



PATIENT SAFETY FOR PARAMEDICS

Advanced Care Paramedicine

Module: 01
Section: 07

- Define Patient Safety and its elements
- Introduce you to the common safety focused organizations
- Understand the history to date of Patient Safety to the Organization
- Understand Patient Safety and the Canadian Health Care system
- Review and identify some adverse events
- Introduce you to the Safety Competencies
- Discuss the role of the Paramedic in patient safety

- The activities of the organization designed to reduce or eliminate harm to our patients that may result from our care, or the activities surrounding our care.

- OH & S
- Patient Safety
- Operations Safety



Some Patient Safety Goals

- Create a culture of safety throughout our company
- Reporting of all adverse events and near misses
- Improve infection prevention and control such as hand hygiene practices
- Reduce the risks associated with clinical care such as medication errors, electrical and airway interventions and clinical judgment
- Reduce patient handling adverse events
- Improve the effectiveness of coordination of communication among care/service providers and with the recipients of care/service across the continuum
- Create a work life and physical environment that supports the safe delivery of care/service
- Ongoing identification of risk inherent in our client population and our activities

- An adverse event is defined as an unintended injury or complication resulting in death, disability, or prolonged hospital stay caused by health care management rather than the patient's underlying condition. (CPSI)

- An event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune. (CPSI)

What Patient Safety is NOT

- A course you take
- A policy
- A directive
- A piece of software

- Establishing measurements (indicators)
- Establishing reporting systems
- Full Disclosure of adverse events
- Prospective/retrospective activities (FMEA/RCA)
- Safety at the forefront & openly discussed
- Understanding how human factors relate to adverse events
- Having a safety plan
- Building of a culture of patient safety (discuss later)
- Patient safety is easier to witness than define / it is demonstrated by many activities happening concurrently every day.

- The Canadian Patient Safety Institute (CPSI) was established in 2003 as an independent not-for-profit corporation, operating collaboratively with health professionals and organizations, regulatory bodies and governments to build and advance a safer healthcare system for Canadians. CPSI performs a coordinating and leadership role across health sectors and systems, promotes leading practices and raises awareness with stakeholders, patients and the general public about patient safety.

www.patientsafetyinstitute.ca



**Reducing Harm, Improving
Healthcare, Protecting Canadians**

www.saferhealthcarenow.ca

On April 12, 2005, ***Safer Healthcare now!*** was born.
There are now a total of 10 SHN Interventions.

- The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world.

www.ihi.org



- The Institute for Safe Medication Practices Canada is an independent national non-profit agency committed to the advancement of medication safety in all healthcare settings.

www.ismp-canada.org



- CIHI tracks data in many areas from information supplied by hospitals, regional health authorities, medical practitioners and governments. CIHI's data and reports focus on:
 - Health care services
 - Health spending
 - Health human resources
 - Population health



www.cihi.ca

www.accreditation-canada.ca



- As a Paramedic please save these sites in your favorites
- Explore each site
- There are many free articles, papers, downloads
- Subscribe to free periodicals or newsletters
- Draw links to our industry

- Initial Efforts & Corporate Wide Staff Survey, December 2008

- Evaluation of Risks versus Current Policies:
- 9 organization wide gaps
- Local gaps identified (EMC, NBEMS, IEMS)

- Securing and moving patients
- Safe stair chair use
- Use of cruise control
- Maintenance of medical equipment
- Responding code 1(4)
- Fatigue while on duty
- Equipment standards
- Vehicle conspicuity
- Vehicle design
- Infection control notification
- Near miss reporting

- Issues Surrounding Incident Reporting
 - No consistent tools
 - Not all current tools used
 - Rate of completion
 - Level of understanding
 - Reliable transmission
 - Consistent follow up and closure

- Company Wide Survey (November 2008)
- 25 Questions & Comment Section
- 650 / 1800 completed the survey
- 210 took the time to write comments

