EMS Event Reporting Program
“Patient Safety First”

Effective December 1, 2007
Contra Costa EMS Agency
EMS Event Reporting Design

- Formerly Unusual Event Reporting
- Redesigned patient safety and recognition program
- Prioritizes patient safety
- Clear line of reporting and follow-up
- New forms and new processes
EMS Events

“What we don’t understand we cannot manage”
What The Experts Know

- Human errors are responsible for an enormous amount of injury, suffering and death throughout the health care system.
- Human errors can be prevented.
- Multiple human errors contribute to the most serious events….not just one thing.
- Punishing people for honest mistakes does little to improve overall system safety.
EXAMPLES

- Care delays causing harm or death - JCAHO
  - Communication (84%)
  - Patient Assessment (75%)
  - Orientation and Training (46%)

- Fire Fighter Deaths (NIOSH)
  - >20% firefighter deaths occur on roadways
  - Root causes: seat belt use and scene safety
What’s in it for you?

- Focus on positive corrections
- Early identification of system problems that put you and your patients at risk
- Promotes accountability and respect
- Supports HR, HIPPA and agency privacy practices
- Recognition system for field care excellence
Implementation Problem #1:
“We punish people for making mistakes”

- “The single greatest impediment to improving system-wide safety”

- Most of what we deal with is “Human Error”

- What is Human Error? The honest mistake.
What You Need To Know

Report on equipment
Report on events you observe
Report on own human error
Report on own knowing violation of policy

Movement in Reporting as the Learning Grows
So...what is an EMS Event?

- Any event that has led to or has the potential to lead to an adverse patient outcome
- “Great Catches” events that are recognized and prevented BEFORE they occur
- Community event that may cause public concern
- Exemplary care in the field
- Events that represent a threat to public health and safety defined by 1798.200 CA H&S Code
Your Responsibility

- **Assure patient safety** by immediately notifying medical and nursing staff when an event has affected or has the potential to impact patient care.

- **Immediately report** to on-duty officer or supervisor using appropriate chain of command:
  - Community events on duty officer gives EMS Agency a verbal “heads up”

- **Complete EMS event form**

- **Submit** to on-duty officer who forwards to agency QI coordinator.
Who can report

- Anyone in the EMS system
- Private parties
- Anonymous reporting
- Self report
- Reporting can occur directly to the EMS agency or to the provider agency involved
- Typically goes through your chain of command
EMS Event Report Form

- Forms available through your agency on duty officer/supervisor
- EMS website
- Step by step directions
- Seek out your agency QI coordinator if you need assistance
Why is this a better system?

- Helps us focus on what is REALLY important
  - Patient and Provider Safety
  - Exemplary Care in the field
- Early notification system
  - Pink Flags
  - Red Flags
- *When you catch problems when they are small they stay small*….Gordon Graham
## EMS Event Reporting
### Jan-July 2007

<table>
<thead>
<tr>
<th>Type of Agency Reporting</th>
<th>#</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>6</td>
<td>23.1%</td>
</tr>
<tr>
<td>MD</td>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td>Fire</td>
<td>5</td>
<td>19.2%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td>Patient</td>
<td>3</td>
<td>11.5%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>26</td>
<td>100%</td>
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EMS Event Characteristics

“We have the same issues”

<table>
<thead>
<tr>
<th>Event Type</th>
<th>#</th>
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<tbody>
<tr>
<td>Communication</td>
<td>16</td>
<td>61%</td>
</tr>
<tr>
<td>Medication</td>
<td>4</td>
<td>15%</td>
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<tr>
<td>Destination</td>
<td>10</td>
<td>38%</td>
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<tr>
<td>Patient Care</td>
<td>23</td>
<td>88%</td>
</tr>
<tr>
<td>Billing</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Documentation-ePCR</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td>Response Time</td>
<td>7</td>
<td>27%</td>
</tr>
</tbody>
</table>

100% of events where communication played a factor also affected patient care.

AHRQ: Communication is a major factor in >65-75% of sentinel events
High Risk Communication

- **Patient Handoffs** (2005 EMS Annual Report)
  - > 100,000 handoffs
  - Potential for 4 or more different communications for each patient transport
    - First Responders to 911 Transport
      - May involve up to 5 responders (Fire & Transport)
    - Transport to ED personnel
      - May involve 1-2 medics and 2 or more nurses, MD
  - Base Hospital Communication
  - Receiving Hospital Communication
## Evidence Based Patient Safety: Communication Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handoff (I PASS the BATON)</td>
<td>Improves communication during handoffs</td>
</tr>
<tr>
<td>Situation Monitoring (SBAR)</td>
<td>Communicates critical info that requires action immediately</td>
</tr>
<tr>
<td>Check-Back</td>
<td>Technique to assure effective communication</td>
</tr>
<tr>
<td>Call-Out</td>
<td>Used to communicate critical info</td>
</tr>
<tr>
<td>CUS</td>
<td>Technique to communicate pt safety concern</td>
</tr>
</tbody>
</table>
Scenario: Things didn’t go according to plan

- Mary Medic reports a 2 hour delay in offload of patients due to ED back up causing delay for 22 year old in active labor.
- Patient ended up delivering in the ambulance
Scenario: Great catch

Joe Medic reports that on a routine check of equipment prior to a call, the defibrillator was non-functional. The device was replaced, but the time to find another, change it out could have caused a delay if the unit had been called into service.
Scenario: Community event causing public concern

- Any event of interest to the press.
- Report of a truck crashing into a nursing home.
- Report of ambulance or fire vehicle accidents

- We need your eyes and ears!
- Your role: Report through chain of command
Scenario: Exemplary Care

- First responder ALS medics Jones and Allen arrive at a scene of a near-drowned 3 year old. They provide excellent CPR and the child has ROSC.
- Response time is excellent and due to the efforts the child makes a full recovery.
Citizen Kane calls to report his elderly mother received an arm injury while EMS transported his mother. He threatens to call the media. The medics involved report the scene was chaotic and Mr. Kane was abusive and interfering in the care of the patient.
What would you do?

- New medic Guy Fire reports that the narcotics count is incorrect & asks you what he should do.
- During a chaotic resuscitation a medic has an EMT push an IV medication the medic has drawn up because his “hands are full”.
- Adenosine is given to a patient for suspected SVT the ED tells you that the patient was in Atrial Fib and there was no indication for Adenosine.
- After a difficult intubation the ED finds that the ETT is in the esophagus.
Questions

- **Contact your agency QI Coordinator**

- **Pat Frost EMS Agency QI Coordinator**
  - Pfrost@hsd.cccounty.us
  - 925 646-9211