PSO's as SOP's!

Getting Patient Safety Organization Buy-In for EMS CQI

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Questions

1. What is the value to participating in a Patient Safety Organization?
2. What are the hurdles to participation in a Patient Safety Organization?
3. What are some of the keys to making participation successful?

Confession is Good for the Soul

“Almighty Paul Pepe, who does freely pardon all who confess; forgive all of our sins, dosing errors and missed intubations”

From the Book of Eagles, Talons 20:15

History

Pre 1990's: "Punitive Culture"

Individual is always responsible; errors not reported

1990's: "Blame Free Culture"

System to blame, not the individual

2000: "Just Culture"

Holds both system and individual accountable

Barriers to Error Reporting

- EMS culture discourages sharing
- Embarrassment and loss of reputation
- Discovery by peers, lawyers, media, etc
- Many states don’t provide adequate peer review or liability protections for agencies or providers

Patient Safety and Quality Improvement Act of 2005

- Response to the 1999 Institute of Medicine report, “To Err Is Human”
- Federally-listed Patient Safety Organizations & national database
- Framework for hospitals, doctors, and other providers to voluntarily report on a confidential basis

Primary PSO Activities

- Collection and analysis of “Patient Safety Work Products”
- Development and dissemination of best practices recommendations, protocols, etc.
- Provide case specific feedback and assistance to help minimize risk
- Encourage a culture of safety!

PSO Protections

- Focused case reviews by Medical Director
- Internal QA studies
- All paper and electronic data, notes and documents related to the CQI process
- Conversations and personal opinion!
- Performance feedback to crews

Not Included!

- Medical record (PCR)
- Billing info
- Original patient or provider information, i.e. factual recall
- Information collected, developed, or maintained outside a PSO system

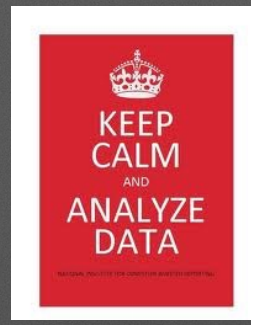
Key Exceptions

- Federal, State, Local subpoenas (criminal or administrative)
- Professional disciplinary proceedings
- De-identified patient safety work product

Feds vs. State

Federal requirements for patient safety work product protection preempt any conflicting state requirements

Advantages



- Independent, external experts
- Aggregate data locally, regionally, and nationally to better understand safety events
- Learn from other's mistakes
- Trends can be developed across similar type services
- Develop best practices, benchmarks, and compliance standards

Other Benefits

- Protecting the reputation of the agency or provider
- Interagency collaboration
- Data sharing

Reports and Alerts

Center for Patient Safety

Home | Who We Work With | Safety Culture

Alerts / Safety Watch: Stretchers

Multiple stretcher-related incidents have been reported to the Center's Patient Safety Organization. The following areas of concern are from real events:

SAFETY WATCH

- Stretcher collapsed while a patient was on it
- Stretcher rolled out of control with a single attendant guiding it
- Head of the stretcher collapsed while in upright position
- Bolts or screws were missing from stretcher
- Power function was not operational and manual mode was not engaging
- Unable to raise or lower stretcher using power function

How to Mitigate Risk

The Center advises you to take appropriate actions to prevent events from occurring at your organization. Please follow the manufacture recommendations and guidelines for maintenance as well as usage of the equipment. It is also recommended you conduct a refresher on the device and all supporting equipment.

For more information, contact your manufacture and have the serial number available.
Ferno- 877-733-0911
Stryker-800-327-6511

08.11.14

Posted in: EMTs

Periodically send out reports/alerts for adverse events, near misses or dangerous condi

KCFD

- All ALS Service
- 125,000 calls/year with 75,000 patient transports
- Strong Labor-Management Cooperative Agreement

KCFD Experience

- Signed contract in December 2010
- Early-Mid 2011
  - “Patient Safety System” policies and guidelines were developed and vetted by Labor-Management Steering Committee
    - “Self-reported” errors removed from the disciplinary process
- Mid-Late 2011
  - Reporting system and submission tool were created
  - Initiated training of personnel

KCFD INTRANET

Crew Information

- Email Access for KCFD
- 2013 Survey
- PSO Web Submission
- VisiNet Rostering

- Hospital Closures
- Equipment Failure Report
- EM Systems
- Info about MAST Intranet Login
- Zoll Upload Procedures
- E-Pro Scheduler

- Telestaff Web Login
- 2011 EMS Protocols
- KCFD Info
- AR1-16 Technology Use
- I/T & Password Info
- Arrest Study Survey

- Letter to Employees about KCFD Membership
- KCFD Membership Application
- KCFD Membership Brochure

KCFD PSO Web Submittal

* are required

Medic Name:

Call Number:

Booklet Number:

Unit:

* Date:

Time:

Did issue occur while on a call?

Yes No

Negatively affect patient care?

Yes No

Incident reported elsewhere?

