal airways |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adult Bag/Valve/Mask |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pediatric Bag/Valve/Mask |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Infant Bag/Valve/Mask * |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | In line suction _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Suction tubing(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nonmetallic suction tip (s) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Portable suction _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Laryngoscope and blades |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endotracheal tubes |

Splinting

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | LSB with stabilizers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | SSB with stabilizers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | C-collars/stabilizers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Upper ext. splints |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lower ext. splints |

Medical Supplies

- | Yes | No | Corrected | |
|--------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | B/P manometer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pediatric cuff |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adult cuff |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Extra-large cuff |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stethoscope |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | O.B. kit |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1 L. sterile water/ saline |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bandage shears |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Occlusive gauze pads |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sterile gauze dressing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rolled bandages |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adhesive tape |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Large trauma dressing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burn sheets |

ALS Equipment/Supplies

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I.V. solutions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Administration sets |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Caths, syringes, needles |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arm boards |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IO and bone needles * |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Monitor/Defibrillator |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12 lead capability * |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drugs per protocol |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Current dated medication |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cric. Kit * |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Decompression kit * |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

(*) indicates equipment not required by law, but used for data collecting purposes only.

Service Representative

KBEMS Inspector

(H)/Shared/Forms/Inspection/4



Kansas Board of Emergency Medical Services

900 S.W Jackson, LSOB, Room 1031

Topeka, KS 66601

785-296-7296



Medical Protocol Inspection Form

Name of Service _____ Service Number _____

Inspection Address _____ Date _____

Ambulance Inspections are conducted Pursuant to **KSA 65-6130**

Each ambulance service operator shall adopt and implement medical protocols developed and approved in accordance with K.S.A 65-6112, and amendment thereto. **K.A.R 109-2-5 (u)**.

Each operator's medical protocols shall include a table of contents and treatment procedures at a minimum for the following medical and trauma-related conditions for pediatric and adult patients: **K.A.R 109-2-5 (v)**.

Adult Protocols

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | (1) Diabetic Emergencies |
| <input type="checkbox"/> | <input type="checkbox"/> | (2) Shock |
| <input type="checkbox"/> | <input type="checkbox"/> | (3) Environmental Emergencies |
| <input type="checkbox"/> | <input type="checkbox"/> | (4) Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | (5) Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | (6) Respiratory distress |
| <input type="checkbox"/> | <input type="checkbox"/> | (7) O.B. emergencies and care of newborn |
| <input type="checkbox"/> | <input type="checkbox"/> | (8) Poisoning and overdose |
| <input type="checkbox"/> | <input type="checkbox"/> | (9) Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | (10) Cardiac Arrest |
| <input type="checkbox"/> | <input type="checkbox"/> | (11) Burns |
| <input type="checkbox"/> | <input type="checkbox"/> | (12) Stroke or cerebral-vascular accident |
| <input type="checkbox"/> | <input type="checkbox"/> | (13) Chest injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (14) Abdominal injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (15) Head injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (16) Spinal injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (17) Multiple-systems trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | (18) Orthopedic injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (19) Drowning |
| <input type="checkbox"/> | <input type="checkbox"/> | (20) Anaphylaxis |

Pediatric Protocols

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | (1) Diabetic Emergencies |
| <input type="checkbox"/> | <input type="checkbox"/> | (2) Shock |
| <input type="checkbox"/> | <input type="checkbox"/> | (3) Environmental Emergencies |
| <input type="checkbox"/> | <input type="checkbox"/> | (4) Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | (5) Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | (6) Respiratory distress |
| <input type="checkbox"/> | <input type="checkbox"/> | (7) O.B. emergencies and care of newborn |
| <input type="checkbox"/> | <input type="checkbox"/> | (8) Poisoning and overdose |
| <input type="checkbox"/> | <input type="checkbox"/> | (9) Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | (10) Cardiac Arrest |
| <input type="checkbox"/> | <input type="checkbox"/> | (11) Burns |
| <input type="checkbox"/> | <input type="checkbox"/> | (12) Stroke or cerebral-vascular accident |
| <input type="checkbox"/> | <input type="checkbox"/> | (13) Chest injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (14) Abdominal injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (15) Head injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (16) Spinal injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (17) Multiple-systems trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | (18) Orthopedic injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | (19) Drowning |
| <input type="checkbox"/> | <input type="checkbox"/> | (20) Anaphylaxis |

