

THE CARE FRAMEWORK

ADVANCING JUST CULTURE IN PREHOSPITAL EMERGENCY MEDICAL SERVICES

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The Problem: A safety event is only the beginning

A clinical gap is identified  What happened?  Why did it happen?

- Prehospital decisions occur in dynamic, unpredictable environments.
- Clinical gaps may be influenced by human, clinical, environmental and system factors.
- A punitive response alone may reduce openness and limit organisational learning.
- The response needs to be proportionate to the behaviour and contributing factors.

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Just Culture: learning and accountability are not opposites



LEARNING

+

ACCOUNTABILITY

The key question is not simply:
“Was the action correct or incorrect?”

It is:

“Why did the action occur?”

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A structured clinical discussion process balancing psychological safety, learning and professional accountability.

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C – Case Walkthrough

Start with the practitioner's story

“Tell us what happened?”

- Agreed ground rules establish an open and respectful environment.
- The practitioner provides a chronological account of the event.
- The walkthrough may begin at dispatch or arrival on scene and progress through assessment, treatment, transport and handover.
- The practitioner explains the sequence in their own words before structured probing begins.
- This helps the review team understand the information available and the reasoning at the time.

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A – Analysis

Move from the event to the contributing factors

WHAT HAPPENED?

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WHY DID IT HAPPEN?

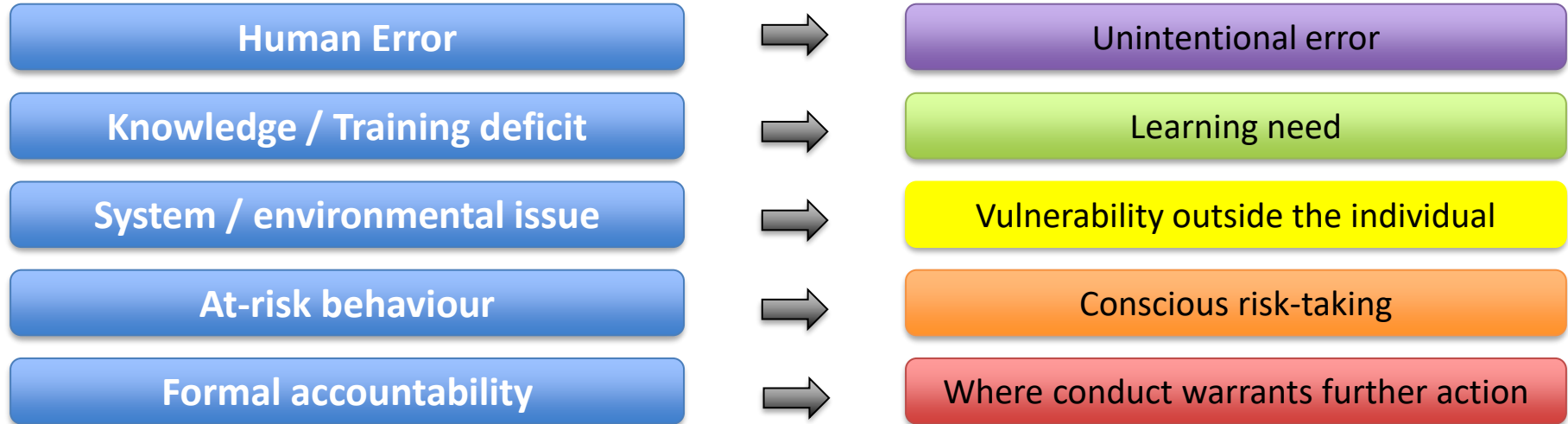
- Assessment findings and clinical reasoning
- Decision-making and guideline knowledge/interpretation
- Communication and documentation
- Workload, environment and available resources
- Practitioner experience and human factors
- System and operational influences

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R – Reflection

Understand the behaviour before deciding the response

Not every clinical error represents the same type of behaviour.



The organisational response should be proportionate to the behaviour and contributing factors.

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E - Education

Turn learning into action

Clinical Coaching

Targeted Training

Internal memoranda

Policy development / revision

Patient Safety Alerts

Process Improvement

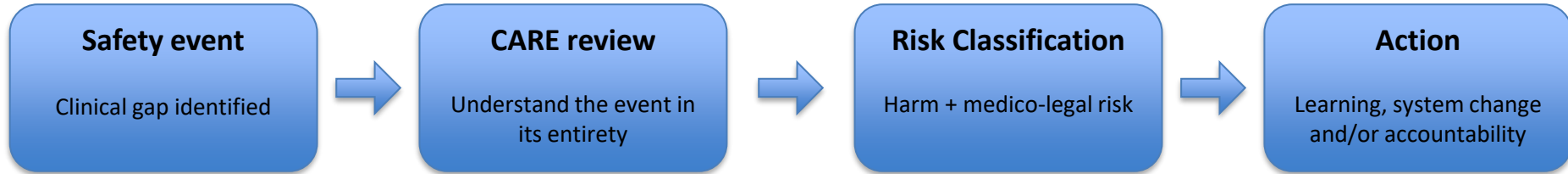
Formal disciplinary action where indicated

Education does not replace accountability

It ensures that identified gaps become opportunities for practitioner and organisational learning.

