TO: All MCFRS EMS Providers DATE: September 30, 2004

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SUBJECT: Patient Safety through a Patient Care Action Plan

When Chief Carr released Directive 04-16, the "Safe Driving Action Plan" pertaining to safety issues in the operation of apparatus, I saw an analogy much in common between the goals he outlined in the driving arena, and our goals in the medical arena. I hope to use the same tools and data to instill a measured sense of caution as part of an enhanced solution for patient safety, as has been put forth for our vehicles.

Modern EMS medical oversight models seek to use trends to address quality in advance of adverse events. Starting in March 2001, I began a strategy of education, first a memo about hot topics in the System (6/01), then a series of "Insta Faxes" to every station, then a mailing to each and every medic (Summer 2002) to underscore reasons to adjust or modify practice habits. We had given definitions of high risk complaints, and used scientific evidence to point out that EMS as yet lacks the tools for a safe widespread treat and release program. That having been said, we hope the word has been out on the street for a while about avoiding the less than prudent habit.

Unfortunately, as is the case in vehicle accidents, the very nature of our work links less than prudent practice with unsafe decisions for patients. Some are masked refusals legally not supported, some are downgrades at risk of resulting in sub-optimal medical outcomes, and any of these may result in catastrophic public relations failures. It is both by necessity and a good time to underscore hot topics in the spirit of a safety program. I wish to support you medically, but each practitioner must make smart decisions in practice the same way we would in apparatus operation. Fortunately however, the adoption of just a few bits of knowledge and habits in avoiding pitfalls makes our patients safer in the short term, and our job easier for us in the long term.

**Situations associated with non-transports:** It is well documented in national literature that the greatest liability we face after auto accidents is in the care of patients. Within that realm, the largest area of trouble is from situations surrounding failure to transport. The sub-areas that are reported that would place EMS at risk are:

- Patient based refusals: Although required by law to accept the will of an alert and oriented adult, this should only occur after we have informed the patient of our advice to transport them and we have described appropriately the risks they have by not going to the hospital. Only once we have clearly offered or urged transport and then described the risks, can we accept the patient's refusal.

- Provider-based refusals: Again, national studies have failed to find a system or program in paramedicine that supports routine treat and release habits which are safe so far, mainly because so much of what we see needs evaluation sooner than later, and we lack the diagnostic tools of the Emergency Department.

**High risk chief complaints** mean symptoms reflecting problems with vital organs or blood/nutrient/nerves supplying them. This includes chest pain, dyspnea, syncope/collapse, altered mental status, seizures, neurologic deficit, severe trauma, abdominal pain or severe pain elsewhere, occurring at any time to generate a 911 call.

**Customers**: We should institute "complaint avoidance", by taking a moment to think about how something we do might generate a complaint. If this were your family, or your boss in another job, would your actions be tolerated? Systems cannot defend members who do not fulfill basic job tasks, or display poor bedside manner.

These related topics having been identified, solutions are multi-factorial, but just a **few simple rules or habits** for ourselves will enhance safety and avoid risk:

- Begin by assuming that most patients who called thought they needed medical attention, and were expecting not to be released and referred elsewhere later.
- Leaving medical decisions to lay-patients by casually "offering" transport leads many to think you believe nothing is wrong, so they'll elect to stay home. When things go wrong, they'll often pin that decision on EMS, who "gave me a choice". Moreover, without a careful assessment, such a posture can never be defended.
- Simply urge all patients with risky chief complaints to submit to transportation after an assessment which takes into account the pre-arrival (in addition to scene) complaints. No reason exists why patients who have or had such complaints should be left on the scene, with the exception of a bona fide patient refusal.
- The practice of "talking patients out of going to the hospital", or "milking" a refusal is not tolerated for high risk chief complaints in most systems.
- Personnel make a mistake to speculate to a patient about how little an Emergency Department visit will accomplish (i.e. the "ED will probably not do much for you"), because this invariably intimidates the public into submission and is often medically inaccurate.
- Along these lines, refrain from suggesting such patients be transported in a car.
- Renew a commitment to comprehensive narratives on patient encounters; any medic who assesses a patient as the highest level provider dispatched to assess a patient should consider a narrative to justify "downgrading" patients to BLS providers, or else no paper trail exists.
- All encounters resulting in non-transport should result in a narrative
- All bona fide patient refusals will be documented in the narrative, including any attempts by the providers to coax the patient to comply, and be accompanied by a signed refusal of services when the patient is informed of the refusal risks.
- If it is believed that a transport is counterproductive or wholly unnecessary and the patient is expressing interest in options (ex "frequent flyer" with low sugar, "called to be checked out"), the medic will consider consult with a base physician.

- As we embrace the concepts in Crew Resource Management, all team members dispatched for patient care who reach the scene should consult with each other and the most compulsive opinion should generally be carried out, with no constructive input being dismissed, especially before any non-transport.
- In a single patient encounter, every member of the team should be encouraged to know what has happened so far to the patient and the plan being carried out. This specifically clues in folks with good ideas to chime in if they have helpful information, and also reminds us to make sure that an assessment was done.
- ALS providers should not "ignore" a BLS provider who thinks a patient is ill-appearing, but think twice before compelling a downgrade, or at least take the time to justify and explain to BLS why the patient is assessed as lower risk.
- If any transfer of care occurs shy of the hospital, or by any unit crew to another, it is vital that all known factual information and medical opinion be transmitted, allowing a more detailed assessment to follow, or to prevent redundant efforts.
- It is more likely a losing proposition to "police" patients or facilities' utilization of our services "on the fly" at the scene: Scolding does not stop us from having responded to the scene, it often generates a fight in real time, and a complaint later. And worst, a stern posture when responding will sometimes jade us into dismissing a real medical condition because we are annoyed at past utilization. Even if we are right in most given cases, the issues can be addressed later. When it comes to true EMS abuse by a frequent caller, careful remedies are available. Simply approach each call with a new open mind, without feeling as though the public's shortcomings are a personal attack on you.

These simple habits will first enhance quality and patient safety, while secondarily keeping us out of trouble ethically, perceptually and legally. Please remember that colleagues in Quality oversight have the luxury of hovering over the system and knowing about bad outcomes and problems that do not reach the whole rank and file. This allows us to see the common causes that bond the outcomes together and seek best practices. I maintain that none of what is expected of providers is aimed to always hogtie them into any one decision on any one call. Following this general outline is simply shown to have a better long term result. I welcome constructive discussion about any and all issues that enhance quality of care and the safety of the public.