FOURTH QUARTER 2020 SafetyMatters

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Situational Awareness of Patient Safety

By Bev Meade, DNP/HSL, RN, MHA, CEN, CCRN, CFRN, CTRN, TCRN, EMT-P
MedFlight Flight Nurse

A sobering statistic by the World Health Organization (WHO) (2019) states "the occurrence of adverse events due to unsafe care is likely one of the 10 leading causes of death and disability in the world". Reflect on that for a moment and understand the WHO further indicates that almost 50% of these untoward events can be prevented! So, what is our responsibility to patient care in transport? We become the advocate and caregiver for the patient and all members of our team. Whether in the air or on the ground, we are the foundation of safe transport initiatives.

MedFlight has a strong history of providing and promoting safety as one of the important components of quality care for our customers and patients. The culture at MedFlight promotes a high level of importance on safety and encourages each of us to adopt the value and attitude of patient care injury prevention. Take a look at our Standard Operating Procedure (SOP) that includes Exposure Control, PAIP, and Crew Shift Risk Assessment. The SOP has been designed, revised, and reviewed to ensure that we have the information and guidance to transport our patients in as safe a manner as possible. Furthermore, as we look at our Guidance Circulars (GC) we find Cabin Temperature and Safe Handoff of Care/EMS Time Out Report to be of great importance in promoting safety in transport.

We know that safety is a fundamental component of providing patient care and this begins before we even arrive to the bedside. We must follow and be truthful with our risk assessment guidelines that delineate how prepared we are to assume care and safely complete our mission. In addition, making certain that our patients are secured in our vehicles as well as ensuring appropriate temperature control (especially as we enter our winter season) is a primary safety aspect of patient care.

Prevention of harm to patients and emphasis on safety measures as well as supportive SOP/GC components is the foundation of patient transport at MedFlight. Together and individually we will continue to do our part in moving unsafe care out of the top ten causes of death and disability. ■

Sources: World Health Organization (2019) Patient Safety.

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Mission. Ready.

Changing the Acceptance Culture in Medical Transport

By Jeff White, M.S., MTSP-C, FP-C
Director of Safety, HealthNet Aeromedical Services

I have always heard that the devil is in the details. I have experienced the truth behind this common expression time and time again. Missing the small details and things that seem unimportant can lead to disastrous results. We can all remember "that one time" when we let something seemingly miniscule go by and never realize the significance of the ripple effect.

Maybe you forgot the portable radio in the rig while grabbing lunch, which ultimately delayed response to a critical patient. The time you were in a hurry to get to the aircraft and relied on the rest of the crew for a walk-around and there was a piece of FOD hidden that another set of eyes may have caught. That 3:00 a.m. red light that you ran through to get back to station, even though you checked for other cars. The time you walked into a patient's room for an interfacility and transferred the IV pump and never checked the flow rates for correct concentrations of medications. Your truck breaks down because you failed to do a truck check off and you delay the transport of a patient being taken home for end of life care. These seemingly small but common occurrences have a ripple effect that is routinely an afterthought.

In the grand scheme of things, these occurrences do seem minor. However, when trying to build a true safety culture in EMS you must remember the details. Many of these things are shrugged off as minor errors, never reported officially but always talked about by the crews. These are always the small things that come out during an investigation of a much larger event.

A simple example is backing an ambulance without a spotter. We have all done this before without consequence. The one time we have a minor incident and back into a pole or sign seems like no big deal. The ripple effect is adding your bumper repair to all the others in the fleet that have had the same thing happen. This causes insurance companies to look at the increasing accident rate and premiums go up. There is also the downtime of the truck which puts stress on other employees which can change how they interact with patients.

How many times have you completed a walk-around of an aircraft and the fasteners blend into the background and the other latches, door handles, and cords take precedence? It would be easy to miss one of these which is missing a screw. This issue could prevent the aircraft from taking off, per regulation, until the screw could be replaced. This could lead to a longer response time, potentially affecting patient outcomes negatively.

It has become common place in the industry to answer everything with "that's just how EMS works." As an industry, healthcare has an allowable measure for medical errors. In an industry that is built on helping people in their worst hours, why do we accept this?

