PATIENT SAFETY CAMPAIGN

EMS FORWARD 360

12 TOPICS THAT WILL MOVE EMS FORWARD
Mission
To reduce preventable harm.
WHAT IS EMSFORWARD 360?
EMSFORWARD 360 is part of an ongoing campaign to develop awareness, understanding and action to improve your organization’s safety culture.

WHAT IS CULTURE?
An organization’s culture is comprised of the many attitudes, beliefs, values and perceptions which can shape behaviors or decision making.

WHY THESE 12 TOPICS?
The 12 topics presented in this booklet are based on a tool used to measure patient safety culture in Emergency Medical Services (EMS).

WHO SHOULD READ THIS?
EMS professionals who wants to improve their culture of safety.

HOW TO USE THIS BOOKLET?
Discuss the questions around each topic to better appreciate how culture impacts your organization.

NEXT STEPS?
Ask yourself, “How can I take action? What are the necessary steps to improve my organization’s safety culture?”
EVERY TURN IMPACTS SAFETY

PERCEPTIONS

Definition -
The ability to see, hear, or become aware of something through the senses.

ATTITUDES

Definition -
A settled way of thinking or feeling about someone or something, that is typically reflected in a person's behavior.

BELIEFS

Definition -
Trust, faith, or confidence in someone or something.

VALUES

Definition -
A person's principles or standards of behavior; one's judgment of what is important in life.
FOUR STEPS TO UNDERSTAND AND IMPROVE YOUR PATIENT SAFETY CULTURE

STEP 1
BECOME INFORMED

STEP 2
DESIRE CHANGE

STEP 3
ASSESS & MEASURE

STEP 4
IMPLEMENT CHANGE
AS A PROVIDER OR LEADER, ASK YOURSELF... HAVE I CHANGED THE WAY I THINK?

<table>
<thead>
<tr>
<th>WHAT WE USED TO DO/THINK</th>
<th>WHAT WE NEED TO DO/THINK</th>
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<tr>
<td>Who did it?</td>
<td>Why did it happen?</td>
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<tr>
<td>Blame the people involved</td>
<td>Learn from the people involved</td>
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<td>Failure oriented</td>
<td>Achievement oriented</td>
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<td>Focus on bad events needing RCAs</td>
<td>Focus on near misses and unsafe conditions</td>
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<td>Reactive</td>
<td>Proactive</td>
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<td>Punish people</td>
<td>Fix processes</td>
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<td>Manage by fear</td>
<td>Instill desire</td>
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<td>Punishment is the result of poor outcomes</td>
<td>Extraordinary efforts and achievements are recognized and celebrated</td>
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<td>Define employees with rules</td>
<td>Guide employees with strong values</td>
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<td>Actions are dictated by written policies and rules</td>
<td>Good judgment and situational evaluation drive employee actions</td>
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<td>Management-oriented</td>
<td>Individuals are self-governing (values)</td>
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<td>Managers don’t interact with employees</td>
<td>All employees are accountable and two-way communication is expected</td>
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<td>“Your idea is wrong”</td>
<td>“Your idea is different”</td>
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<tr>
<td>Beliefs are ethnocentric and self-serving</td>
<td>New ideas are appreciated and acceptance is the norm</td>
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<tr>
<td>Safety is a priority</td>
<td>Safety is a value</td>
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<tr>
<td>Goals and processes are documented</td>
<td>Safety is the basis for new ideas and necessary change</td>
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A perception of patient safety is... understanding the possible risks and potential harm that might reach the patient, either directly or indirectly, while providing care.

THE SCENARIO. An EMS crew is called to a cardiac arrest victim. During the resuscitation, one of the paramedics intubates the patient and places an endotracheal tube. The paramedic confirms tube placement by listening to breath sounds. Once satisfied, he states “the tube is in”. The other paramedic is concerned about the tube placement and the way it was confirmed. He speaks up and reminds his partner they should use waveform capnography for intubation confirmation and ongoing monitoring until they transfer care at the hospital.

As a leader, ask yourself... do providers understand what patient safety is? Is your culture proactive or reactive?

As a provider, ask yourself... does your leadership discuss patient safety proactively or only after an event occurs?
Information exchange is…

ensuring that pertinent information is passed on to the next healthcare provider as part of the communication process.

