Prehospital Care Administration – Second Edition
Case Study Answers

Some of these questions have no clear cut right or wrong answers and are designed to stimulate the reader's thought processes. The suggested answers provided are not meant to be inclusive. The instructor should evaluate the reasonability of the answer and the support for the position.

Case One Questions

1. What policies are in place, or missing, within your organization that might have changed the outcome of this situation?
    - Automated attendance monitoring.
    - Random drug testing.
    - Employee Assistance Program

2. Why didn't management know that Bob was chronically tardy instead of relying on crews to report an infraction? What systems or approaches could be employed to ensure supervisor awareness?
    - Supervisors are provided copies of attendance report summary.
    - Supervisory charting or logging of interactions with staff.

3. What actions, if any, should have been taken against the crew who suspected narcotics were missing but failed to report their suspicions?
    - Discussion with the crew to reemphasize the importance of sharing observations in a timely manner to avoid a negative outcome for the service and employee.

4. Was the supervisor's comment to the head nurse about Bob's personal life "out of bounds"? If not, why not? If so, how could the situation have been handled differently?
    - The non-specific reference was not out of bounds in the confines of an investigation which the head nurse had already initiated.

5. Could the supervisor have limited discussion of the incident by asking the crew members to write the incident report while on duty instead of calling them at home?
    - Asking them to come in or to write the report while on duty is preferable to calling them at home and requesting a report. This would have limited the "cross talk" between crew members. Crew members should be instructed that in accordance with policy an internal investigation cannot be discussed with others.

6. What course of action would you have taken to explain your actions to your director? The hospital administrator? The press?

   - Followed procedure with a mandatory referral to the EAP.
   - The hospital administrator would have been briefed based about the service's action based upon their internal investigation.
   - Upon direct inquiry, the press would be advised that the matter was handled in accordance with the service's personnel guidelines and that as a matter of policy further comment cannot be made.

7. What was one ethical dilemma the supervisor faced in deciding a course of action?

   - Was there evidence a crime had been committed?
   - The supervisor was torn between his personal feelings and professional obligations.

8. Had Bob not "volunteered" his story, were there enough grounds to terminate him? What are the due process issues involved in this case?

   - If the hospital determined that there was not evidence to create a criminal complaint, there may not have been adequate grounds for termination. While the employee's affair was bad judgment, that and the tardiness incidents alone may not have provided sufficient grounds for a termination. This depends on the personnel policies and the employee's previous exemplary record.
   - Due process issues are dependent upon the laws of the state in which the incident occurred, the personnel policies and the past practices of the service.

Case Two Questions

1. What was the total response time (as measured from call receipt to unit arrival) for the incident?
    - Patient/Family, staff member, company and system
    - Issues include inadequate internal procedures

2. What was the interval between call receipt and arrival at hospital?
    - 22 minutes

3. What portion of the delayed response can be attributed to the dispatch call processing time? Why is this important?
    - Call processing time is unmeasured.

4. What alternate action could the medic have taken upon discovering the key was missing?
    - Broken the lock rather than wait for back-up

5. How was the medic's patient report deficient?
    - Times don't add.
    - No mention of difficulty finding address or reasons
    - No mention of lost key or documenting time delay

6. What action should the supervisor have taken at the hospital?
    - Required written incident report

7. What can you discern about the company's internal QI processes from this incident?
    - Not well defined. Inadequate

8. What other ways did the EMS *system* (beyond the field providers and ambulance service fail this family?
    - Non-mandatory reporting to Regional Councils

9. What specifically did the medic's deposition reveal?
    - Patient Care Record did not reflect reality. (e.g. could not validate the times medications were given)

10. How could the state's efforts to investigate this incident be described?

    - Bureaucratic response to cover themselves. Not timely.

11. What specific action was taken against the medic by the company? By the state?

    - No action was taken by the company. The medic received a letter of deficiency from the State

12. List the specific changes that should be implemented to reduce the probability of a similar incident occurring?

    - Improved double signed checklist to ensure key transfer.
    - Dispatch mapping systems.
    - Requesting law enforcement help locating address when lost.
    - Better procedures and supervisory training
    - Appropriate documentation and investigative processes
    - Required self disclosure of incidents

Case Three Questions

1. What are the issues to be considered?
   - Clinical, Operational, and Financial.

2. What operational and financial rationale for making or not making this move would you develop?
   - The responses should discuss the perceived advantages and disadvantages of the move. Clinical implications of not continuing to use MPDS should be mentioned. Operational considerations could include changes to response determinants and how day to day oversight will occur. Financial rationale should include a detailed financial assessment including costs and savings of personnel and technology.

