Northwest Community EMS System

EMS RFC / Complaint Investigation form

Confidential under the Medical Studies Act. All information contained in or relating to any medical audit performed by the EMS MD (or his designee) or care rendered by System personnel, shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure. Disclosure of such information to IDPH shall not be considered to be a violation of that Code. Please make the following notation on all Requests for Clarification (RFCs), Run Feedback Forms or notes, CE classes using a case-study format, and/or coaching notes:
PRIVILEGED AND CONFIDENTIAL - PEER REVIEW DOCUMENT - PATIENT SAFETY WORK PRODUCT. Protected under the Patient Safety and Quality Improvement Act. Do not disclose unless authorized by the NWC EMSS EMS MD or his designee.

"This report is not part of any patient's permanent medical record. All information provided, including any a*ppended materials, is furnished as a report of quality management and is privileged and confidential, to be used solely in the course of internal quality control for the purpose of reducing morbidity and mortality and improving the quality of patient care in accordance with Illinois Law (735ILCS 5/8-2004 et seq)."*

Do NOT file or store QI-related notes or documentation near or with the PCRs to avoid inadvertent disclosure

General principles: The NWC EMSS takes all allegations of unsatisfactory performance, nonconformities to EMS practice standards and/or EMS-related complaints seriously and is committed to facilitating speedy and satisfactory resolutions in the interests of excellent patient care and maintaining a professional working and education environment.

System leaders, members, students, and authorized representatives involved in EMS-related RFC/complaint investigations will be guided by the principles of a Just Culture and the requirements of relevant legislation, rules, standards, and EMS policies in dealing with EMS-related complaints or alleged performance gaps/wrongdoing. It is desirable that all alleged performance nonconformities/complaints are resolved at the earliest possible time via the steps outlined in the System Quality Assessment and Performance Improvement Plan and policies D-1 Due Process: Corrective coaching/ Disciplinary Action and G1 Grievance Recourse STEP 1: Request for Clarification (RFC); complaint investigation

Investigation Steps:

1. Alert the EMS MD, EMS Administrative Director, and others per policy if this is a reportable incident (Policy R-7)
2. Define the nature of the incident: Gather all known facts, review relevant evidence; interview parties involved
3. Identify and note National/State/System standards of practice relevant to the situation
4. Use this form to document findings, conclusions, & recommendations
5. Conduct a meeting and obtain signatures from those involved and agency leadership
6. Forward the completed form to the EMS MD and EMS Administrative Director for final review and determination

Date of occurrence:	Time of occurrence:	Location :
Date of discovery:	Time of discovery	Means of discovery: (email; QI review; complaint filed)
EMS Agency	Incident #:	OLMC hospital:

EMS Agency/Hospital	EMS/hospital personnel involved (print names)	EMS License #

Nature of the problem/concern/description of the alleged infraction/complaint:

Person filing the complaint/requesting the review (contact info)	Date filed

Key Performance Area(s) being reviewed		
☐ Accountability	☐ Ethical issue/concern	☐ Respect | empathy | cultural competence
☐ Appearance and personal hygiene	☐ Fitness for duty	☐ Safety issue/concern
☐ Assessment (patient, situation)	☐ Follow up/follow through	☐ Self-motivation
☐ Competent delivery of service	☐ Integrity	☐ Self-confidence
☐ Communication (team/OLMC)	☐ Knowledge; judgment	☐ Supervision (OLMC/students)
☐ Conformity to standards	☐ Legal issue/concern	☐ Technique/skill proficiency
☐ Critical thinking/problem solving	☐ Patient advocacy	☐ Time mgt; response, interventions, care
☐ Documentation	☐ Prioritization & delegation	☐ Teamwork & diplomacy
(Other: Please explain)		

Findings of the investigation: What happened?

What policy(ies), procedure(s), or standards apply?

Findings of a root cause analysis: Why did this happen? What factor may have contributed to the person's actions?

Is this allegation isolated or does it reflect a pattern of behavior?

Date and time of meeting | persons present:

Just culture considerations - General category of alleged behavior violation:

☐ **Duty to avoid causing an unjustifiable risk or harm**: "Don't do" or "Never event" allegations
☐ **Duty to follow procedural rule(s)**
☐ **Duty to produce an expected outcome**: "Expected behavior and by when" violation

Yes	No	Considerations
		Was the duty known to the individual?
		Was it possible to produce the duty?
		Was the act inconsistent with program values or standards?
		Did the behavior cause a substantial and unjustifiable risk of harm for the safety of the clinician/others?
		Did the individual believe their act or omission was justified or insignificant?
		Is the behavior culturally normalized within the context in which it occurred?
		Were there explainable causes of the behavior?
		Can the person be reasonably and appropriately helped?