- General awareness of safety requirements, professionally and legally
- 80% of respondents state that patient safety is not discussed at staff meetings
- Less than 40% report any form of organized staff meetings
- 40% of respondents report that they do not have any form of opportunity for interaction with their supervisor/manager
- There is an interest in participating in safety initiatives

- Respondents understood the importance of patient and workplace safety
- All agree that patient and workplace safety must be a standing agenda item at staff meetings
- 50% of respondents feel that management's approach to safety is punitive (same number will not report Near Misses)
- 50% of respondents are unsatisfied with the content and timeliness of follow up to their safety concerns
- 90% of respondents are clear about what is expected of them in their job

- Narrative Themes (210 comments summarized)
 - Operations in inclement weather
 - Extreme hours of work
 - Infection control notification
 - Staff Meetings and Safety Agenda
 - More training
 - Communication
 - Punitive approach
 - Leadership

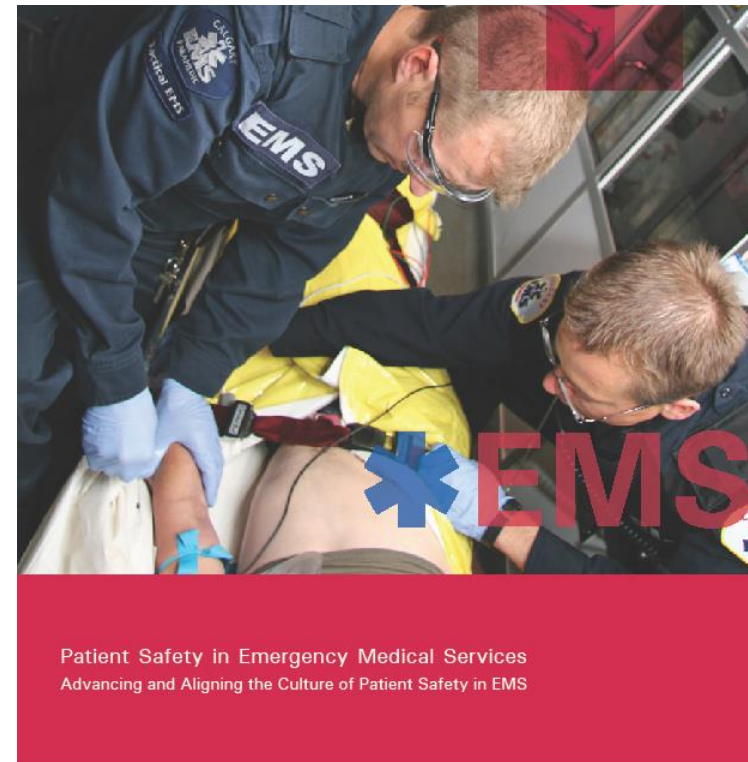
- Patient Safety Competencies*
- Required Organizational Practices
- FMEA / RCA training*
- Transfer Checklist
- Vulnerable Patient Groups
- Adverse Event Reporting System
- Infection Control
- Falls Prevention
- Enhanced Vehicle Safety
- Fatigue/Hours of Work
- Adverse Weather
- Another Staff Survey

Patient Safety and the Canadian Health Care System

- 7.5% of medical/surgical admissions experience an adverse event
- 185,000 adverse events per year
- Majority of adverse events resulted in temporary disability or prolonged hospital stay
- 5% of these patients suffered permanent disability
- 1.6% fatality rate associated with these adverse events
- 37% of these events were potentially preventable (70,000)

- 110 nosocomial infections per 1000 adult patients
- 89 nosocomial infections per 1000 child patients
- 87% of hospitals have not employed all surveillance procedures
- Less than 80% are applying all infection control recommendations
- Events classified as: Dx errors, surgical, fractures, anesthesia, medical, medications, system error

- Who knows?
- CPSI, EMS Chiefs and EMS Foundation, Calgary just commissioned and published the first paper on patient safety in EMS.
- Patient Safety in EMS; Advancing and Aligning the Culture of Patient Safety in EMS. Bigham, Blair L. et al.



