SAN JOAQUIN COUNTY
EMERGENCY MEDICAL SERVICES AGENCY

TITLE: **EMS UNUSUAL OCCURENCE REPORTING PROCESS** EMS Policy No. **6102**

PURPOSE: ~~The purpose of this policy is to outline a process for reporting non-sentinel event issues occurring within the EMS system.~~ The purpose of this policy is to outline a process for reporting unusual occurrence events within the EMS system.

AUTHORITY: Health and Safety Code, Division 2.5 Section 1797.220 & 1798 et seq.

DEFINITIONS: See SJCEMSA Policy Definitions

~~"Unusual Occurrence" means any of the following:~~

~~a. Breech of any standard of care or care outside scope of practice;~~
~~b. Key equipment failure;~~
~~c. Deviation from EMS policy that have potential to result in patient, EMS personnel, or public harm;~~
~~d. Clinical treatment or medication administration errors that have potential to result in patient, EMS personnel, or public harm;~~
~~e. Suspected violations of Health and Safety Code;~~
~~f. Actual or potential injury to a patient or EMS personnel;~~
~~g. Any occurrence that EMS personnel perceive as benefiting from a SJCEMSA review.~~

a. "Unusual Occurrence" means any of the following:
    a. Breech of any standard of care or care outside scope of practice.
    b. Medication or procedural errors.
    c. Key equipment failure.
    d. Deviation from EMS policy or protocol that has potential to result in patient, EMS personnel, or public harm.
    e. Suspected violations of Health and Safety Code.
    f. Actual or potential injury to a patient.
    g. The refusal and/or failure of prehospital EMS personnel to implement a Base Hospital order.
    h. Failure or refusal to respond to request for aid, whether from the public or another system provider.
    i. EMS response vehicle accident.
    j. Any occurrence that EMS personnel perceive as benefiting from a SJCEMSA review.
    k. Any of the occurrences defined as a threat to public health and safety cited in Health and Safety Code § 1798.200(c).

POLICY:

It the policy of SJCEMSA to maintain a reporting process of unusual occurrences within

Effective: July~~anuary~~ 1, 2026~~July 1, 2023~~
Supersedes: July 1, 2023~~10~~

Approved: _____ _____
Medical Director EMS Administrator

the EMS system to ensure effective process improvement and to reduce or mitigate future negative occurrences. EMS system participants shall report Unusual Occurrences to SJCEMSA in accordance with this policy.

PROCEDURE:

I. This policy reflects SJCEMSA's commitment to improvement through process ownership by all EMS system participants and involved parties. EMS system participants experiencing misunderstandings or disagreements during field operations that do not rise to the level of Unusual Occurrence reporting to SJCEMSA (which may include emergency medical dispatch, on scene operations and hospital related operational issues) are expected to resolve such issues:
   A. As soon as possible after the call.
   B. In person or by telephone with the party involved or parties.
   C. Among the participants.
   D. At a mutually convenient time and location.

II. EMS system participants shall report Unusual Occurrences to SJCESMA by completing and submitting an Unusual Occurrence Report Form (Appendix 6102A) online from the SJCEMSA website or scanned copy sent to the SJCEMSA Duty Officer email emsdutyofficer@sjgov.org within twenty-four (24) hours of the incident. EMS personnel submitting an Unusual Occurrence Report Form shall also include all applicable supporting documentation.

III. An unusual occurrence involving EMS personnel death or serious physical injury shall be reported to the EMS Agency Duty Officer upon discovery, however, notification shall not exceed two (2) hours after becoming aware of the event.

IV. EMS providers, hospitals, non-emergency ambulance providers, and dispatch centers shall participate in Unusual Occurrence follow-up, investigations, and/or requests for information as requested by the SJCEMSA.

V. SJCEMSA will foster a systemwide approach to Continuous Quality Improvement (CQI) emphasizing accountability and fairness when addressing mistakes, misconduct, or failures. This includes learning from mistakes rather than assigning blame, fostering an environment where individuals feel safe to report errors and contribute to the quality improvement process.
   A. **Shared accountability.** Both individuals and organizations or agencies share responsibility for safety and outcomes.
   B. **Learning environment.** Encourage self-reporting of errors or mistakes.
   ~~A.~~C. **Distinction between errors and misconduct.** While honest mistakes are

seen as learning opportunities, willful misconduct or gross negligence may still warrant corrective action.

~~II. This policy reflects the EMS Agency's commitment of improvement through process ownership by all EMS system participants and involved parties. EMS system participants experiencing misunderstandings or disagreements in the course of field operations that do not rise to the level of Unusual Occurrence reporting to SJCEMSA (which may include emergency medical dispatch, on scene operations and hospital related operational issues) are expected to resolve such issues:~~

~~A. As soon as possible after the call;~~

~~B. In person or by telephone with the involved party or parties;~~

~~C. Among the participants;~~

~~D. At a mutually convenient time and location.~~

~~III. EMS system participants shall report Unusual Occurrences to SJCESMA by completing and submitting an Unusual Occurrence Report Form (Appendix 6102A) online from the SJCEMSA website https://www.sjgov.org/department/ems/unusual-occurrences-form or scanned copy sent to the SJCEMSA Duty Officer email emsdutyofficer@sjgov.org within three (3) working days of the incident. EMS personnel submitting an Unusual Occurrence Report Form shall also include all applicable supporting documentation.~~

~~IV.~~VI. Confidentiality~~: The~~: The EMS Unusual Occurrence Reporting Process is part of the CQI process and all interactions that occur under the guidance of this policy are confidential.