ADC
BC
Captain
EFR
IFR
Other : (Please specify)

* Summary:

Submit form

Workgroup

Medical Director

Division Chief of Quality Improvement

Union Representative (Paramedic)

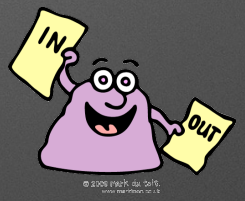
Subject Matter Experts (as needed)

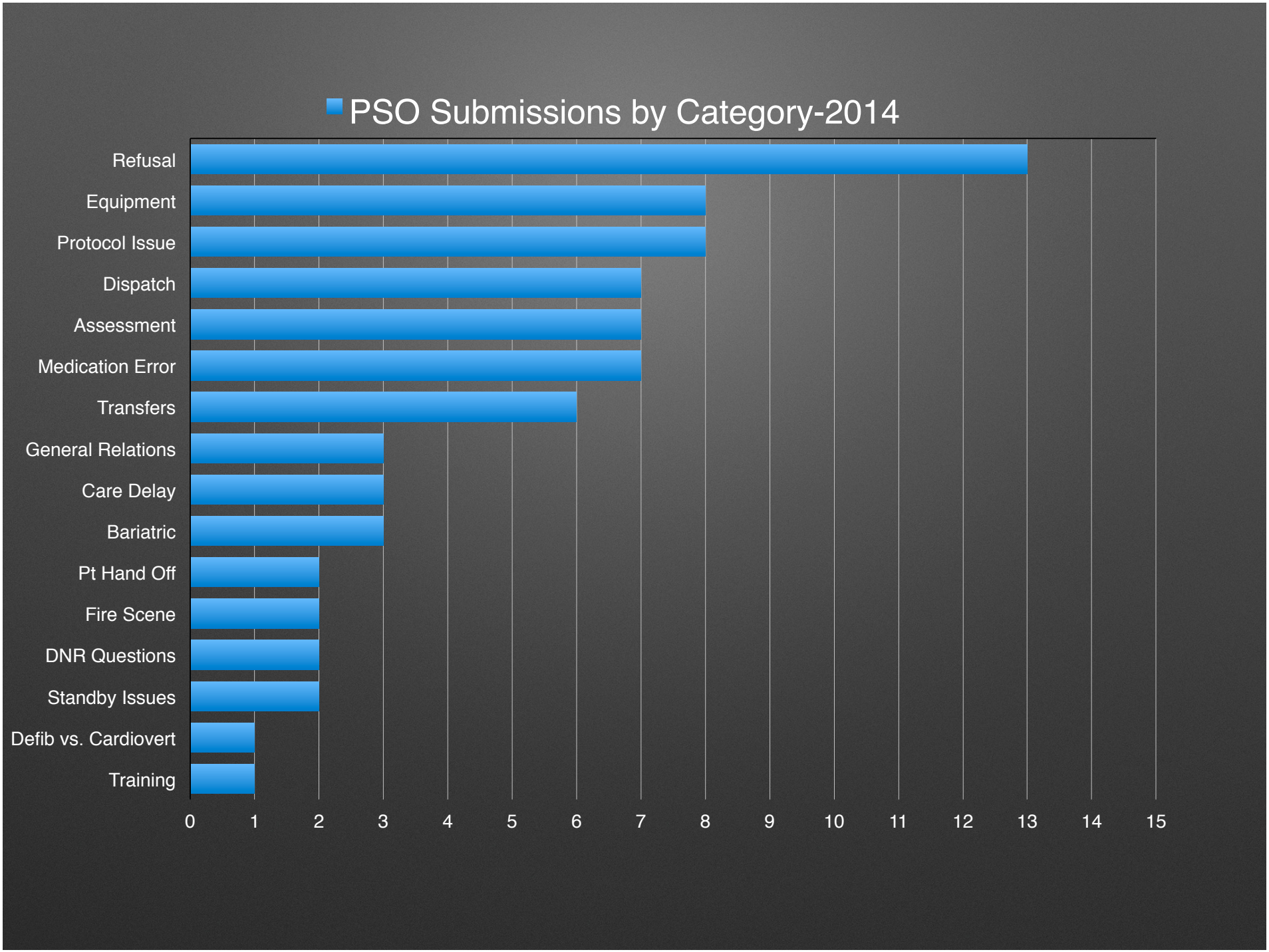
Process

- Submission via web link or verbally
- Record is created and email sent to Chief of QA and Medical Director
- Weekly Meetings
  - Review submissions, gather data and conduct interviews
  - Develop action plan

Yearly Submissions

- 2012
  - Introduced
- 2013
  - 54 Submissions
- 2014
  - 93 Submissions




PSO Submissions by Category-2014
Refusal
Equipment
Protocol Issue
Dispatch
Assessment
Medication Error
Transfers
General Relations
Care Delay
Bariatric
Pt Hand Off
Fire Scene
DNR Questions
Standby Issues
Defib vs. Cardiovert
Training
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15

Work-products —> Systemwide Changes

Morphine and Midazolam

Challenges

- Getting the word out
- Reporting mechanism
  - No home access, no secure phone line
- Reluctance to report/discuss cases
- Unfounded fear of being disciplined

Finding a PSO

- Limited number of PSO's catering to EMS

Center for Patient Safety

Emergency Medical Error Reduction Group

- Hospital-based PSO
- Regional PSO

Questions

1. What is the value to participating in a Patient Safety Organization?
   - Protections and confidentiality
   - Increased reporting
   - Learn from other's mistakes

Questions

2. What are the hurdles to participation in a Patient Safety Organization?

   - Educational process
   - Fear of discipline
   - Cost

Questions

3. What are some of the keys to making participation successful?
   - Joint labor-management effort
   - Provider buy-in
   - Simple reporting mechanisms