Santa Barbara County Quality Improvement Report Form

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PLEASE FAX THIS CONTINUOUS QUALITY IMPROVEMENT REPORT TO THE SANTA BARBARA COUNTY EMS AGENCY AT (805) 681-5142
INCLUDE A COPY OF THE PCR IF APPLICABLE.

Reporting Agency	Name of person completing this report	Date of report

Date of unusual occurrence	Dispatch #	PCR #

Time of incident	Attachments

Personnel involved	Service Provider

Santa Barbara County EMS Quality Improvement Report Form

Describe event:

Attachment: ◯ Yes ◉ No		**Type:**	
Signature:		**License/cert. #**	
Telephone #		**Email:**	

Santa Barbara EMS Service Provider CQI Report
Name of CQI staff member:

Root cause analysis:

Action plan:

Signature of Service Provider Medical Director:

For use by Santa Barbara County EMS Agency only.		
Received:	**Follow up category:**	**Action Required**
Entered into incident log **Date:** _____ **Incident # :** _____	☐ Medication ☐ Equipment ☐ Scope of practice ☐ Policy violation ☐ Other	☐ Non-Event ☐ Investigate ☐ Performance Improvement Plan ☐ State EMSA Referral ☐ Other

Check Box ☐

Objective findings: (see attached)

Recommendations:

Action taken:

Case closed:
Angelo Salvucci, MD, EMS Medical Director:_____
Date:____/___/____

Unable to Notify Employee

Name of Service Provider:

_____

Name of employee from whom report is being requested:

_____

How did you attempt to notify the employee?

_____
_____
_____
_____

When is the employee's next scheduled shift?

_____

Report will be faxed or otherwise delivered to the EMS Agency by the end of the next shift worked by this employee.

YES ☐
N ☐
O

If NO, reason and anticipated date that report will be sent to EMS Agency.

_____
_____
_____
_____
_____
_____
_____
_____