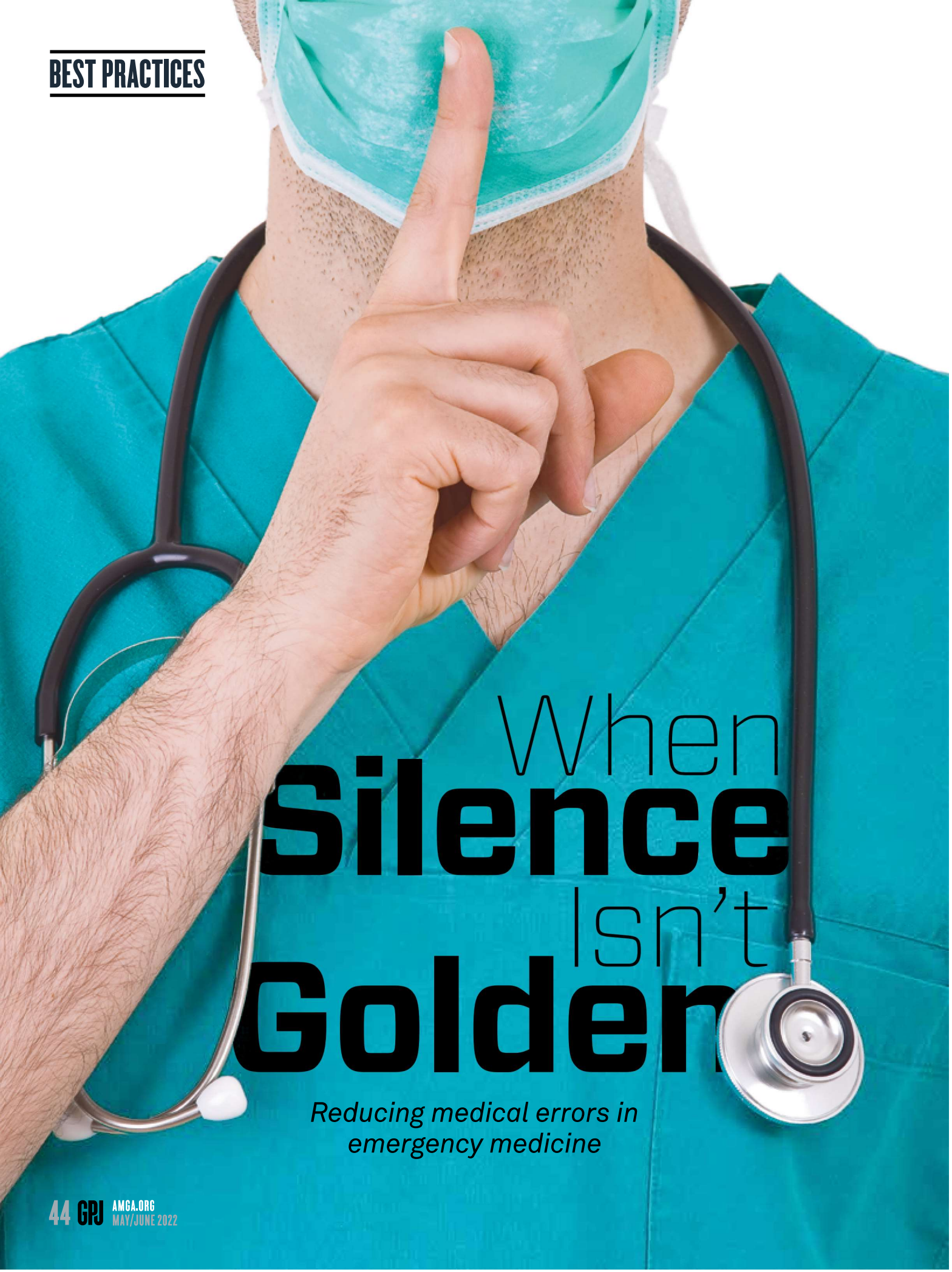

When Silence Isn't Golden

Reducing medical errors in emergency medicine

By Donna M. Prosser, D.N.P., RN, NE-BC, FACHE, BCPA

Hundreds of thousands of people die and millions more are harmed in the United States each year due to preventable emergency medical errors. These are only estimates, however. No national standards exist for tracking the incidence of patient safety events. This is especially true in emergency medicine, since most studies in recent years have focused only on in-hospital system errors.

A major barrier to tracking patient safety across emergency care settings is frontline providers' failure to report adverse events on a timely basis. Too often, when errors occur, we play the "name, shame, and blame" game and look to identify one or more individuals at fault. This leads to a culture of silence among healthcare workers, who understandably do not want to admit to mistakes for fear of repercussions. Most healthcare errors result from system and process breakdowns rather than individual behavior. In most cases, blame is unwarranted in the first place. And when errors go unreported, the opportunity to understand system and process root causes is lost, leading to continuing risk for patient harm.

Pre-hospital settings are, by their very nature, environments fraught with safety risks to both patients and providers. Emergency Medical Service (EMS) personnel are challenged by seasonal climate extremes, exposure to hazardous chemicals, uncontrolled crowding, and other situations over which they often have little control. For example, they may be required to respond to a situation with little knowledge of what to expect and lack necessary staffing and supplies, or unruly bystanders may interfere with their ability to provide timely care. Their personal safety can also be put at risk when they are called to an emergency that is the result of violence. However, many safety risks inherent in emergency medicine *can* be mitigated.

Hazards in the Field

Medication errors often occur because hospital safety systems, such as standardized medication administration cabinets and independent double checks, are difficult to replicate in the field. Art Kanowitz, M.D., founder of Securisyn Medica and retired Colorado State EMS and trauma services director, points out that an EMS crew often has only one paramedic enabled to administer medications. Dr. Kanowitz recommends "EMT-Basics" training as a second set of eyes so paramedics can perform independent double checks, even when administering medications is out of their scope of practice. Using color-confirmation and visualization systems such as Broselow and Certa Dose also reduce the risk of medication errors.

P. Daniel Patterson, Ph.D., associate professor of medicine at the University of Pittsburgh and a practicing paramedic, believes that the biggest impediment to improving patient safety in emergency medicine is a lack of focus on provider health and well-being. EMS personnel are often overworked and sleep deprived due to inadequate staffing and working 24- to 48-hour shifts. The literature fully documents that extreme fatigue is associated with increased medical error.

Additionally, improving EMS pay would enable recruitment of qualified providers and reduce the need for mandatory overtime. Establishing napping protocols would significantly reduce fatigue during long shifts. This would reduce risk of medical harm to patients and improve health and safety for emergency providers. Those on the front line whose well-being is neglected can easily get jaded. This results in a lack of empathy and attention to safety protocols.

Error Prevention Systems

Highly reliable systems experience extended periods of time without any errors. Such systems are inherent in aviation, nuclear power, oil and gas, and other high-risk industries. To improve both patient and provider safety, EMS health care must become as reliable as these other high-risk industries. This requires that everyone, from the front line through the entire chain of command, is hyper-focused on identifying potential risks *before* an error occurs.

Leaders need to ensure providers that it is easy to report potential and actual errors and examine the complex systems and disjointed processes that may be root causes. Measuring the frequency and type of adverse events and near misses in the pre-hospital setting is critical. We know that only what is measured is what gets improved.

Emergency providers have a crucial role to play in preventing harm and death in health care. Populations with the highest use of EMS tend to be the indigent, the elderly, and those without access to adequate primary care. Because these groups are already at risk for harm due to socioeconomic factors, a focus on improving patient safety in the pre-hospital setting is essential. GPJ

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