Patient Safety Events

- A 68 year old female was admitted to hospital to undergo surgery for a hip repair. Her current medications are Atenalol, 50 mg PO, Synthroid, 25 mcg PO qd and Warfarin, 5 mg PO qd. When her medications were reconciled in clinic she was instructed to discontinue her Warfarin 7 days prior to her surgery date. The patient was d/c home 4 days post surgery. The patient returned by ambulance to the hospital ED 5 days after d/c with a left hemispheric ischemic stroke.

- 67 year female , Joan Morris, was admitted to hospital and had undergone repair of two cerebral aneurysms using a procedure called embolization in which tiny platinum coils are injected into the aneurysms through a thin catheter to starve it of blood. She was set to be d/c tomorrow. One floor below a 77 year female , Jane Morrison, was admitted to undergo a cardiac electrophysiology procedure (tomorrow) for an uncontrolled arrhythmia which was an invasive procedure that required insertion of a catheter into the heart chamber.
- To make a long story short what do you supposed happened?

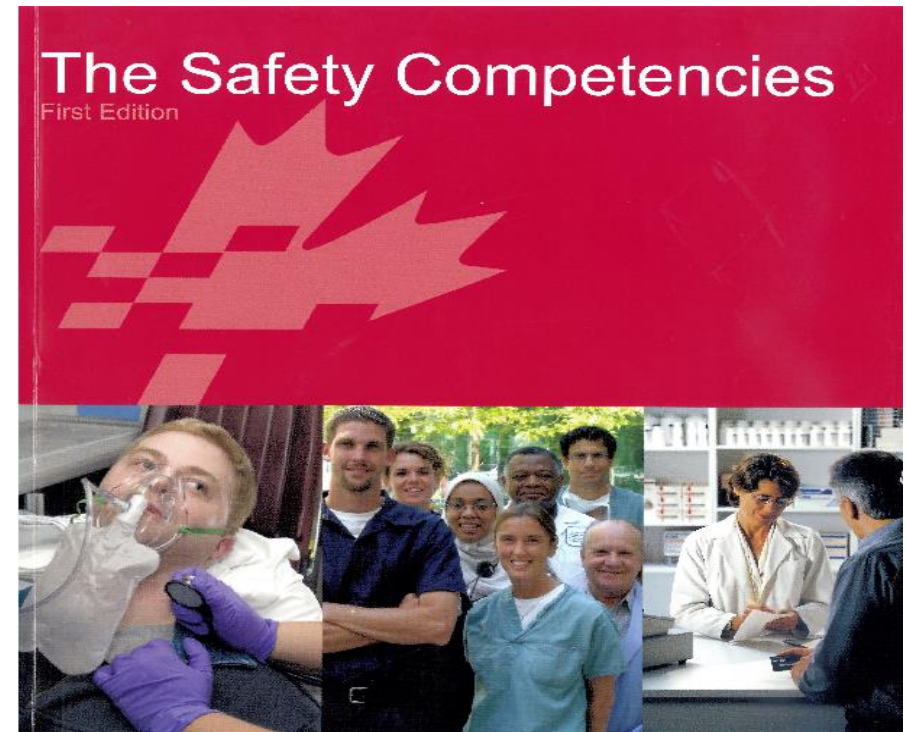
- When lab called for Morrison, they were told that she was not there but had been moved to another floor (this was Morris)
- Patient identity not verified by 6 different health care providers involved
- Both the physician and the nurse in the lab ignored Mrs. Morris' objections
- Physician disregarded Mrs. Morris' "fresh groin wound" from her cerebral angiogram the previous day.
- Overall, there were 17 errors around patient identification associated with this case.

