New Jersey Emergency Medical Services “Just Culture” Environment Guidelines:

Applicability:

All New Jersey Emergency Medical Services (EMS) and EMS Education Agencies, including but not limited to, licensed, non-licensed, non-affiliated, volunteer, municipal, fire, first aid, first responder, rescue, hospital, corporate and private agencies and/or their agents.

Policy:

All EMS agencies shall develop and maintain a verifiable “Just Culture” environment.

Background:

The New Jersey Office of Emergency Medical Services (NJOEMS) has recognized that EMS personnel are at approximately 250% higher risk of injury and death than average workers. These rates are similar to, and sometimes greater than, law enforcement and fire personnel.

EMS personnel are confronted on a daily basis with a diverse, difficult, and ambiguous work environment, which demands dedication, regular training and a focus on providing accurate and critical lifesaving emergency medical services. Personnel, along with the EMS agencies that employ them, must recognize the potential for medical errors during the provision of emergency medical services, and appreciate the subsequent learning opportunities that are created when these errors are appropriately analyzed and managed.

Statement:

The term “Just Culture” refers to a values-supportive system of shared accountability where health care organizations are accountable for the systems they have designed and for responding to the behaviors of their staff in a fair and just manner. In turn, individuals are accountable for the quality of their choices and for reporting their errors and system vulnerabilities, thereby changing attitudes and supporting a culture of safety in New Jersey EMS.

The NJOEMS has determined that a focused effort, which includes the establishment of a “Just Culture” environment within all EMS agencies, is necessary to reduce and combat the risks to our patients, providers, and the public at large.
Discussion:

A "Just Culture" environment provides benefits for patients, EMS personnel, EMS agencies, and the public at large:

**Patients:** When errors are recognized and not hidden through fear of punishment, a "Just Culture" environment allows individuals and organizations to learn from these errors. This promotes improved services and higher standards of patient care which in turn leads to a safer system for both patients and personnel.

**Personnel:** EMS agencies, healthcare systems, and regulators learn how to improve the quality of care and minimize the impact of human error and undesirable behavioral choices. The establishment of a "Just Culture" environment provides shared accountability that is neither punitive nor blame-free.

**EMS Agencies:** By creating a "Just Culture" environment prevention is emphasized, errors and failures are identified and managed effectively. EMS agencies should have an objective framework for a fair and constructive response to human errors, behavioral choices, and adverse events.

**Public at Large:** It is expected that implementing "Just Culture" initiatives will result in improvements to the safety of the public at large.

Vital elements important to the successful implementation of a "Just Culture" environment may include, but are not limited to:

- Instilling a deep understanding that the safety and health of the provider, patient, and public is critical in EMS work.
- Managing risk by evaluating the systems – Policies, Procedures, Protocols – designed to produce a positive outcome, and not on the outcome itself. It also addresses the behavioral choices of the personnel that function within the system. It recognizes:
  - Errors may occur.
  - When an adverse event occurs, the tendency is to punish the provider rather than examine the root cause. This encourages providers to under-report the behaviors that resulted in the event.
  - Consistent and objective evaluation of behaviors instills a sense of confidence in the providers and organizations that are involved. This will encourage increased reporting.
  - Organizational responses to systemic behaviors are separated into three categories:
    - Consoling "human error"
    - Coaching "at risk behavior"
    - Punishing "reckless behavior"
- Since errors do not always result in an adverse event, identification and acknowledgement allows organizations to take corrective action.
Definitions:

**Human error:** Human errors are inadvertent actions in which there is general agreement that the individual should have done something other than what he or she did, and the action(s) inadvertently caused (or could have caused) an undesirable outcome. e.g.: *Medication error*

**At-risk behavior:** At-risk behaviors are situations in which an individual makes a choice to engage in a behavior out of a belief the risk is insignificant, or the behavior is otherwise justified. e.g.: *Not wearing seatbelt*

**Reckless behavior:** Reckless behaviors are behavioral choices to consciously disregard a substantial and unjustifiable risk. e.g.: *Running red traffic lights*

References:

B. NAEMT Position Statement “Just Culture” in EMS
E. To Err is Human: Building a Safer Health System (2000), Institute of Medicine (IOM)
F. TeamSTEPPS™. Teamstepps.ahrq.gov
H. National EMS Culture of Safety Project; www.emscultureofsafty.org

Adopted by the New Jersey EMS Council on **September 9, 2015**

H. Mickey McCabe, Chair