



## JUST CULTURE AND LEARNING FROM ERRORS

*When an employee will not discuss or denies an error*

Through discussions, presentations and your own experiences, everyone knows the critical importance of performing thorough event investigations. They allow us to learn from errors and prevent other errors from occurring. This requires your employees' input about the event. But what if they don't cooperate?

It was a fairly normal shift for a small rural ambulance service, when a medical call came through for a patient with complaints of palpitations, chest pain, and shortness of breath. When the paramedic/EMT crew arrived, the patient was pale and diaphoretic, with a blood pressure of 90/52. EPCR documentation reflects a cardiac monitor was applied to the patient which showed sinus tachycardia with frequent PVCs/bigeminy/trigeminy. An IV was started, medical control consulted, and Lidocaine was prepared and administered to the patient without resolution of the arrhythmia. Patient was prepped for transport with continued chest pain, low blood pressure, and arrhythmias. Patient's condition continued to deteriorate as patient was transported to the nearest ED. Patient was handed off to the ED in critical but stable condition.

While the crew was cleaning up the ambulance back at the station, the EMT discovered an empty box of Atropine on the floor. The paramedic saw the EMT had the box, and said, "That must have been from a previous call." The EMT questioned it, as the counts in the drug box were off – they were short one Atropine, but all Lidocaine was present. The paramedic continued to deny the possibility an error was made. The next day, the EMT was still concerned about the incident, and reported it to their supervisor. The supervisor went through the trash from the previous day, and found the empty Atropine box.

The supervisor had previously attended Just Culture class, and did not want to jump to any conclusions; therefore, she called the employee in for a discussion. The employee adamantly denied that an error occurred. The supervisor assured the paramedic that she just wanted to understand what happened so they could make necessary changes to prevent the error from happening again. Over and over again, the employee denied that an error could have occurred – and therefore had nothing to discuss about the incident.

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The service believed very strongly in the concepts of a Just Culture, and the supervisor struggled with finding the best way to handle the situation and still follow Just Culture concepts. The supervisor verified with the EMT the conversation which had occurred with the paramedic. The supervisor had no doubt that the error had indeed occurred, but she still had no knowledge about HOW it occurred.

The concern began to center on the employee's integrity. The employee's lack of candor about the error occurring is now a breach of a duty to produce an outcome – in this case, to tell the truth to their supervisor, and explain what happened. This breach not only ties the hands of the supervisor as she investigates the error. It places patients at risk for further medication errors and harm.

Many of you have attended the Just Culture Manager's Training class and are at various stages in implementing this philosophy and culture within your service. It seems fairly simple and consistent. But when you run into road blocks like this, remind yourself of two things. First, as Paul LeSage from Outcome Engenuity has said, "It's not about what box you land in; it's about having the conversation." If the employee simply will not have the conversation about the error, then the conversation topic has changed. Secondly, the need to take disciplinary action doesn't interfere with a "just culture". Remember, personal accountability or one's own actions must always be taken in to consideration. ●

### Just Culture Manager's Training – December 11 – St. Louis, MO (St. Peters)

The next Manager's Training class (See [Brochure](#)) is scheduled for Wednesday, December 11 at St. Charles County Ambulance District in St. Peters, Missouri. Kim McKenna, Director of Education, and certified Just Culture instructor, will present the program. For more information, call 636-344-7662, or [register here](#).

## Things to Ask When Considering Joining a PSO

Thinking about joining a Patient Safety Organization (PSO)? The Center highly encourages all healthcare organizations to participate with a PSO – but it should be a PSO that is right for your agency's unique needs. Here is a short list of things to consider.

1. Does the PSO provide consulting assistance with developing your Patient Safety Evaluation System and corresponding policies?
2. Do they provide a template to use for developing your PSO policies?
3. Do they have a data system built to capture unique data points related to errors that occur in EMS?
4. Are they available to call with questions and to ask for guidance when needed?
5. Are they able to send reports and other key information to you securely and confidentially?
6. Does the PSO have enough EMS providers participating to allow for sharing and learning to occur across agencies?

The Center for Patient Safety provides all of these things and much more! Please [contact us](#) for further information. ●

## EMS PSO UPDATE

The Center is thrilled to report we now have 98 agencies of many different locations and sizes participating in the PSO! We have received 75 event reports to date, and data is continuing to come in. If you have not submitted anything lately, [please take a moment to do so now](#). Remember, your legal protections are not fully in place unless you are actively submitting data. [Contact the Center](#) anytime for assistance! ●

## Webinar Series Provided for the American Ambulance Association

The CPS was proud and honored to present a three-part webinar series this fall for the American Ambulance Association! The series, entitled “*Connecting the Dots – What a Culture of Safety and Patient Safety Organizations Mean to Quality and Safety Improvements in EMS*”, covered a variety of topics including the importance of establishing a safety culture to promote error and near miss reporting; how the PSO protections work and how to operationalize them within your service; and stories from current participating EMS agencies. CPS gives special thanks to Jason Shearer (Kansas City Fire EMS), Mike Wallace (Central Jackson County Fire EMS), and Jason White for sharing their stories during the final session. ●

## More Case Law Provides Support for PSO Protections

The Center's participants have heard us emphasize the importance about defining clear boundaries for their Patient Safety Evaluation Systems (PSES) and implementing clear PSES policies. Courts will examine these policies closely in determining whether information generated as part of patient safety activities can be protected as Patient Safety Work Product (PSWP). They will also examine the path of purported PSWP to see if the organization has followed its own policies for protected information.