Working in a high reliability organization, in a high-risk environment you always must pay attention. Every small decision we make in some way affects our co-workers, patients, patients' families and ultimately your company. Moving away from the "it's just the way it is" mentality begins with you. Each person who chooses a profession in patient transport must also make the decision to function at the highest level. ■

OSHA Celebrates 50th Anniversary of Occupational Safety and Health Act

By Lynn Gilmore, CSP
Safety Officer, MedFlight

Photo Courtesy: osha.gov

Did you know it was only in 1970 that the Occupational Safety Health Act was signed by President Nixon? When Congress was considering the OSH Act in 1970, approximately 14,000 occupational fatalities were being reported each year as well as 2.5 million job-related disabilities and 300,000 new cases of job-related illnesses.

The first five industries targeted by OSHA for safety hazards were marine cargo handling, roofing and sheet metal work, meat and meat products, miscellaneous transportation equipment (primarily mobile homes), and lumber and wood products. Five health hazards were also targeted: asbestos, lead, silica, carbon monoxide and cotton dust.

OSHA Milestones

1970s – Occupational Safety and Health Act signed. OSHA Training Institute. Cotton Dust & Lead Standard issued.

1980s – OSHA coverage for Federal workers. Employee Exposure and Medical Records. Hearing conservation. Hazard Communication. Ergonomics. Hazardous Waste.

1990s – Blood Borne Pathogens. Safety Management System. Chemical Process Safety.

2000s – Globally Harmonized System. Recording and Reporting Occupational Injuries and Illness.

As we entered a new decade, the coronavirus created unprecedented workplace safety and health challenges. Let us join OSHA in making a renewed commitment to keeping our country's workforce safe and healthy! ■

Safety Taken for Granted

By Karen Swecker, RN
Exposure Control Liaison, MedFlight

Products today are sealed and labeled letting the consumer know the contents inside are safe. This was not always the case.

In 1982 products were not sealed; there wasn't any plastic wrapping around caps, no foil or paper seals across the inside mouth of the containers. Consumers assumed the product was safe and had not been tampered with.

This all changed in September 1982 when seven people from the Chicago area died from taking Tylenol capsules laced with potassium cyanide. Someone had purposely opened the Tylenol bottles, emptied out the acetaminophen, filled the capsules with poison, and put the product back on the store shelves. No connection between those who died was found. The Tylenol bottles were manufactured at different production plants and purchased at several drug stores throughout Chicago. To date, the case remains unsolved.

There were hundreds of copycat incidents across the country. Pills were contaminated with poisons including rat poison and hydrochloric acid. Food was found with pins inserted through the packaging.

These incidents created a new safety culture. Companies began using tamper-proof packaging and seals to let consumers know the product had not been tampered with since it was packaged at a production facility.

Wearing gloves for patient care is SOP in today's world. This wasn't the norm in the late 1980s. Healthcare workers had to hunt to find a pair of gloves. Disposable gloves for medical use

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were first manufactured in 1965. It wasn't until 1992 when OSHA developed the Bloodborne Pathogens Standard that employers were required to provide disposable gloves for healthcare workers. For many donning gloves before touching patients or their bodily fluids was an added chore and not looked upon favorably. HIV and AIDS changed our outlook and safety precautions for patient care.

Today's healthcare provider dons and wear gloves without a second thought. It would feel strange not to have gloves on, like some aspect of care is missing or forgotten. However, we have now gone to the extreme and wear gloves as if they are magic coats of armor. Next time you wear your gloves take a moment to think about what you are touching and where your gloves have been. Did you start an IV with dirty gloves, did you use contaminated gloves to touch surfaces in the environment? If we could see germs being transferred from surface or person to person many of our practices would change.

Safety evolves and changes as threats and environments change and as we recognize new threats. Do not rely on others for your safety, take an active part in helping to keep yourself and those surrounding you safe. Perform hand hygiene, wear a mask as required, and change gloves frequently. These are simple safety measures we can do to protect us all. ■

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Do you have any ideas for SafetyMatters?
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