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

H&HN
HOSPITALS & HEALTH NETWORKS
DECEMBER 2013
WWW.HHNmag.COM

IT’S ALL ABOUT THE OUTCOMES

Quality organizations want hospitals to collect more data that focus on patients and outcomes rather than processes and payments.
Wrap everything you do in the Triple Aim

- Improve Health
- Improve Patient Experience
- Reduce Costs
Safety Management Systems
Safety Management Systems

The Four SMS Components

Safety Policy
Establishes senior management's commitment to continually improve safety; defines the methods, processes, and organizational structure needed to meet safety goals.

Safety Assurance
Evaluates the continued effectiveness of implemented risk control strategies; supports the identification of new hazards.

Safety Risk Management
Determines the need for, and adequacy of, new or revised risk controls based on the assessment of acceptable risk.

Safety Promotion
Includes training, communication, and other actions to create a positive safety culture within all levels of the workforce.
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

- Blame Culture
- Just Culture
- No Blame Culture

Steps
- Communicate standard
  - Informal discussion
  - Verbal warning
  - Written warning
  - Suspension
  - Investigative suspension
  - Dismissal

Offense
- Minor
- Moderate
- Serious

Traditional Corrective Action Model
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
<table>
<thead>
<tr>
<th>Question</th>
<th>Agree</th>
<th>Disagree</th>
<th>Neutral</th>
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<tr>
<td>I am encouraged to report safety concerns</td>
<td>279</td>
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<td>I have seen others make mistakes that had potential to harm patients</td>
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<td>A confidential reporting system is helpful for improving patient/provider safety</td>
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<td>I may hesitate to use a reporting system because I am concerned about being identified</td>
<td>206</td>
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Few will admit an error when they face the potential of policy enforcement, regulatory enforcement or liability threats.
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 \textit{failure to recognize} a risk that should have been recognized while recklessness is a \textit{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

**Normal Error**

*Inadvertent action: slip, lapse, mistake*

Manage through changes in:
- Processes
- Procedures
- Training
- Design
- Environment

**At-Risk Behavior**

*A choice: risk not recognized or believed justified*

Manage through:
- Removing incentives for At-Risk Behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

**Reckless Behavior**

*Conscious disregard of unreasonable risk*

Manage through:
- Remedial action
- Punitive action

**Support**

**Coach**

**Sanction**
Was it the employee's purpose to cause harm?  

- NO: Did the employee knowingly cause harm?  
  - NO: Did the behavior represent a substantial and unjustifiable risk?  
    - NO: Do not consider employee action.  
    - YES: Consider punitive action.  
      - NO: Support the employee in the decision.  
      - YES: Consider punitive action.  

- YES: Was the harm justified as the lesser of two evils?  
  - NO: Consider punitive action.  
    - YES: Support the employee in the decision.  
    - YES: Consider punitive action.  

- YES: Did the employee consciously disregard this substantial and unjustifiable risk?  
  - NO: Did the employee choose the behavior?  
    - NO: Do not consider employee action.  
    - YES: Console employee and conduct human error investigation.  
  - YES: Coach employee and conduct at-risk behavior investigation.
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.
Was it the employee's purpose to cause harm?

- NO
  - Did the employee knowingly cause harm?
    - NO
      - Did the behavior represent a substantial and unjustifiable risk?
        - NO
          - Do not consider employee action.
        - YES
          - Did the employee consciously disregard this substantial and unjustifiable risk?
            - NO
              - Should the employee have known they were taking a substantial and unjustifiable risk?
                - NO
                  - Do not consider employee action
                - YES
                  - Consider punitive action.
            - YES
              - Consider punitive action.
    - YES
      - Was the harm justified as the lesser of two evils?
        - NO
          - Support the employee in the decision.
        - YES
          - Consider punitive action.
- YES
  - Consider punitive action.
  - Coach employee and conduct at-risk behavior investigation

- Console employee and conduct human error investigation
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
Safety Begins at the Top of an Organization

**Who’s at the Top?**
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- Dispatch

What is their role as a Leader?
Safety Begins at the Top of an Organization

Who’s at the Top?
- CEO/President
- VP/Op’s Manager
- Supervisor

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
- VP/Op’s Manager
- Supervisor
- Crew Member
- VST/Fleet
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Safety Means Employee Engagement

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How do you engage these employees in Safety?
Safety Means Employee Engagement

**Who to Engage?**
- CEO/President
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- Crew Member
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- Dispatch

How do you engage these employees in Safety?

Commitment
Communication
Safe Choices
Ideas/Solutions
Health
Safety Includes Monitoring Results

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

Empowerment  Knowledge

Openness and Inclusiveness  Improvement

An Environment Consisting of

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.
Ambulance Standards - NIOSH

Meets US Standards
Pull Tested to 2,220 lbs.
Int’l Standard – 20g
National Competition
Thanks!