- EMS arrive at the ED with a 61 year old male who is unresponsive. The patient has terminal cancer and signed DNR orders at the home. The crew provided the basic vital signs (BR,HR,RR) but no other history. The ED staff prepared to offer comfort measures for the patient until they could contact the FD. When the RN spoke to the family she discovered that the patient was also an insulin dependent diabetic. When the RN checked BGL, it was <1.0. The patient received 50cc Dextrose 50%, woke up and was d/c home one hour later.

- EMS transports an 86 yr male from a local LTC to the ED with a CC of vomiting, diarrhea. The pt is febrile, actively vomiting and is ++ incontinent of feces. Once clear from this call the EMS crew transfer a patient being treated for leukemia from the cancer treatment center back to their secondary HCF. The next day you are informed that this patient has succumbed to their illness after a fulimant onset of sepsis and secondary massive fluid loss.

- EMS Unit 5022-Sydney have been assigned a transfer upon just dropping off a patient at the NHI-Cath Lab. Pt. George Stevenson is to be transferred from the cardiac catheterization lab back to the CBRH.
- Task: In terms of patient safety, list all the potential risks associated with the various processes applied with this transfer.

- To identify key knowledge, skills and attitudes towards patient safety
- Deliver a flexible framework that is simple to act as a benchmark for training and educating health care workers.
- To make it easier for everyone to understand the patient safety competencies



Enhancing Patient Safety Across the Health Professions

Canadian
Patient
Safety
Institute

Institut
canadien
pour la sécurité
des patients

cpsi icsp

- Let's Do Some Ambulance Calls!



- Unit 262 respond Code 1 to the industrial park in Bayers Lake for an unresponsive male. Further information unknown.



- As you pull in this is what you see. Next steps?



- What could be wrong? What are the possibilities?
 - Responsive only to pain
 - Sonorous respirations
 - Pale & moist
 - ++ ETOH odor
 - +++ ammonia odor
 - HR 100
 - RR 20
 - BP 150/90
 - BGL 1.0 mmol/L
 - Unkempt
 - Cachectic appearance.



Next Steps and concerns?



- Code 2 to the hospital: next steps? Concerns?



- What are the Patient Safety concerns?

- Unit 262 respond Code 1 to Ochterloney Street for a male c/o chest pain. Further information unknown.