EXCHANGING INFORMATION

WHY IS EXCHANGING INFORMATION IMPORTANT?

THE SCENARIO. You are an EMT working on a non-emergent transfer ambulance. It’s the end of your shift and you are cleaning up the ambulance when you find a manila envelope with hospital markings on it. Inside the envelope is patient information including discharge information, nursing instructions and prescriptions. The packet is for a patient that you transferred to a long term care facility earlier in the shift, but forgot to leave it with the staff. Realizing the importance of this information, you contact your supervisor who will deliver it to the long term care facility.

As a leader, ask yourself... are employees aware of the importance of timely information exchange?

As a provider, ask yourself... is there an expectation that you deliver the information in a timely manner or take steps to assure the handoff is completed?
Teamwork is…
about being in the right relationship
with yourself and others as you
work together for a shared
purpose or goal.

THE SCENARIO. An EMS crew is at a local hospital and preparing to leave when they see an out-of-town ambulance pull into the ED bay. Curious as to what’s happening, they see the patient has multiple IV pumps, a ventilator, and a balloon pump; they realize it’s a critical care transport. The EMS crew recognizes they should help out, so they walk over and give a hand unloading the patient and help to take them to the ICU.

As a leader, ask yourself… what steps are you taking to build and improve relationships and teamwork at your organization?

As a provider, ask yourself... would you take action to help a fellow provider even if it did not directly benefit you but might help prevent harm to a patient or the other provider?
Response to a mistake is… reacting in a non-punitive manner by first gathering the facts and then working toward an understanding of any related process failures or human behaviors that contributed to the event.

THE SCENARIO. You are at the local hospital cleaning up the back of the ambulance after completing a call. You notice an empty medication vial in the back of the ambulance that doesn’t seem appropriate for the care of the last patient. When your partner comes out of the hospital, you ask if there might have been a mistake with medications. He acknowledges that he gave the wrong the medication and asks you “what should I do?”

As a leader, ask yourself… is your culture such that your staff will support one another but also practice peer-to-peer checking?

As a provider, ask yourself… have you ever made a mistake but were fearful in reporting it because of punitive action or embarrassment?
Staff training is an opportunity to integrate learning about patient safety principles and philosophies, and integrating a model of shared accountability into essential job training.

THE SCENARIO. It’s time for your annual skills training or recertification class, and you expect it will repeat the same thing you’ve heard for years. However, this year you are surprised, as some of the skill stations have integrated patient safety events into the scenarios. In one station you learn what it feels like to make a mistake as the scenario is built for failure. You learn to identify causal factors and how they can lead to patient harm. In addition, you experience how the perceptions or attitudes of providers can lead to safety events. At the completion of the class, you have a new level of respect for your organization and the leadership as they commit to improve provider and patient safety.

As a leader, ask yourself... are you teaching a culture of safety in your ongoing educational offerings?

As a provider, ask yourself... are you prepared to competently and safely face the real life scenarios that you encounter?
A patient hand off is... an intersection in time where providers come together to exchange critical patient information.

THE SCENARIO. An EMS crew arrives at a busy emergency department with a non-urgent patient. They are sent to check in at triage and wait until a bed is available. Once the room is assigned, the EMS crew moves the patient to the hospital bed and waits for a nurse to give their report. Meanwhile, the crew’s supervisor and dispatcher call to see when they will be back in service. When the nurse walks into the room, she hardly acknowledges the EMS crew or patient, but goes to a computer and starts typing. The paramedic, who feels pressured about the time spent waiting, rapidly fires off the basics about the patient and leaves.

As a leader, ask yourself... have you thought about the many types of transitions of care that are done every day and how well are they done? Do you follow a standardized process?

As a provider, ask yourself... does your relationship with other providers interfere with the transitions of care? If so what are doing to improve those relationships or address the problems?
Management support for safety is.....
integrating patient safety into the
organizational strategic plan while
encouraging staff to report concerns
they observe or experience.

THE SCENARIO. You are an EMS manager. Several providers report concerns about “home-
made” cricothyrotomy kits on the ambulances. You thank them, and assure them it will be
discussed with senior leaders and the medical director. During the next leadership meeting
a process improvement plan is developed with the medical director to standardize all kits.
Frontline staff will be notified and trained on the standardized kit.