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A clinical governance pathway



Harm classification

No harm | Low | Moderate | Severe | Death

Medico-legal risk

Low risk | High Risk

Outcome severity is considered alongside behaviour and contributing factors;
it is not the **sole determinant** of accountability.

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Implementation: 39 CARE discussions

10

2024

19

2025

10*

2026

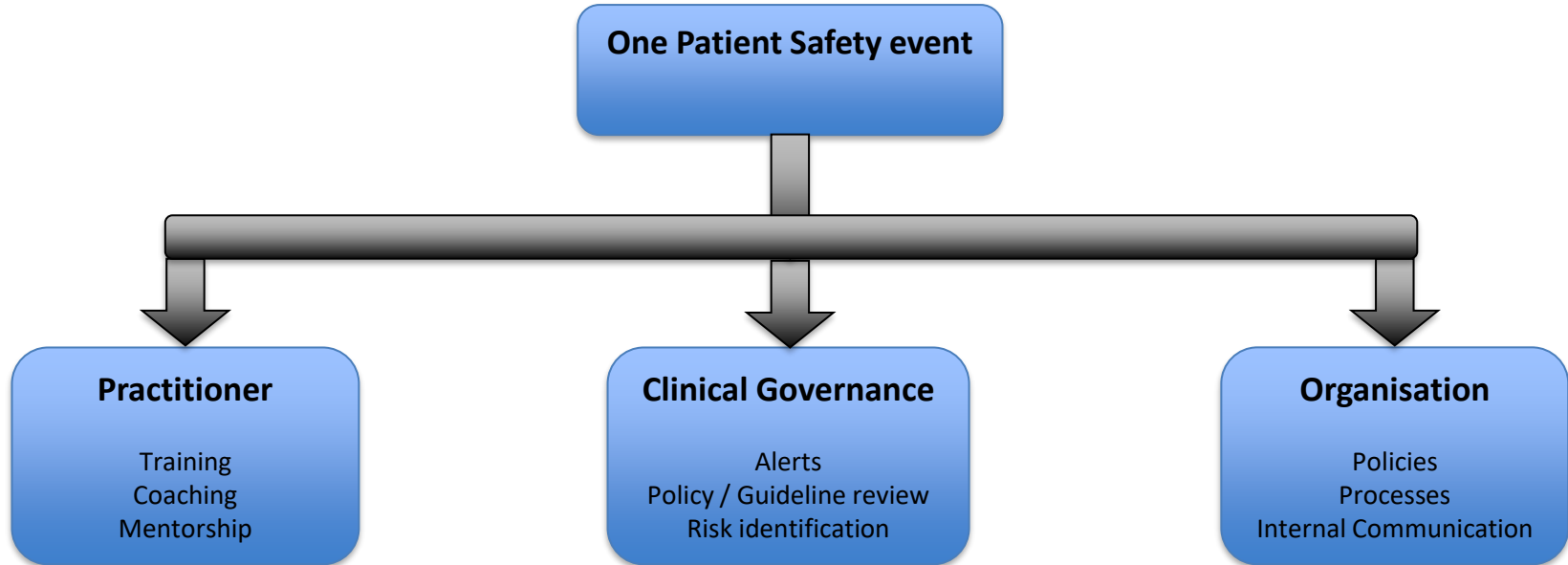
First **CARE** discussion: 4 April 2024

- 39 clinical discussions from 4 April 2024 to 24 August 2026.
- Reviews created a consistent mechanism for exploring clinical, behavioural, human and system factors.
- Observed implementation outcomes included improved practitioner engagement and identification of educational requirements, behavioural trends and system vulnerabilities.

*2026 figures through 24 August 2026

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From individual events to organizational learning



Examples from implementation included clinical short courses (example: BLS for HCP), specific training requirements, conflict management, policy changes, Patient Safety Alerts, internal memoranda and disciplinary processes where indicated.

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Limitations and next steps



- Current evaluation is descriptive implementation experience rather than a controlled research study.
- No baseline dataset was established for formal comparison.
- Practitioner engagement, psychological safety and perceived fairness have not been measured systematically.
- Repeat-event data are not currently available to assess recurrence.
- Intervention volume by event category and time to corrective action have not been formally analysed.

Future evaluation

Practitioner experience | Psychological safety | Intervention uptake | Corrective-action completion | Recurrence | Patient safety indicators

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The shift CARE is designed to create

From

“Who was responsible?”



Towards

“What happened, why did it happen,
and what can we do differently?”

CARE provides a structured approach to embedding Just Culture
within prehospital EMS clinical governance.

Learning | Accountability | Organisational learning | Patient safety

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Selected references



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THANK YOU