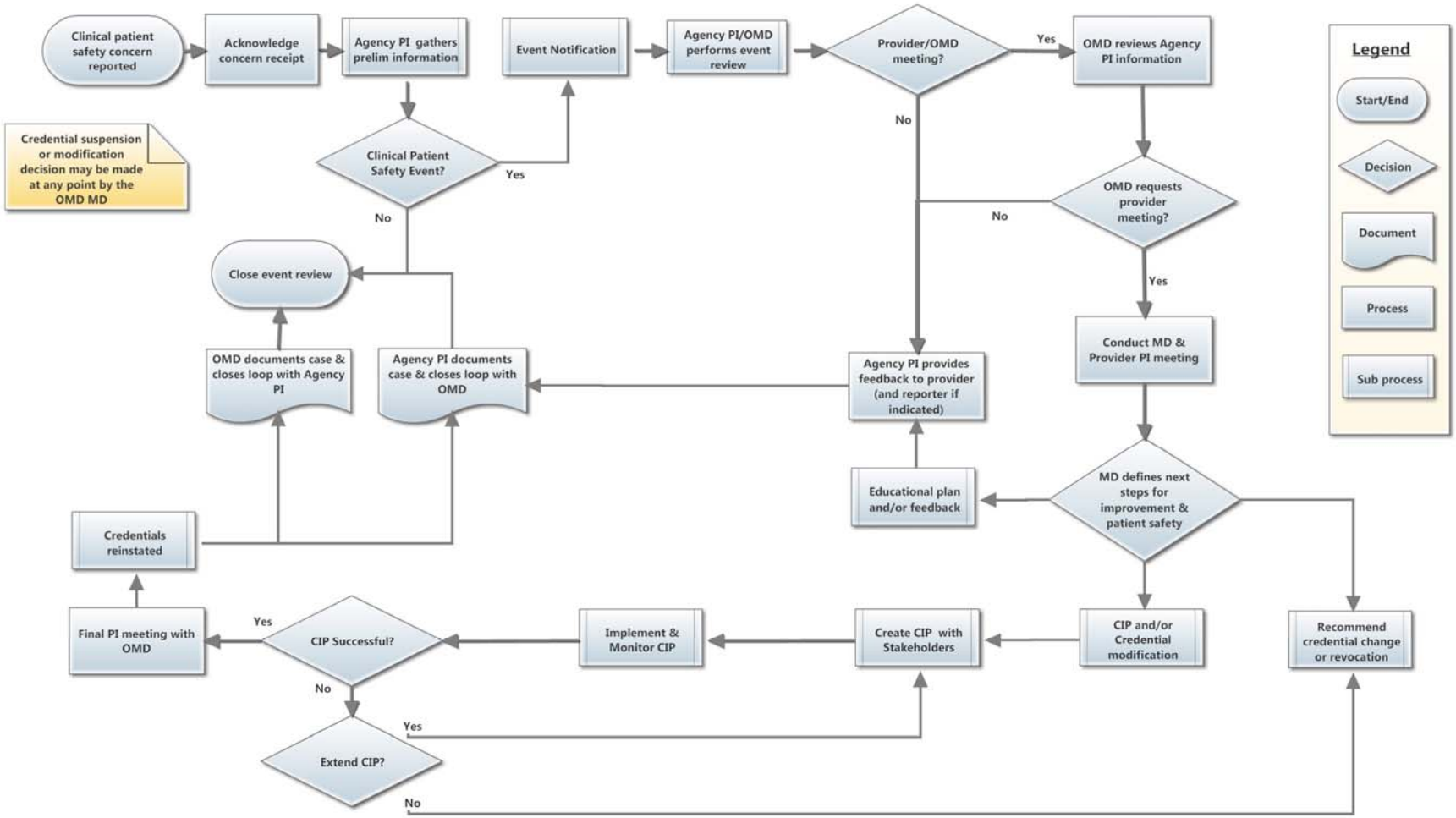
Austin-Travis County EMS System Patient Safety Event Review Process (rev 11.10.2016)



Rev 3/2017

Patient Safety Event Review Process Overview
Austin-Travis County EMS System

The following is a very brief overview of the patient safety event review process. For more information, contact your Agency's Performance Improvement group or the Office of the Medical Director.

Most healthcare providers including prehospital providers want to perform meaningful clinical assessments and deliver effective clinical care while minimizing the risk of additional harm to patients.

- When a patient safety event or clinical error occurs regardless of whether patient harm occurred, an opportunity to improve is created.
- The Patient Safety Event Review process has four specific objectives aimed at improving clinical quality and patient safety.
    - Determine the facts using a systems approach
    - Identify why the safety event occurred
    - Determine what specific improvements could be made to reduce the risk of recurrence
    - Measure reduction of this risk after improvement implementation
- The degree of discussion and review is based upon the extent of the concerns, degree of risk to patients, and the extent of the improvement needs. It is not based on the final patient outcome.
- The process seeks improvement in clinical care & service. It is not about placing blame.
- The process is designed to ensure confidentiality of the details to allow open discussion.
- The process utilizes the just culture philosophy to determine the severity of the concern

The patient safety event review process offers an objective, consistent and fair process for reviewing errors and adverse events for the purpose of improving future performance and ensuring the safety of patients while also minimizing the risk of professional harm to the provider. Improved performance may occur at the system level, individual level, or both.

- Examples of system level improvements include:
    - Clarifications to a policy, procedure or guideline
    - Education for all providers regardless of involvement in an adverse event or error
    - Equipment designed to reduce the probability of error or harm such as critical alarms on medical devices and stocking redundant medical devices
- Examples of individual level improvement include:
    - Provider-specific education to eliminate specific knowledge gaps
    - Patient simulations designed to assist in learning the desired techniques
    - Provider specific education and/or simulations to improve team communications