Sedgwick County, Kansas

EMS

ACCREDITED

Patient Focued...Patient Centered...Patient Driven

Monthly Report

March 2012

Nothing lasts forever...almost. While the mild temperatures continued for March, we experienced a substantial increase in call volume! Overall call demand was up 8.8% from March 2011 and it was the first month this year we have noticed an increase. Our busiest day was on March 26 with 178 responses, and our slowest call volume day was on March 11 with 128 requests for service.

To Err is Human...

The Institute of Medicine (IOM) released two reports that changed the way the public and health care systems think about patient safety and quality of care; *To Err is Human: Building a Safer Health System*, was released in November of 1999, and *Crossing the Quality Chasm – A New Health System for the 21st Century* in March 2001. The first report focused attention on the specific issue of medical errors and the second report recommends a sweeping redesign of the health care system to improve the quality of care. How much progress have we made in the past decade?

To Err is Human….but how human err is identified, viewed, and addressed, in the vast majority of cases, still needs to change. Human fallibility is present in every aspect of our personal and professional lives. When someone makes a mistake, especially when it jeopardizes safety or causes harm, "social justice" dictates us to name, blame, shame, and punish the offender. This viewpoint is omnipresent in many professions, including health care, where a human error can cause injuries and in some cases be fatal.

> ***"The single greatest impediment to error prevention in health care is that we punish people for making mistakes."***

Many believe there is too much at risk...the pilot, the surgeon, the nurse, the paramedic cannot make a mistake, and are often held to a different standard. If one of these professional's commits an error, they are often labeled as careless, reckless, or incompetent. They are "bad apples" - punish them, get rid of them and the errors will stop. Does a punitive model and approach really deter or prevent errors from occurring? Unequivocally the answer is no.

Dr. Lucian Leape, professor at the Harvard School of Public Health and national patient safety leader has testified before Congress and stated "the single greatest impediment to error prevention in health care is that we punish people for making mistakes." Punishing human error only camouflages the problem, discourages near-miss and error reporting, and exacerbates an existing problem.

According to the IOM, approximately 80 percent of medical errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them. Creating volumes of disciplinarily polices aimed to dissuade people from committing errors only adds to the complexity of the problem– the latent error is still there. The first question that needs to be asked is "could this error happen again tomorrow, or to someone else?" If the answer is yes, it is not "people" problem, it is a system or process problem.

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Sedgwick County... working for you

Monthly Report

Call Types	Call Volume Emergent	Non-Emergent	Month	YTD
Transports	2,849	445	3,294	9,321
All Calls	4,340	487	4,827	13,505
Avg Calls/Day	139.9	15.7	155.6	148.4

Standard	Target	Performance	Target %	Actual
Chute Time	< 1 min		90%	**93.74%**
Hospital Drop	< 30 min		90%	**96.72%**
Time on Task (xport)	< 75 min		90%	**95.41%**
Urban DE	≤ 8 min 59 sec		90%	**92.21%**
Suburban DE	≤ 10 min 59 sec		90%	**86.59%**
Rural DE	≤ 15 min 59 sec		90%	**92.31%**
Response UHU	0.40		N/A	**0.42**
Transport UHU	0.32		N/A	**0.29**

Human Resources/Public Relations

	Month	Month (hrs) (hrs)	YTD	YTD (hrs)
# of PR Events & Hours Conducted	9	29.5	11	35.5
# of Dedicated Standby Events & Hours	28	153.5	64	340.5
# of Employee Training Hours Provided	N/A	770.75	N/A	2,087
# of Reserve (Volunteer) Hours Provided	N/A	N/A	N/A	997.75

Logistics

	Target	YTD
# Critical Vehicle Failures/100,000 Fleet Miles	2	1.95
# Critical Durable Equipment Failures/1,000 Calls	1	0.2
% Time of at Least 3 Reserve Ambulances Available	95%	92%

Safety

	Month	YTD
Preventable Accidents (Vehicle & Personnel)	8	14
Non-Preventable Accidents	0	2
Work-Related Injury Accidents	5	11
Lost Work Time (Hours) Due to Work-Related Injury	204	648

Patient Focued...Patient Centered...Patient Driven

Clinical	Target	Month	YTD
% STEMI Patients to ED < 45 min of Time Call Received	90%	80%	84.21%
% Stroke Patients to ED < 45 min of Time Call Received	90%	93.55%	93.48%
% Return of Spontaneous Circulation (ROSC)	30%	41.30%	38.17%
% Sustained ROSC (> 20 minutes)	10%	10.87%	12.21%
% of Patients Transported	72%	68.2%	69.0%

Financial	Target (2012)	Target (Month)	Month	YTD
Cost per Call	$295.00	N/A	$232.12	$272.20
Cost per Transport	$375.00	N/A	$340.14	$394.40
Avg Collection	$310.00	N/A	N/A	$290.14
Gross Collection %	51%	N/A	N/A	50.06%
Gross Collections	$12,491,510	$1,040,960	$1,087,150.35	$2,891,917.73

To Err is Human…

To build a safer health care system for our patients and become a learning profession, we have to shift our mindset and approach on how we view human error. Health care is a decade or more behind many other high-risk industries in its attention to ensuring basic safety. We must inculcate the new view of non-punitive near-miss and error reporting throughout our profession, which will create a culture of transparency and accountability.

Safe systems cannot be created or effectively managed without accurate, reliable data. We must implement changes at the macro-organizational level regarding system design, processes improvement, and policy development. Countermeasures are based on the assumption that although we cannot change the human condition, we can change the conditions under which humans work.

Sedgwick County EMS is committed to patient safety and the delivery of quality care. We have embraced the new view of human fallibility and have implemented non-punitive near miss and error reporting. Although this transition is in its infancy, we have already experienced an increase in near miss and error reporting– yes, this is good. The data we have received thus far has proven invaluable and has enabled us to make system design and process changes that have improved patient and provider safety.

"Health care is a decade or more behind many other high-risk industries in its attention to ensuring basic safety."

With adequate leadership, attention, and resources improvements can be made. It may be a part of human nature to err, but it is also part of human nature to create solutions, find better alternatives, and meet the challenges ahead– our patients are depending on it.

Respectfully,

Scott