As a leader, ask yourself... how much time do you spend discussing patient safety with your
staff? Do you have a patient safety plan? Likewise, when something is reported to you, do
you follow up and explore new processes while integrating the science of safety?

As a provider, ask yourself... if you needed additional training on a device or process, would
you ask for it?
Communication openness is.... the way people are allowed to express their thoughts and ideas with respectful listening by their peers or leadership.

THE SCENARIO. You are a new EMT working with a senior paramedic when you notice the medic taking a short cut that is likely to cause a mistake. Even though you are a new hire with less experience and training, you are confident that this presents a risk. Instead of saying nothing, you politely ask the paramedic to hold on for a second. You both step away from the patient and review the next steps together pointing out your concern.

As a leader, ask yourself... do you promote an open and trusting environment where providers are encouraged to speak up if they feel something might be wrong? Do you support them even if they are wrong?

As a provider, ask yourself... do you work at an organization where you have peer to peer checking and where is it okay to speak up if you see something unsafe?
Staffing, work pressure and pace... is the employee perception of staff resources and momentum which, in turn, impacts the decision making processes and behaviors.

THE SCENARIO. Your EMS organization has a policy that all ALS equipment will be carried in on every call. While on duty you receive a call for a sick case. You know the address as you have been there many times in the past for the same patient. It’s near the end of your shift and you are tired. Since you know this patient, you grab just the basic jump kit. When you walk into the house you find the patient in full arrest with a neighbor performing CPR.

As a leader, ask yourself... do you see shortcuts being used to save time or for staff convenience?

As a provider, ask yourself... has your performance or decision making process ever been impacted by fatigue?
Feedback and communication is... recognizing safety risks in a proactive manner, reporting them, then collaborating about the solutions.

THE SCENARIO. A paramedic is dispatched for a critical care transport and finds the patient has multiple pumps infusing various medications. The medic is not familiar with the pump model and asks the nurse a few questions about how it works. The medic gets a short in-service on how to silence the alarm and troubleshoot some basic problems but is still unsure how to manage the device. Following the call, she talks with other crews who have had similar concerns. Later, she calls her supervisor and explains that without more training on the pumps, she will need to decline similar transfers since she isn’t sure how to safely manage the device.

As a leader, ask yourself... do you collect and assess reported events? Do you follow up with providers and engage them in the resolution?

As a provider, ask yourself... do you have channels for reporting adverse events, near misses or unsafe conditions?
Organizational learning is… about developing a culture where there is trust and transparency around failures so improvements will take place to prevent future events.

THE SCENARIO. You are an EMT and you hear about a recent mistake that’s happened on your shift. Management won’t share information, calling it a “management issue”. Several weeks later, you learn the provider was fired. The frustrated staff knows the same mistake has happened other times, and management was aware. The staff concludes that management is setting them up to fail or just doesn’t care. Some of your coworkers are looking for new jobs. Morale is very low.

As a leader, ask yourself… what is the process if an event is reported or discovered at your organization? Do you take responsibility to understand what happened, why it happened and how to prevent it the next time?

As a provider, ask yourself… do you receive information in a learning environment rather than a punitive one?
Communication during a response is... developing a plan prior to the call which offers direction for clear communications as well as coordinated care. This includes adopting appropriate tools and tactics from crew resource management to support provider and patient safety.

THE SCENARIO. An EMS crew arrives at a complicated medical emergency scene with other first responders, family members and law enforcement present. They receive fragments of information from the other responders as they try to piece things together, but the information is not clear or complete. They have to ask many of the same questions over again. Providers duplicate tasks.

As a leader, ask yourself... do you provide crew resource management tools for your staff? Do you hold joint training with other first responders so there is clarity on roles and responsibilities?

As a provider, ask yourself... have you taken the initiative to develop a professional relationship with other providers?
Together, we can move #EMSForward.

Follow the EMSForward 360 Campaign on Twitter, LinkedIn, or Facebook.

Resources and recommendations to support improvement efforts addressed in this booklet are available on the CPS website.

www.centerforpatientsafety.org/emsforward

SAVING LIVES. EVERY SECOND. EVERY MINUTE. EVERY DAY.

Do you have questions for us?
Contact a patient safety expert today!

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