Remarks: _____

Service Representative

KBEMS Inspector



Kansas Board of Emergency Medical Services

900 S.W Jackson, LSOB, Room 1031

Topeka, KS 66601

785-296-7296



Operational/QA Inspection Form

Name of Service _____ Service Number _____

Inspection Address _____ Date _____

Ambulance Inspections are conducted Pursuant to **KSA 65-6130**

Each operator shall provide a quality improvement or assurance program that establishes medical review procedures for monitoring patient care activities. This program shall include policies for reviewing patient care documentation.

K.A.R 109-2-5 (r)

Yes No

- Is Written Quality Improvement/Assurance program on file that meets requirements of **K.A.R 109-2-5 (r)**
- Is operator reviewing patient care activities at least once each quarter of each calendar year to determine if Patient care is commensurate with attendant's scope of practice and local protocols?
- Are patient care activities reviewed once each quarter by the service's medical director? **K.S.A 65-6126**
- Is documentation of review of patient care activities on file for three years?

Each ambulance service operator shall develop and implement operational policies or guidelines, or both that have a table of contents and address policies and procedures for each of the following topics: **K.A.R 109-2-5 (s)**

Yes No

- (1) Radio and telephone communications
- (2) Inter-facility transfers
- (3) Emergency driving and vehicle operations
- (4) DNR, power of attorney, and living wills
- (5) Multiple-victim and mass casualty incidents
- (6) Hazardous material incidents
- (7) Infectious disease control

Yes No

- (8) Crime scene management
- (9) Documentation of patient reports
- (10) Consent and refusal of treatment
- (11) Management of firearms and other weapons
- (12) Mutual aid
- (13) Patient confidentiality
- (14) Extrication

Remarks: _____

Service Representative

KBEMS Inspector



Kansas Board of Emergency Medical Services

900 S.W Jackson, LSOB, Room 1031

Topeka, KS 66601

785-296-7296



Service Inspection Form 201_-_____

Name of Service _____ Service Number _____

Inspection Address _____ Date _____

Ambulance Inspections are conducted Pursuant to **KSA 65-6130**

Name of service representative present for the inspection? **Inspection policy**

Can operator produce the service permit? **K.A.R. 109-2-5 (k)** Yes No

Are current copies of each attendant certification card on file? **K.A.R. 109-2-1 (b) (4)** Yes No

Is the attendant list on file and current? **K.A.R. 109-2-1 (b) (3)** Yes No

Are all required operational policies on file? **K.A.R. 109-2-5 (s)** Yes No

Are all required medical protocols on file? **K.A.R. 109-2-5 (v)** Yes No

Are vehicle equipment lists approved and on file? **K.A.R. 109-2-2 (h) (2)** Yes No

Are all component of the daily log in order? **K.A.R. 109-2-5 (n)** Yes No

Date, Time, Location, Vehicle number, Trip Number, Caller, Nature of Call, and disposition of patient

Is quality assurance being performed and on file? **K.A.R. 109-2-5 (r)** Yes No

Is patient care documentation completed and on file? **K.A.R. 109-2-5 (r) (3)** Yes No

Are there deficiencies in vehicle inspections? **K.A.R. 109-2-8, 11, 12, & 13** Yes No

Are there deficiencies in the garaging requirements met? **K.A.R. 109-2-5 (g)** Yes No

Is the air ambulance safety program complete? **K.A.R. 109-2-10 (a)** NA Yes No

Is the air ambulance informational publication available? **K.A.R. 109-2-10 (c)** NA Yes No

Is the service required to submit corrective documentation? **Inspection policy** Yes No

Comments: _____

Service Representative

KBEMS Inspector

I verify that all problems listed above are corrected.

Date

Service Director

Please submit this signed form to BEMS by the date (s) identified on the "Inspection Summary" sheet. It is recommended that you retain a copy for your file.