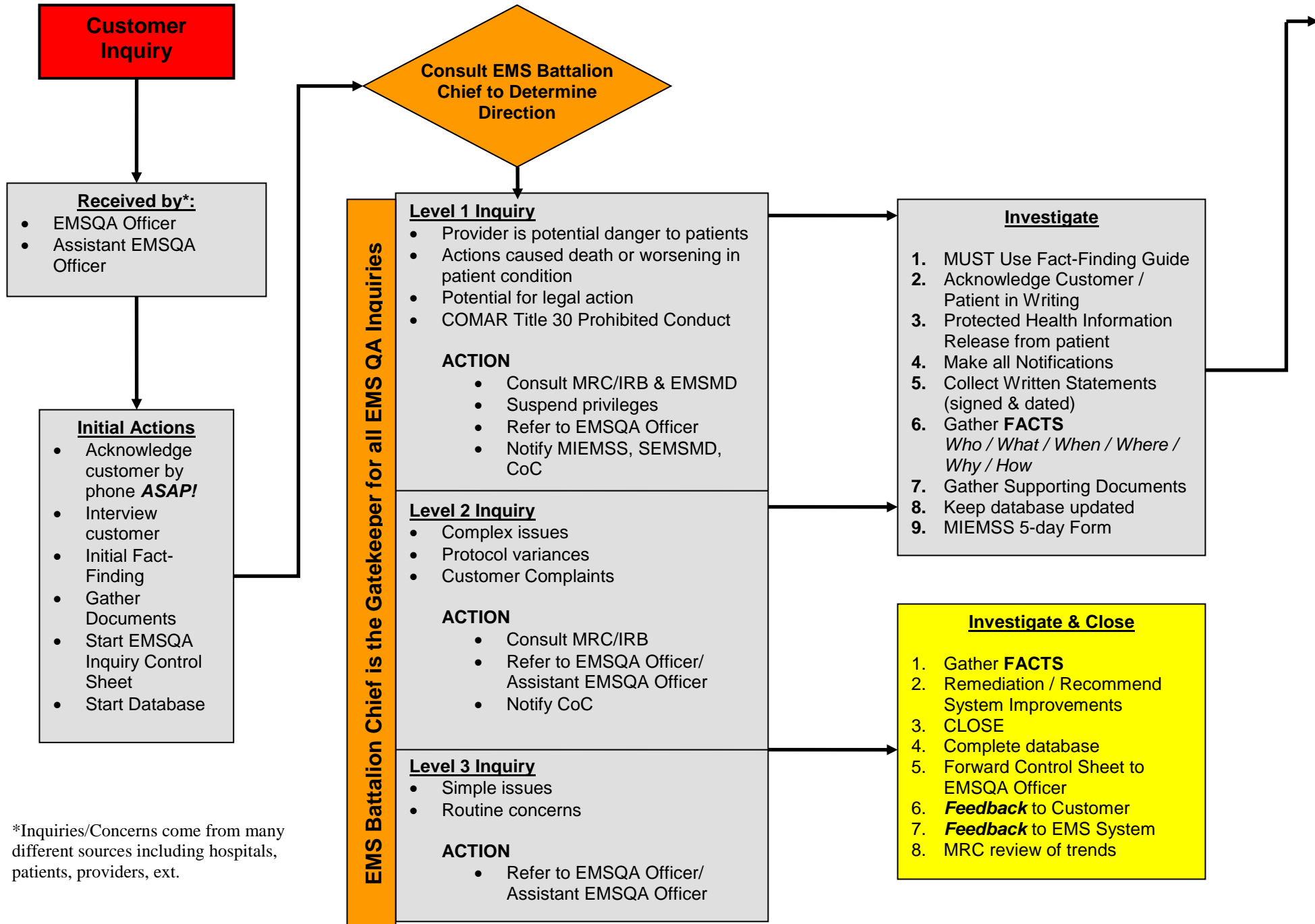
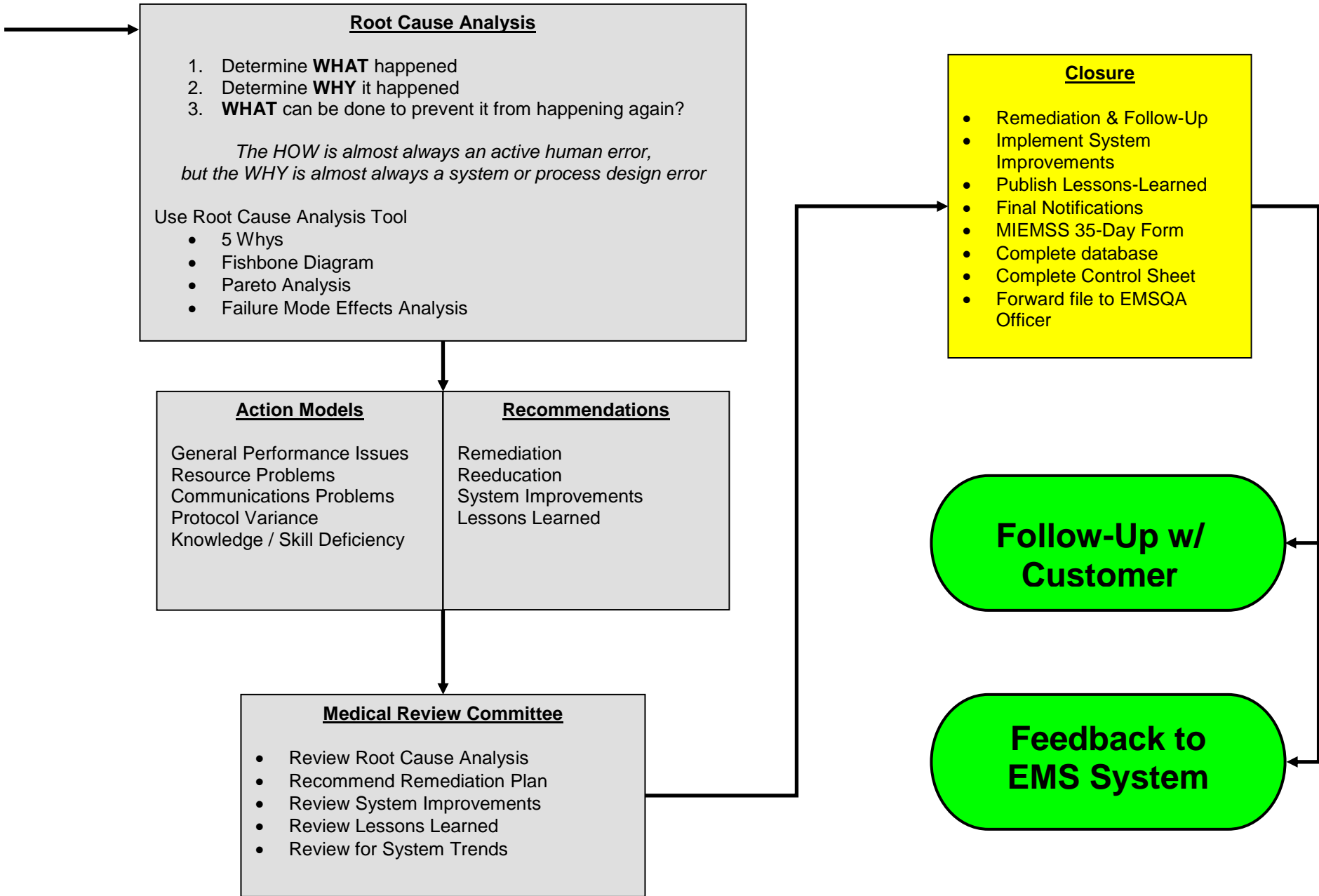


MCFRS EMS QA Inquiry Process Flow



*Inquiries/Concerns come from many different sources including hospitals, patients, providers, ext.



Root Cause Analysis

1. Determine **WHAT** happened
2. Determine **WHY** it happened
3. **WHAT** can be done to prevent it from happening again?

*The HOW is almost always an active human error,
but the WHY is almost always a system or process design error*

Use Root Cause Analysis Tool

- 5 Whys
- Fishbone Diagram
- Pareto Analysis
- Failure Mode Effects Analysis

<u>Action Models</u>	<u>Recommendations</u>
General Performance Issues Resource Problems Communications Problems Protocol Variance Knowledge / Skill Deficiency	Remediation Reeducation System Improvements Lessons Learned

Medical Review Committee

- Review Root Cause Analysis
- Recommend Remediation Plan
- Review System Improvements
- Review Lessons Learned
- Review for System Trends

Closure

- Remediation & Follow-Up
- Implement System Improvements
- Publish Lessons-Learned
- Final Notifications
- MIEMSS 35-Day Form
- Complete database
- Complete Control Sheet
- Forward file to EMSQA Officer

**Follow-Up w/
Customer**

**Feedback to
EMS System**