OMD Clinical Administrative Policy
Clinical Errors Event Reporting

Approved 3/8/2017,
Effective 5/8/2017; replaces 9/14/2011 & all prior versions
Review Before 3/2019

Reportable Event Review:

The purpose of an Office of the Medical Director (OMD) Event Review is to determine the facts surrounding reported concern(s) and direct change to avoid similar occurrences. In situations involving clinically oriented errors, actions will be directed with a goal to minimize and/or prevent reoccurrence of similar errors.

A major force for the improvement of patient safety is the intrinsic motivation of all Credentialed Providers to report clinically related errors. It is our system's collective responsibility to decrease the risk of medical service related errors. The OMD will facilitate a lead role in the Reportable Event Review, including systemic data collection in its review of incidents of concern(s).

Reportable Event Review – OMD Notification:

Any clinically oriented concern(s) formally conveyed by a patient, patient's family, incident involved citizen and/or healthcare provider should be forwarded to the OMD as indicated below. The classification listing that follows, while indicative of numerous examples is not an all-inclusive or exhaustive list of events expected to be reported to the OMD.

Class 1 Event: reported to the OMD Division Director as soon as the preliminary concern(s) or event(s) is known. This class of events includes, but is not limited to, the following examples:

- Unrecognized esophageal intubation;
- Failure to attach ETCO2 to evaluate and monitor endotracheal tube position.
- Unsynchronized cardioversion for pulsatile ventricular or supraventricular tachycardia.
- Medication error with related harm to the patient;
- High profile emergency medical events, such as:
    - Significant injury or illness of an elected official, public safety staff, or high profile community member;
    - Any significant injury related to a law enforcement activity;
    - Mass casualty incident(s)
- Inability to provide a critical and indicated intervention due to device failure. Examples include, but are not limited to:
    - Defibrillator failure;
- Patient respiratory or cardiac arrest occurs immediately following an invasive care intervention or restraint (either EMS or law enforcement-placed);
- Any potentially decredentialing issues.
    - Intentionally verbally or physically harming a patient. This specifically excludes harm that could result when acting in self-defense in avoidance of being assaulted by a patient.
    - Providing patient care while intoxicated with alcohol or under the influence of illicit substances; (examples: cocaine, marijuana, heroin, etc.).
    - Intentionally falsifying a patient care record or clinically - related document utilized in our EMS system;
    - Intentionally falsifying written or verbal statements made in the course of clinical care reviews conducted by the Office of the Medical Director
    - Theft, misappropriation, or personal usage of any controlled substance.

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Class 2 Event: reported to the OMD Division Director within 24-hours and during normal business hours (0800-1700). This class of events includes, but is not limited to, the following examples:

- An inappropriate deviation from an apparatus/unit activation protocol with clinical detriment;
- Provider practicing beyond authorized System Credential level;
- Medication error;
- Any controlled substance variance;
- ED Physician Director or Hospital Administrator Complaint/Concern/Conflict regarding clinical care;
- Transport to an inappropriate receiving facility;
- Hospital refuses a patient who is appropriate for that facility.

Class 3 Event: Reported to the OMD on a monthly basis as part of the System Provider Organization's CQI reporting requirements. This category of events includes:

- Cricothyrotomy;
- Needle decompression;
- Disarming of ICD with magnet;
- Use of Tourniquet(s);
- Untimely capnography attachment/initiation (with inclusion of etiology and intubating personnel) of:
  - Greater than 60 seconds;
  - Greater than 120 seconds (provide actual timing).
- EMD address entry error by call taker with 5 minute or greater delay for priority 1 emergency calls;
- Use of a non-system resource (mutual aid) by type of use: response, scene care, and/or transport and by call prioritization (1, 2, or 3)

Reporting an event to OMD

1. The responsibility for notification of appropriate System Provider Organization administration personnel, both in timeliness and completeness and as specified by the respective System Provider Organization standard operating guidelines, rests with the involved providers.
2. Notification numbers for the Office of the Medical Director (call until direct contact made):
   - Western Division
     - First Call, David Howerton: (405) 520-0711
     - Second Call, Duffy McAnallen: (918) 830-4478
     - Third Call, Curtis Knoles, MD (405) 514-4877
     - Fourth Call, Jeff Goodloe, MD (918) 704-3164

   - Eastern Division
     - First Call, Duffy McAnallen: (918) 830-4478
     - Second Call, David Howerton: (405) 520-0711
     - Third Call, Curtis Knoles, MD (405) 514-4877
     - Fourth Call, Jeff Goodloe, MD (918) 704-3164

3. The notification to the OMD should include the following information:
    a. Name and organization of the reporting person; and
    b. A brief description of the event; and
    c. A summary of the primary concerns and specific information available to date.

