Building a Culture of Safety in EMS

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Disclaimer:
The presenter does not have a significant financial relationship to report.

Overview

EMS in 2013

EMS is a practice of medicine

EMS in 2013

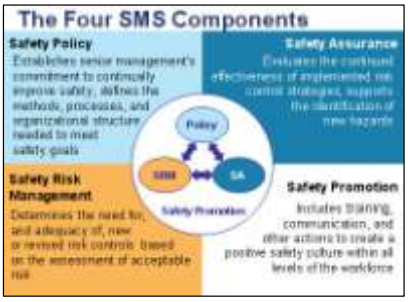
Triple Aim – Institute of Healthcare Improvement

Wrap everything you do in the Triple Aim

- Improve Health
- Improve Patient Experience
- Reduce Costs

Safety Management Systems

Safety Management Systems



Safety Management Systems

What are the components of your Safety Program?

Safety Management Systems

- Do Policies Change Behaviors?
- What motivates employees to “Choose to Act Safely”?
- DuPont – changed Safety Goal from “Zero Accidents” to “Choosing Zero”

Just Culture in EMS

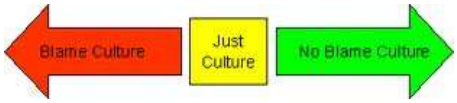
Just Culture

- Safety Culture refers to belief's/perceptions that employees have about the organization and safety of the workplace operations
- Organizations learn through knowledge of adverse events
- 300:29:1

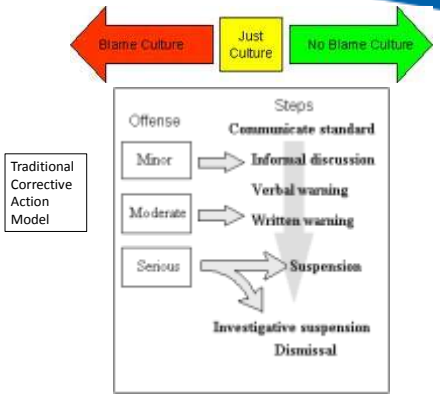
Just Culture

To Err is Human
To Drift is Human
Risk is EVERYWHERE
We Must Manage in Support of Our Values
We Are All Accountable

Just Culture



Just Culture



Just Culture

- Most systems literally prohibit human error.
  - Severity Bias: the more severe the outcome, the more blameworthy the actor.
- Discipline in response to honest mistakes does little to improve overall safety.
- Few will admit an error when they face the potential of full force policy, regulatory enforcement scheme or tort liability threats.

Just Culture

- Because of a punitive work environment:
  - Only 2% to 3% of errors are reported
  - Only report what cannot be concealed
- Single greatest impediment:

"WE PUNISH PEOPLE FOR MAKING MISTAKES"

Just Culture

What is clear:

- "Hospital employees recognize and report only one out of seven errors, accidents and other events that harm Medicare patients while they are hospitalized, federal investigators say in a new report.
- 90% of adverse events are unreported
- Yet even after hospitals investigate preventable injuries and infections that have been reported, they rarely change their practices to prevent repetition of the "adverse events," according to the study." OIG

Few will admit an error when they face the potential of policy enforcement, regulatory enforcement or liability threats.

Question	Agree	Disagree	Neutral
I am encouraged to report safety concerns	279	90	113
I have seen others make mistakes that had potential to harm patients	185	195	102
A confidential reporting system is helpful for improving patient/provider safety	344	32	96
I may hesitate to use a reporting system because I am concerned about being identified	206	178	88

Just Culture – The 4 Evils

Human Error:

General agreement that the person should have done other than what they did…and in the course inadvertently causes/could have caused an undesirable outcome.

Negligent Conduct:

More culpability than **human error**. Failure to exercise the skill, care and learning expected of a reasonable prudent person under similar circumstances.