3. Where in the city structure would you look to support for your position?
   - Medical Director, Chief and Public Safety Committee of Council.

4. What are the total savings if all five jurisdictions consolidate to one facility?
   - Annual operating difference in current year dollars is $4,504,998.
   - One time capital costs to equip all five centers is $8,882,300 compared to $2,678,300 for one center. The difference in one time (capital) costs is $6,204,000.

5. What can you ascertain about the staffing methodology from the anticipated benefits costs?
   - Given that benefits are less than 25% it is highly likely that communications personnel are civilian rather than sworn personnel.

6. What are the specific reasons that there will be a 41.83 full time equivalent (FTE) position savings in the consolidation?
   - Better utilization and workload management.

7. Are you still supportive of the consolidation?
   - The student response should clearly articulate their rationale.

8. What should your actions be at this point?
   - If this is in the best interest of the division, the personal concerns should be secondary.

Case Four Questions

1. What are the issues and different perspectives in this case?

   - Issues include appropriate procedures, insensitivity of the medics in discussing this in a loud and non-respectful manner. The nurse used poor communications skills when responding to the family member's questions.

2. How can the service's management team deal with Mrs. Jones' complaint? How can this be done in manner that helps Mrs. Jones deal with her grief and her feelings that the ambulance staff has betrayed her trust?

   - Timing is important. If this is brought to the service's attention before the funeral, communicating clearly that the matter is being investigated and arranging for a specific time to discuss the results of the investigation may avoid this becoming a major topic among family and friends.
   - Sharing preliminary results of your review indicating that the service had an excellent response time and that the first responders and crew did everything possible to resuscitate are important themes to communicate.

3. What are the other potential ramifications for the ambulance service? The hospital? The Medics?

   - Handled poorly the ramifications could include negative stories being told throughout the community, and even legal action against the physician, hospital and medics.

4. Should the EMTs involved be commended for their commitment to maintain clinical competency or reprimanded for their actions?

   - The medics were trying to maintain competency. However, practice without direct supervision was not appropriate. The fact that teeth were broken and were unreported means that someone was not truthful in this situation. Employee sensitivity given the situation was lacking.

5. How could the nurse have handled this differently? What would be the most positive way the ambulance service director could influence this?

   - The nurse could have immediately discussed this with the physician that technically was the EMT's clinical supervisor rather than commenting to a family member about intubation practice.
   - The most positive way to influence this is through an informal QI process meeting where the issue is discussed and a joint resolution to develop future policy is discussed.

6. Should a policy be written regarding procedure practice on the newly deceased? If so, what should it be?
    - Written policies should be in place. Any practice should be supervised by the authorizing physician and this practice should be disclosed in the consent procedures that are utilized by the hospital upon admission to the emergency department.

7. What other actions should be taken in this situation?
    - Physician, nurse and medics should be engaged in a dialogue about the customer issues from the family's perspective. No discipline action is required.

Case Five Questions

1. Describe the different ways a call screening system similar to the one used in Middleburg negatively impacts patient outcome.

    - Non-trained/certified communications personnel
    - Time delays occur
    - Multiple entry points
    - Little opportunity for meaningful QI

2. What system decision points in Figure 1 could be eliminated without changing the system?

    - Dispatch BLS ambulance resource simultaneously with call receipt to be canceled if ALS

3. What actions could you take to facilitate improvements with this system if you were the county administrator? A fire chief responsible for first responder? A private ambulance owner?

    - Convene key stakeholders. Brainstorm issues and opportunities for service improvement.

4. How is the medical director's authority limited in this system? What mechanisms could be employed to improve quality assurance processes?

    - Communications are not part of the current area responsibility. Legislative mandate is required.

5. Outline major litigation and risk management concerns regarding EMS operations as described in this case.

    - Potential for litigation is high given that multiple agencies are engaged in call receipt and dispatch decisions. Delays are inherent in this system design and need to be addresses.