National EMS Culture of Safety

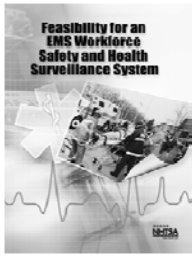
Improving Safety In A High Consequence Enterprise

Scott R. Hadley
Director, Sedgwick County (KS) EMS

Project Background

- Emergency Medical Services (EMS) has been identified as a high risk industry with injuries and deaths among both EMS personnel, their patients and the public.

- The National EMS Advisory Council (NEMSAC) in 2009 recommended that the National Highway Traffic Safety Administration (NHTSA) and the rest of its Federal partners move forward with the development of a “Culture of Safety” in EMS.



Project Background

- Funded by the National Highway Traffic Safety Administration (NHTSA) Office of EMS and EMS for Children, the American College of Emergency Physicians (ACEP) was selected to lead the project
- Stimulate the growth of a "Culture of Safety" within the EMS community through development of a Strategy document
- **Where are we?**
- **Where do we want to be?**

Project Overview

JUNE 2011

- National EMS Culture of Safety Conference
  - 18 Member Steering Committee
  - 21 Member Group of National EMS Organizations
  - Additional invited groups/media
- Develop National EMS Culture of Safety Draft Strategy

JUNE 2012

- National Review Meeting
- National EMS "Culture of Safety" Strategy Document

SEPT 2013

- Dissemination of Strategy

National Stakeholder Meeting

- Affects patients, responders and the public
  - Violence
  - Vehicle Operations
  - Medication errors
  - Infectious diseases
  - Lifting and moving patients
- Lack of EMS injury data system
- Limited sources of data

Considerations

- Balance between patient – provider – community safety
- Recognition that this is a long process but has intermediate “wins”
- Disparate nature of EMS
- Respect for unique circumstances and environments of EMS

EMS Culture and Safety

How do we use the vision / strategy document to seed change in culture?

What are we trying to create?

EMS Culture and Safety

- Environment of empowerment
- Environment of knowledge
- Environment of openness
- Environment of inclusiveness at every level
- Environment of measurable safety improvements
- Environment of measurable quality improvement
- Environment of continuous improvement

Suggested Elements

- Just Culture
- Coordinated support & resources
- Education initiatives
- National responder and patient safety data systems
- Safety standards
- Reporting and investigation tools
  - Example: the data system and reporting fields at CPS

Identified Elements

Just Culture

- Separate behaviors from outcomes
  - Base the response to unsafe acts on the **behavior** itself and the risk it presents,
  - Not on the **outcome**
- **Console** human error.
- **Coach** at-risk behavior.
- **Punish** reckless behavior.
- …independent of outcome.

Coordinated Support and Resources

- Unified message
- Providing visibility to support culture
- “One-stop shopping” for tools
- Collaborating
- Sharing research

National Data System

- Linkage
- Unified taxonomy
- Anonymous reporting

Education Initiatives

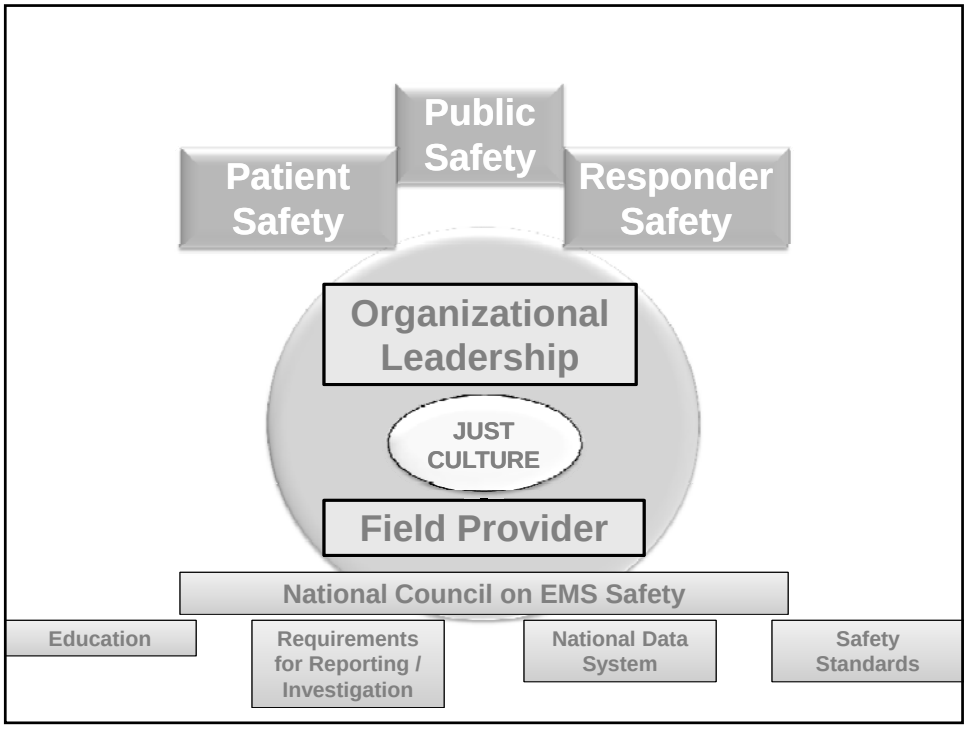
- Education of leaders
- Build clinical judgment
- New employee on-boarding
- Integration and practice of safety in education

Standards

- Evidence based approach
- Development of standards

Steps to Adoption

- Dissemination
- Implementation
- Integration
- Culture Change



On the Horizon

- Responder – Patient – Community Safety
  - Vehicle design
  - Road/Air safety*
  - Response mode
  - Restraints
  - Conveyance
  - Medication administration
  - Shift durations

Thank You!

- Questions?

Scott R. Hadley, MBA, BSN, RN, EMT-P
Director, Sedgwick County (KS) EMS
shadley@sedgwick.gov

www.emsculturesafety.org