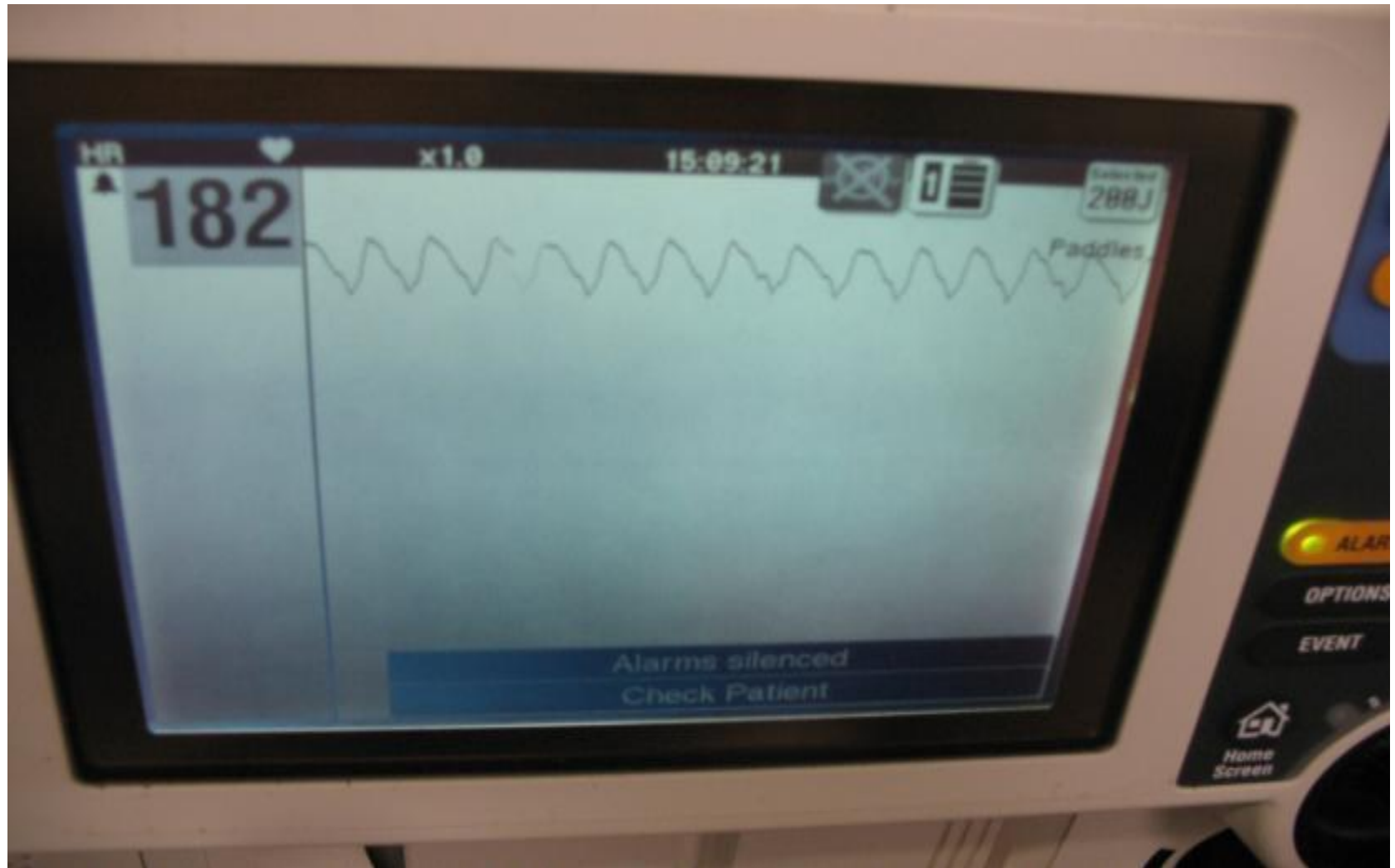
He is upstairs.
What are you thinking now?





- Oxygen (omission)
- ASA (allergy)
- Nitroglycerin (--BP)
- IV (embolism)
- Versed (resp arrest)
- Morphine (--BP, resp arrest)
- Electrical therapy
 - incorrect → cardiac arrest
 - delay → cardiac arrest
- Defibrillator failure





Many buttons, Many procedures



- What are the Patient Safety concerns?

- Unit 262 Respond Code 1 to Bayers Rd and Young St. for an MVC. Car versus Bicycle.



- MOI?
Immediate Patient Safety Concern?



- Actively seizing
- Cyanotic
- Copious amounts of blood from his mouth, nose, ears.
- Copious blood from a head lac
- His right humerus bone is broken and is protruding through his skin and shirt.
- Multiple lacs and abrasions.
- Processes, procedures etc:
 - Airway management
 - Stop the seizure
 - Cervical spine
 - Control hemorrhage
 - Pharmacology/benzodiazapines
 - Intubation?
- Trauma team activation



4.5 minutes of care



- Look at safety through “SYSTEM” eyes
- Separate error from recklessness
- Champion and encourage adverse event – near miss reporting
- Discuss safety at every opportunity
- Participate in safety investigations at every opportunity
- Apply/adopt the Safety Competencies into your practice
- Communicate / Communicate / Communicate – using the language of safety
- Lead by example

- Leadership commitment to safety
- Organizational resources for patient safety
- Priority of safety versus production
- Effective and open communication
- Open discussion around problems and errors
- Organizational learning
- Frequency of unsafe acts