Just Culture

Reckless Conduct: (aka Gross Negligence)

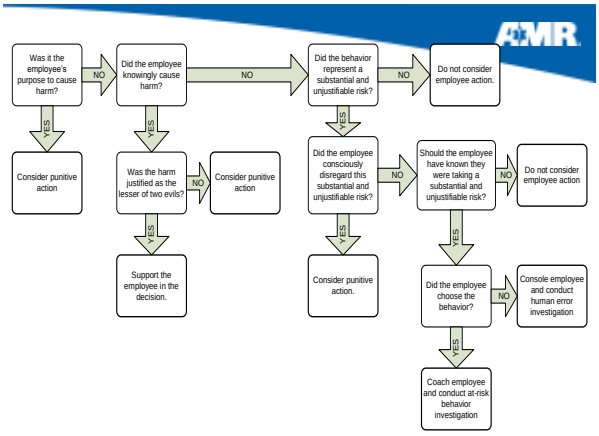
Negligence is the ***failure to recognize*** a risk that should have been recognized while recklessness is a ***conscious disregard*** of a visible, significant risk.

Intentional Rule Violation:

Shows that an individual knew of or intended to violate a rule, procedure, or duty in the course of performing a task.

Just Culture:

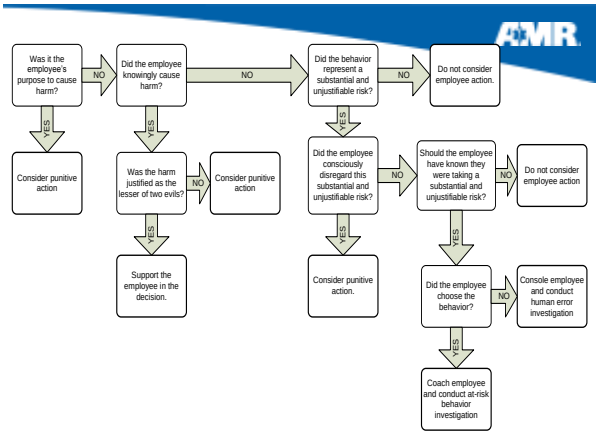
The Three Behaviors



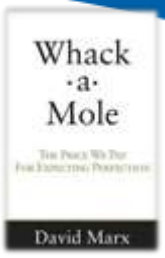
Just Culture

Example

A crewmember responding Code 3 to an emergent call was involved in an intersection collision. The Road Safety device indicates that he slowed to 4 MPH as he approached the intersection and then accelerated to 12 MPH when the collision occurred. He successfully completed EVOC 8 months ago when hired and has been counseled for attendance issues on two occasions. His IR stated – "I stopped at the intersection…I still feel anxious when driving Code 3". Policy requires a complete stop before taking a controlled intersection.



Just Culture



Create a Learning Culture
Create an Open and Fair Culture
Design Safe Systems
Manage Behavioral Choices

We need to "change" our culture.
In EMS, this begins with the LEADERSHIP TEAM

Safety Leadership

Safety Begins at the Top of an Organization

Who's at the Top?

- CEO/President
- VP/Op's Manager
- Supervisor
- Crew Member
- VST/Fleet
- Dispatch

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What is their role as a Leader?

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What is their role as a Leader?

Commitment
Example
Resources
Equipment
Materials

Engagement
Celebration
Monitoring
Goals/Expectations
Communication

Safety Means Employee Engagement

Who to Engage?

- CEO/President
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How do you engage these employees in Safety?

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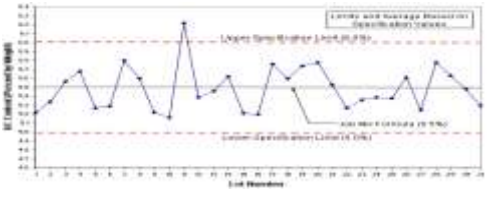
Commitment
Communication
Safe Choices
Ideas/Solutions
Health

How do you engage these employees in Safety?

