NAEMT news
Serving our nation's EMS practitioners
A quarterly publication of the National Association of Emergency Medical Technicians
Summer 2012

A Just Culture for EMS can improve safety

by Mark Alexander

With the new emphasis on EMS practitioner and patient safety now emerging within our profession, EMS agencies are exploring new approaches to enhancing EMS safety for all stakeholders – practitioners, patients, agencies, and the public at large. The concept of "Just Culture" within EMS is at the forefront of this movement. A Just Culture can be defined as a culture that recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms, such as shortcuts or routine rule violations – but has zero tolerance for reckless behavior.

In 2009, the Missouri Ambulance Association and the Missouri Center for Patient Safety embarked upon a partnership to bring the state's EMS industry under the protective umbrella of its Patient Safety Organization. The goal for this partnership was to achieve peer review protection for EMS quality improvement activities and to create a culture of open reporting of adverse event data. Bolstered by a grant received from the Missouri Foundation for Health, a group of EMS professionals from across the state, along with staff from the Missouri Center for Patient Safety, began developing the tools necessary to collect this data.

The group acknowledged that the current culture in EMS was not conducive to open reporting. Historically, EMS professionals had been punished for making mistakes. We chose to partner with Outcome Ingenuity, the creators of the Just Culture program, as our avenue to address our culture issues and create the open reporting environment necessary to enhance safety in EMS.

Systems, not outcome, evaluated

The Just Culture program focuses on managing risk by evaluating the systems – policies, procedures, protocols – designed to produce an outcome, and not on the outcome itself. It instead focuses on the behavioral choices of the people that function within the systems. We realize that humans are imperfect and as such will make mistakes. Yet, when a mistake results in an adverse event, our tendency is to punish the behavior; the worse the outcome, the worse the punishment. In so doing, we drive the individuals to hide or cover up the behaviors that resulted in the event. In short, we only learn of the events when they cannot be hidden.

In the Just Culture program, behaviors are separated into three categories: 1. "human error"; 2. "at risk behavior"; and 3. "reckless behavior". We console the "human error", we coach the "at risk behavior" and we punish the "reckless behavior". This creates a foundation of consistency for the evaluation of human behaviors and instills a sense of confidence in the individuals who are involved with the behaviors. This in turn makes it more likely that they will "raise their hand" and notify us when mistakes occur. Since mistakes do not always result in an adverse event, acknowledgement of a mistake allows us to take action before an event occurs.

A culture of learning

Consider the crew who inadvertently runs a red light. If there is no accident, and no ticket issued for the infraction, do you learn from the behavior? Do you even find out about the event? If not, you are prevented from evaluating the systems to determine ways to prevent the distraction that resulted in the outcome of running the red light. If it happened once, it will happen again - perhaps with a much different outcome. Through the principles of the Just Culture, we gain knowledge from these behaviors, educating us on areas of risk and enabling us to enhance the safety of the environment in which our staff and patients reside. Instead of a culture of punishment, we create a culture of learning.

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Our hospital-based EMS system employs nearly 200 field and dispatch staff and has recently begun the Just Culture training at the staff level. We have found our staff to be very responsive to the Just Culture principles. Already, they have assisted us in identifying behaviors and system flaws that have allowed us to enhance safety within our service.

To date, we have trained more than 250 leaders in the EMS industry in Missouri and in some services outside of Missouri, and are beginning to push the training to staff in other areas. Our efforts to engage practitioners in the changing of our culture will ultimately result in a safer EMS system and will help drive better outcomes for our patients.

It is truly a pleasure to share our experiences here in Missouri with the rest of the nation. Our hope is that you, too, will consider the impact of the Just Culture within your service and state, and join us as we work to make EMS a safer place for our staff and our patients.

Mark Alexander has been director of CoxHealth EMS since 1987, and received his certification as an instructor of Just Culture in June 2011. He currently serves as the vice chair of the Missouri Emergency Service Agent Corporation, (MoEMSAC) that administers the EMS FRA program for Missouri. Alexander previously was the director of Webster County Ambulance and a field paramedic. He was appointed to the State Advisory Council on EMS in 1996 and currently serves as its Legislative Committee Chair. He is a past president and board member of the Missouri Ambulance Association, and is past president of the SW Missouri Critical Incident Response Team.