Reportable Event Review – OMD Process:

1. System provider(s) involved in incidents with an active reportable event review initiated may have Medical Control Board/OMD clinical credentials temporarily restricted or withdrawn pending detailed event review until reinstated with approval by the Medical Director (or designee within the Medical Control Board or the OMD). The purpose of temporarily restricting or withdrawing clinical credentials pending event review resolution is to provide a safety mechanism for both patient(s) and involved provider(s) until clinically-related facts are definitively ascertained.
2. The decision to institute a temporary clinical credential status change will be made by the OMD within two (2) hours of receiving the reportable event review notification. When circumstances are involved that prevent adequate initial review within the two (2) hour timeframe, temporary clinical credential status change decision(s) will be based in the best interest of patient and provider safety. Temporary clinical credential status change in these situations does not automatically assume provider error. This process is similar in philosophy to widespread, long-standing law enforcement organizational process reviews for officer-involved shootings.
3. The System Provider Organization will notify the OMD of their Primary Reviewer assigned to the Event.
4. The Office of the Medical Director will conduct the review as indicated by the specific events/concerns with assistance from the appropriate System Provider Organization's clinical / operational personnel. A review will typically necessitate an incident report be completed by personnel determined by the OMD Director and/or Medical Director.
5. Preparation of Incident Reports
   The purpose of writing an Incident Report is to provide a factually-based description of event. Like a prologue, incident reports provide the "who", the "what", the "when", the "where", and the "why".

   There is no room in an incident report abstract for subjective or personal editorial comments. Make every attempt to simply describe the event(s), without labeling or negative characterizations, and record exact quotes or paraphrases as precisely as possible. Incident reports should not be written to embarrass or punish anyone or to implicate an individual(s) of wrongdoing. Incident report should contain, at minimum:

   Reporter's name,
   Date of incident,
   Incident number
   Time(s) of incident
   Location of incident
   Events of incident
   Incident reports must be signed and dated by the author.

Reportable Event Review – OMD Resolution:

1. The OMD will resolve a reportable event review in one or more of the following determinations:

   No clinically-related error/care within Medical Control Board standards
   Clinically-related error – no patient impact – no further education/remediation
   Clinically-related error – no patient impact – further education/remediation
   Clinically-related error – mild patient impact – no further education/remediation
   Clinically-related error – mild patient impact – further education/remediation
   Clinically-related error – moderate patient impact – no further education/remediation
   Clinically-related error – moderate patient impact – further education/remediation
   Clinically-related error – major patient impact – no further education/remediation
   Clinically-related error – major patient impact – further education/remediation
   No lapse in professional behavior of potential clinical impact
   Lapse in professional behavior of potential clinical impact

2. Current and future clinical credentialing status linked to specific reportable event reviews will be determined by the Medical Director and is in addition to the determinations above.
3. In situations involving the OMD prescribing further education/remediation, appropriate CQI and/or educational personnel within the respective System Provider Organization will file a written report with OMD at the conclusion of the provision of the indicated education/remediation to include at minimum:
   a. Date(s) and time(s) of education/remediation
   b. Instructional personnel involved
   c. Content of education/remediation
   d. Performance evaluation of knowledge/skills remediated
   e. Definitive recommendations for personnel status
      i. Clearance to resume usual and customary clinical privileges
      ii. Further education/remediation warranted (with specific content)
      iii. Discontinuance of clinical credentials at previous provider level
      iv. Discontinuance of any clinical credentials

Reportable Event Review – OMD Information Management:

1. All communications relating to reportable event reviews filed with and generated by the OMD will be placed in CQI-privileged access information files, kept within the OMD and access to be limited to control by Medical Control Board physicians and OMD personnel.
2. Upon completion of the reportable event review a summary of findings may be (with the approval of the Medical Director) provided to the appropriate designated EMSA compliance officer.