Notes:

Summary determinations for patient-related QI review

1.	**Patient Outcome** (quality of life/ functional status impairments)	**2.**	**Effect on patient care**
	No adverse outcome		Care not affected
	Minor adverse outcome (complete recovery expected)		Increased monitoring/observation required
	Major adverse outcome (complete recovery expected)		Treatments/interventions in ED (ADV airway, IVF, reversal agents)
	Major adverse outcome (pt. lived/complete recovery NOT expected)		Treatments/interventions as inpatient
	Patient did not survive		Other:
3.	**Documentation**	**4.**	**Communication**
	Documentation meets System standards		Communication complete, timely, meets System standards
	Documentation does not substantiate clinical course, treatment, and/or decisions made		Communication timely, incomplete understanding between sender and receiver of messages
	Documentation not timely to communicate with other caregivers		Communication not timely and/or complete and inconsistent with System standards
	Other:		Other

Outcome determination

☐ **Non-sustained/no action**: Evidence was insufficient to either prove or disprove the complaint.
☐ **Sustained/valid:** Complaint was supported by sufficient evidence to justify corrective coaching/disciplinary action. Determine nature of error below.
☐ **Unfounded/Not involved**: The facts revealed did not support the complaint (e.g., the complained-of conduct did not occur or the accused individual was not involved).
☐ **Exonerated**: The alleged conduct occurred, but based on facts and circumstances considered, the individual's actions were deemed proper, within guidelines, or acceptable.

If sustained: Nature of error determination (check one)

☐ **Human error**: Unintentional mistake; requires education/remediation plan

☐ **At-risk behavior**: Individuals knew or should have known that behavior could risk safety. Requires remediation & corrective coaching.

☐ **Reckless behavior**/willful defiance: conscious disregard for a substantial and unjustifiable risk. Disciplinary action warranted.

If sustained: Level of action recommended (check one)

☐ **Verbal counseling/warning, education, and remediation plan**
☐ **Written warning with corrective coaching/performance improvement plan:** If the violation does not warrant suspension, design a corrective action plan that requires education, remediation, expectation of immediate/sustained performance improvement, and ongoing assessment, monitoring, and evaluation.
☐ **Final written warning:** May include restriction of practice privileges and/or a suspension recommendation, with the warning that failure to immediately exercise appropriate and sustained appropriate judgments and behaviors or prohibited behaviors that persist and/or are repeated will result in serious consequences that may include, but not be limited to, withdrawal of System privileges and/or separation from the program.
☐ Recommendation to IDPH to **take action on the individual's EMS license**

Action plan: Education, remediation, disciplinary action; expected changes in behavior / desired outcomes / how performance will be assessed/measured / compliance date

Consequences if behavior is repeated or plan is not successfully completed

List suggested policy/procedure/form/engineering control revisions. How can process improvements prevent similar situations from happening again?

Rebuttal statement if desired

Findings communicated: To whom: When and how:
Date:
Primary investigator(s):

Affirmations:

Each signature below signifies that the above findings have been reviewed and understood.

PRINT NAME | Signatures Date

Personnel involved

Personnel involved

Personnel involved

Personnel involved

Agency Leadership

Hospital EMS Coordinator/Educator conducting the discovery investigation

Forward the completed form to the EMS System Administrative Director with copies of the blinded PCR and Communication Log (if patient-related) and any other documents important to the investigation/outcome results

☐ I agree with the findings, recommendations, and outcome conclusions
☐ I recommend the following modifications/additions:

Matthew T. Jordan, MD, FACEP | NWC EMSS Medical Director

Notes of intent:

Even the most educated and careful individuals will learn to master dangerous shortcuts and engage in at-risk behaviors when the rewards for risk-taking are more immediate and positive than the potential for harm, which is remote and very unlikely.

These intentional and unsafe practice habits emerge in a culture where there is a normalization of deviance AND tolerance of at-risk behaviors. This type of culture is evident when there are more positive rewards (e.g., time-saving, high regard of colleagues) than negative rewards (e.g., patient harm or disciplinary action) for at-risk behaviors. Look deeper than the overt behavior to find the real contributing causes.