Safety Includes Monitoring Results

- Results should be measured
- Enables goals for future achievement
- Establish Frequency
- Communicate/Publish
- Control Charts – may be better measures



Effectiveness of Safety Systems

	Program						
	Road Safety	Drive Cam	Power Pro Stretchers	Power Load	Safe Driving	Patient Safety	Safe Lifting
Mgmt Sponsor	Ops Mgr	Needed	Amstein	•	GM	CMO	
EE Engagement	Yes	15-Nov	Will	•	Sup'v	Pt Safety Committee	
Goal	Level 6	Review/ Feedback	35% reduction	o	0.32	Choice Zero	
Implementation	Yes	1-Dec	2012	o	Completed	Yes	
Communication	Coaching	Promote	Training	•	Awareness	All	
Monitoring	Each Friday	As needed	Comment Box	o	Monthly	Weekly Chart Review	
Results	Level 7	TBD	27%	o	.34 YTD	0.004	
Review/Update	Zoll Online	Annual	None	•	Nov	6 months	

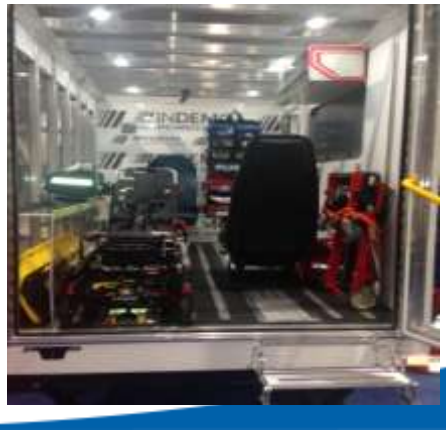
Safety Update

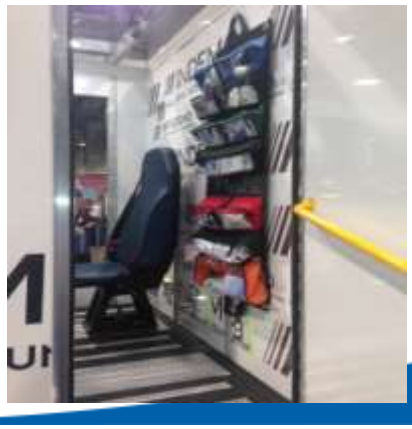
Use of Seat Belts in Patient Compartment

- Leading cause of Fatality among EMS Caregivers
- One fatality each month to an EMS Caregiver
- Three fatalities each month to a member of the Community

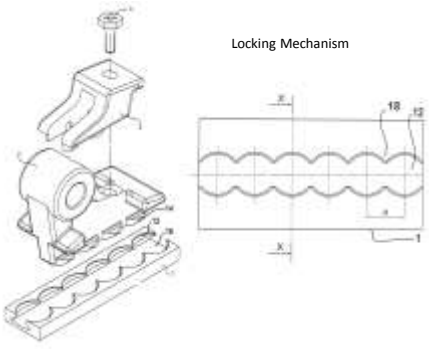
Left to their own devices

- Scissors
- BP Cuff
- Bandages
- IV Kit
- Alcohol Wipes
- Glucometer strips
- What else would you keep this close?





Locking Mechanism



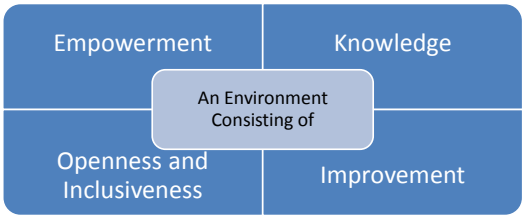
Ford Transit Van

Ford Transit Van

Type I and Type III
2018/2020 timeline for Cutaway chassis
(E350/E450)
F 650 – move from Mexico to Ohio

Type II
Econoline Vans – production ends 2d week in June 2014
When will commodities run out?
Transit production – KC,KC
T350, T250, T150
Ambulance unit available 90 days after Job One (Sept 2014)
Engines – 2 gas, 1 diesel

ACEP/NHTSA Culture of Safety



Final Version of Paper
available December 2013

NFPA 1917

- Committee Meeting October 16/17
- Review input for Version 2.0
- Medical Gas
- Driver Training
- AMD Test Standards
- Third Party Certification on all tests
- 77 MPH removed
- Aisle/Walkway
- Patient Egress – two methods
- Cabinets/Compartments – options
- Cot restraints/Seatbelt Restraints – aligned with NIOSH
- Seatbelt Warning System

NFPA 1917

- Other Options – KKK until 2015, NASEMSO, etc.

KKK Ambulance Specifications

Ambulance Standards - NIOSH

Meets US Standards
Pull Tested to 2,220 lbs.
Int'l Standard – 20g

Ambulance Standards - NIOSH

National Competition




Thanks!