

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Safety Event Review		Policy Number 121	
APPROVED Administrator: Steven L. Carroll, Paramedic		Date: July 1, 2023	
APPROVED Medical Director: Daniel Shepherd, MD		Date: July 1, 2023	
Origination Date: April 13, 2023		Effective Date: July 1, 2023	
Date Revised:			
Date Last Reviewed:			
Review Date: October 31, 2023*			

- I. PURPOSE: Identify and address events which may risk the safety of patient(s), provider(s), or communities.
  
- II. AUTHORITY: Health and Safety Code, Division 2.5. California Code of Regulations, Title 22, Division 9. California EMS Authority Model Disciplinary Orders.
  
- III. DEFINITIONS:
 

Reportable Safety Event: Any circumstance, error, or action, which causes an actual or potential risk to the safety of provider(s), patient(s), or the community. Reportable safety events include, but are not limited to, incorrect medication administration, deviation from policies and/or procedures, vehicle accidents involving EMS personnel, and events which may delay the response to an EMS incident. Reportable safety events are not limited to incidents that have already occurred and may include any observations of potential safety risks or other concerns.

Just Culture: A system of shared accountability in which organizations are accountable for the systems they have designed and for responding to behaviors of individuals in a fair and just manner.
  
- IV. POLICY: Reportable safety events will be submitted and reviewed in accordance with the following procedures. VCEMS will be the coordinating agency for these reviews.

\*Review of this policy will take place in 6 months in order to discuss and review this new process and any areas where additional improvement can be made as the EMS system navigates these changes.

V. PROCEDURE:

A. Reporting

1. Reporting safety events is encouraged and is considered an essential component of system development and oversight.
2. Safety events will be reported directly by the provider(s) who identified the risk or were directly engaged in the event. When a safety event is identified after the fact through base hospital or provider agency CQI programs, the safety event may be submitted by a responder agency or base hospital representative.
3. *Reportable Safety Events* will be reported to VCEMS utilizing the online tool provided.
4. *Reportable Safety Events* involving actual/potential harm to patients will be reported immediately. All other events will be reported within 24 hours of event occurrence or subsequent identification.
5. Agencies are encouraged to report any minor unexpected occurrence. This would include minor mechanical issues, equipment failures, misinterpretation of policy, etc. While seemingly innocuous, these events provide important insight into our EMS system.
6. When the incident is severe enough to warrant immediate review or communication, the reporting party should contact the EMS Agency Duty Officer.

