EMS Subspecialty Certification Review Course

Patient Safety

2025

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ABEM EMS Core Content

2.4.6 Patient Safety

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Learning Objectives

Upon the completion of this program participants will be able to:

1. Identify sources of potential risks to patients in the pre-hospital setting.
2. Define the term adverse event (AE.)
3. Describe the culture of safety as it relates to reducing AEs.
4. Describe the importance of investigating “near misses”
5. List 3 methods of reducing AEs caused by system issues

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Institute of Medicine

- *To Err is Human: Building a Safer Health System*
  - Sentinel document: Committee on Quality of Health Care in America. Washington, DC Institute of Medicine 1999
  - Risks and harms health care system can inflict on patients
  - Led to research on patient safety

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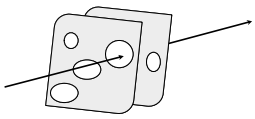
Adverse Events (AE)

- An occurrence resulting in unintended patient harm
- AEs stem from:
  - Systemic issues (flaws in design)
  - Individual behavior (unsafe acts)
  - Combination of both
- How AEs occur
  - Swiss Cheese Model



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Factors

- Human and ergonomic
  - Complacency, fatigue, eyesight, inattention
  - Task fixation
  - Ergonomics: design-out error
  - Communication
- Judgment and clinical thinking
  - Important to review how we think and arrive at conclusions: many are in error (EP's 10-15 % of the time)

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The Unique Environment

- Cold
- Dark
- Chaotic
- Unsafe
- Time sensitive

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Patient Safety in EMS

- No common language to define adverse events in EMS
- WHO: pt safety = acceptable minimum
  - "Collective notions given current knowledge, resources available and context in which care was delivered weighed against the risk of non-treatment"
  - In other words: acceptable risk fluctuates based upon context of healthcare delivery system

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AE Events

- Identifying AEs
  - Provider self reporting
  - Secondary reporting (partner, patient, hospital)
  - Audits
- Harm need to not occur for safety principles to apply: evaluate near misses as if harm occurred
- Services should track and categorize
- Develop strategies to prevent

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Culture of Safety

- Reduce the fear of reporting
- Unintentional human error is not punished
- Supported from the top, ingrained in policies and procedures, adhered to by workforce
  - Shared attitude with respect to safety
- Empower workforce

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Culture of Safety

- Most common tool used to measure: EMS Safety Attitudes Questionnaire (SAQ)
- Prior research has demonstrated wide variation in safety culture across EMS Agencies.
- EMS-SAQ scores linked to safety outcomes, including injury, errors, adverse events and safety-compromising behaviors.
- In general, air medical agencies, private free-standing EMS systems, systems with fewer employees, and EMS organizations with fewer total patient contacts tend to have higher safety scores.

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Just Culture

- A safe culture requires Justice
- Just Culture: A system of shared accountability exists where an organization is responsible for safe system and process designs and employees are responsible for safe choices and behaviors

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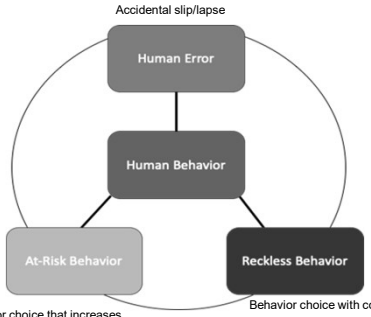
Just Culture - Types of Human Behavior



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Under Just Culture, human behavior falls into one of three categories:

1.Human Error: an inadvertent action; inadvertently doing other than what should have been done; a slip, a lapse, a mistake.

2.At-Risk Behavior: a behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified.

3. Reckless Behavior: a behavioral choice that consciously disregards a substantial and unjustifiable risk.

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Preventing AEs

Patient Safety = Reduced AEs

Human Factors
- Guidelines for med administration, adequate training, reducing fatigue ….

The System
- Culture, policies and procedures to reduce AEs
- Check lists
- Ergonomics

Forcing functions!

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Low Hanging Fruit

- Clinical Judgment
  - Actions taken without adequate fundamental knowledge
- Ground and aircraft operation
  - Light and sirens
- Intubation
  - Tube confirmation
  - Success

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Take-Home Points

- Be able to define AE's
- AEs are caused by system issues, individual behaviors or both
- Be familiar with Just Culture

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