### KEY FACTORS TO MAINTAIN PSO PROTECTIONS

A summary of key findings from recent court cases provided below illustrate this point:

1. The Patient Safety and Quality Improvement Act pre-empts contrary state law (KY courts have refused to apply their quality privilege to protect patient safety work, but they did recognize the need to apply the federal law).
2. Appropriate Patient Safety Work Product (PSWP) can be protected, even if doing the work also satisfies another requirement.
3. The provider must participate with a PSO and develop a PSES to claim the privilege—good intentions are not enough.
4. Negligence of the provider in the underlying patient care does not negate the privilege.
5. The products of the patient safety work, such as new policies, educational programs or shared lessons learned, cannot be protected PSWP. They become part of the new way things happen in the organization. Courts may, however, prevent their use as evidence under state law provisions that keep later improvements from being used as evidence of negligence. Discuss that possibility with defense counsel.



Protection depends on a nexus between the protected work and reporting to a PSO. Background work on an issue can be considered functionally reported, meaning it has the protections but has not literally been submitted to the PSO. However, there must be a connection between the work and the reporting of events.

As you develop and periodically review your PSES, the Center recommends involvement with your legal counsel to ensure they are adequately educated about the PSQIA and your policies, so he/she can knowledgeably defend your protections if needed, without falling back on state law provisions or antiquated federal ones. ●

#### Case Citations:

- *Fancher v. Shields, et al.*, Jefferson Circuit No. 10-CI-4219 (August 16, 2011)
- *Norton v. Cunningham*, Kentucky Court of Appeals, No. 2012-CA-000646-OA (August 16, 2012)
- *Morgan v. Community Medical Center Healthcare System*, Pennsylvania, No. 2008-CV-4859 (Lackawanna Co. June 14, 2011)
- *Gooden v. CVS Caremark Corp.*, No. 11CVA-10885 (Nov. 20, 2012)
- *Mercy Health Partners-Lourdes, Inc. v. Kaltenback*, No. 2013-CA-000053-OA (July 11, 2013)

## FINAL RECOMMENDATIONS PUBLISHED FROM THE NHTSA CULTURE OF SAFETY PROJECT

The final National Culture of Safety recommendations were published from NHTSA, the American College of Emergency Physicians, and Health Resources and Service's Administration (HRSA) EMS for Children Program on October 3. The Steering Committee, headed by Dr. Sabina Braithwaite of Sedgwick County EMS in Wichita, KS, provided a list of actions for EMS agencies to take now:

- Collaborate with EMS personnel in the development, promotion, and implementation of a comprehensive system-wide safety program for their EMS system such as JustCulture or other similar programs and make EMS safety a corporate value.
- Promote the need for coordination of all EMS safety-related programs at the local, regional, state, and federal levels and integrate these into the agencies SOP's.
- Promote the need for better national EMS responder and patient data collection and facilitate EMS personnel participation in systems currently available such as the E.V.E.N.T. system.
- Support new EMS educational safety initiatives within initial EMS education curriculum and through other certification courses such as NAEMT's EMS Safety Course.

### Just Culture Staff Training Materials Available

The Center has Staff Training kits available which includes one copy of the DVD movie "On the Scene", and a facilitated Director's Panel Discussion; one copy of the Safe Choices "On the Scene" Facilitator's Guide; and copies of the EMS Staff Brochure. The full kit is available to Missouri Ambulance Association members for only \$75, plus \$2 for each staff brochure; and \$150 per kit plus \$4 per staff brochure for non-members. Contact Marilyn Keilholz at the Center for ordering information – [mkeilholz@mocps.org](mailto:mkeilholz@mocps.org).

#### FOR MORE INFORMATION

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For additional information on the Center's PSO activities, resources, toolkits, upcoming events, and more, please visit our website at [www.emspso.org](http://www.emspso.org) or [www.centerforpatientsafety.org](http://www.centerforpatientsafety.org) or follow us on Twitter @PtSafetyExpert for the most up-to-date news.

- Promote the development of new and improved safety standards that affect all aspects of the EMS system based on best practices and successful safety programs.
- Support the creation of a national EMS safety data system that collects both patient and EMS personnel data.

Your participation in the PSO goes above and beyond these recommendations. As participants, your agency has examined your QI processes and made improvements. Many of you have committed to instilling a culture of safety within your agency through implementing Just Culture. Our PSO participants have committed to reporting data on adverse events in EMS in a manner that receives federal confidentiality protections for that data. Kudos to all of you for being trailblazers!

The Center will keep you updated on other activities surrounding these national recommendations

Reference: Strategy for a National EMS Culture of Safety. (2013). Retrieved Nov. 4, 2013 from:

<http://www.emscultureofsafety.org/wp-content/uploads/2013/10/Strategy-for-a-National-EMS-Culture-of-Safety-10-03-13.pdf> ●

### EMS Data System Gets a Boost from Verge Solutions

The Center is excited to announce the transition to our new PSO data platform for EMS, the CPS ShareSuite powered by Verge Solutions, is 100% complete! All of your historical data is available to view and you can enter new events at any time. We have received a great deal of positive feedback on the ease of using the system, and its many options for viewing and sorting events. The reports module is also available, and CPS will be providing a webinar to demonstrate all of its capabilities in the near future. Stay tuned! ●

## UPCOMING EVENTS

**NOVEMBER 18-20, 2013 – American Ambulance Association Convention, Las Vegas, NV.** The Center is hosting booth #208. Please come and visit us!

**DECEMBER 11, 2013 – Just Culture Managers' Training, St. Charles County Ambulance District.** See: [Just Culture Brochure](#)

**FALL 2014 – Fifth Annual EMS Patient Safety Conference - Details Coming Soon!**

#### ABOUT THE CENTER

The Missouri Center for Patient Safety, dba Center for Patient Safety, was founded by the Missouri Hospital Association, Missouri State Medical Association and Primaris as a private, non-profit corporation to serve as a leader to fulfill its vision of a health care environment safe for all patients and healthcare providers, in all processes, all the time.