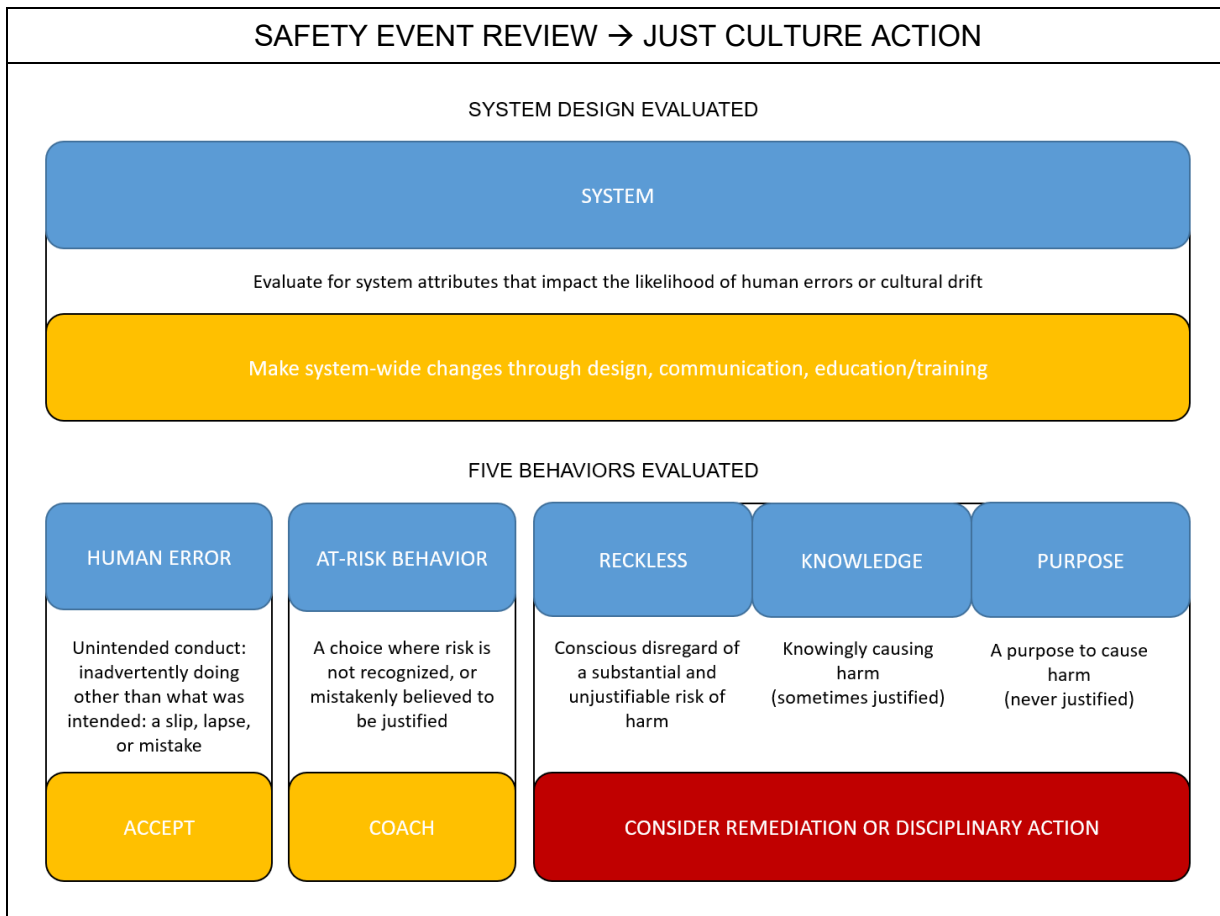
B. Event Review

1. The intent of the review is to evaluate system design and individual behaviors with a focus on learning and improving safety and is not intended to be punitive in nature.
2. When a Reportable Safety Event is submitted VCEMS will receive notification of the submission and the reporting party will receive confirmation that the submission was received.
3. Initial review will determine if additional information is needed.
4. Agencies, Pre-hospital Care Coordinator(s), and personnel involved will be notified that a reportable safety event has been received.

5. When it is determined that additional information is needed, VCEMS will collaborate with providers and clinical management teams for review and follow-up.

C. Just Culture Algorithm

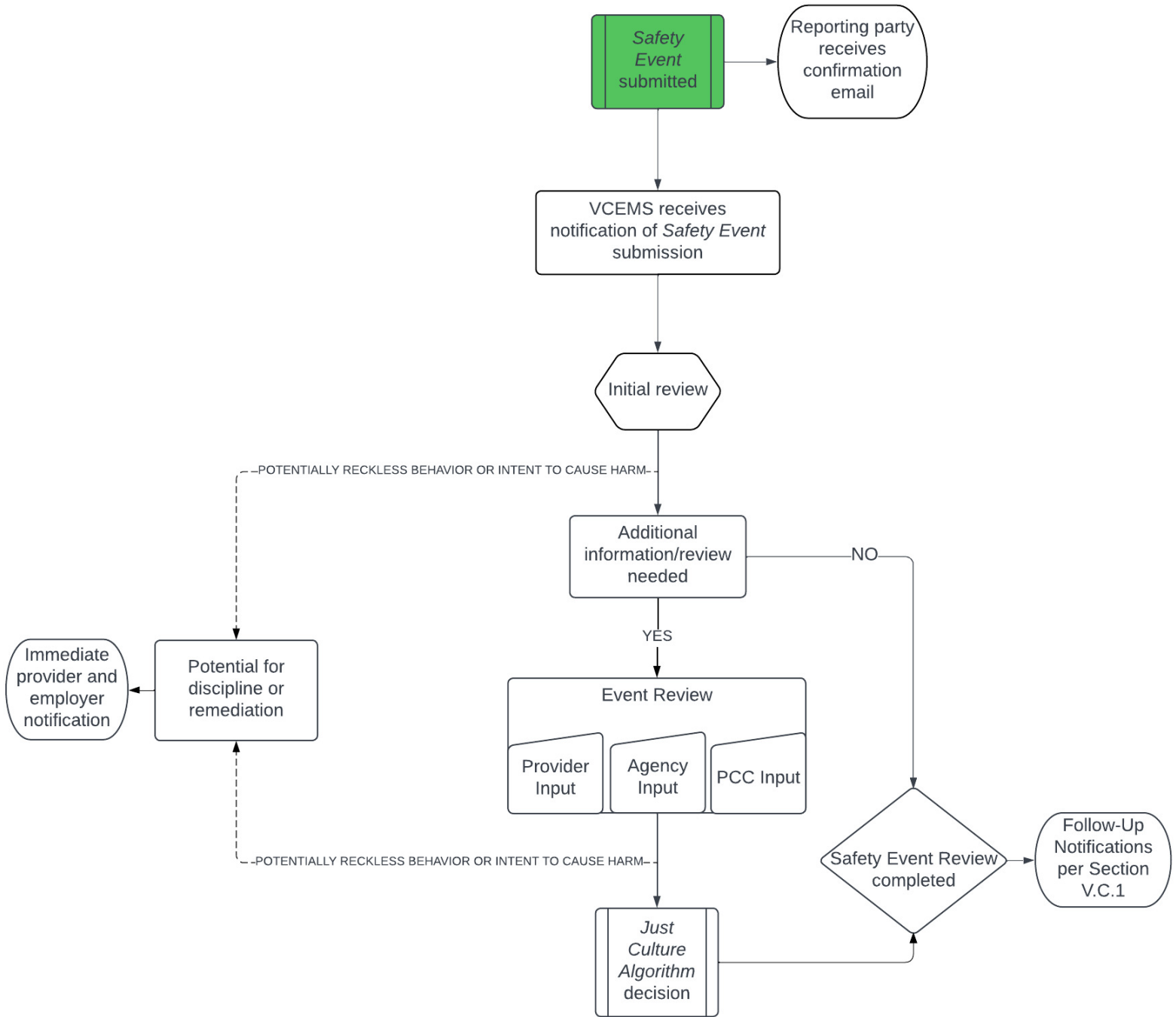
1. *The BETA Healthcare Group Just Culture Algorithm* is the accepted VCEMS framework for identifying the appropriate actions when a *Safety Event Review* is complete.
2. System design will be evaluated when reviewing a safety event for factors that impact the likelihood of the five behaviors.
3. There are 5 behaviors that will be evaluated when reviewing a safety event in order to determine which action is appropriate.



D. Safety Event Review Follow-Up

1. Once a *Safety Event Review* is considered complete the following parties will be notified:
  - a. The person who reported the safety event
  - b. The agencies involved in the safety event
  - c. The personnel involved in the safety event
    - i. Notification may be provided directly by VCEMS or via the provider's employer.
  - d. The Pre-hospital Care Coordinator(s) involved
  - e. EMS System Stakeholders
    - i. A CQI report including aggregate safety event information will be provided to the Prehospital Services Committee (PSC) on a quarterly basis.
    - ii. All events will be de-identified in order to maintain privacy for everyone involved.

### SAFETY EVENT REVIEW PROCESS





## Reportable Safety Event Form

To access the electronic form, use this QR Code:



-OR-

Use this link:

[REPORTABLE SAFETY EVENT FORM](#)