

Statewide EMS Quality Improvement
2002-2003 Plan
EMS Office
Pennsylvania Department of Health

A written document or a system audit does not accomplish continuous improvement in the EMS system and individual EMS services. Instead, continuous improvement comes from an ongoing commitment of EMS system stakeholders who are dedicated to improving the quality of emergency medical care delivered by that system to its patients.

This statewide QI plan will guide the QI process, and it will encompass all levels of EMS providers and personnel within the Commonwealth. The plan will not micromanage the QI projects of various entities. This plan will set the framework for local and regional QI coordinators. It is clear that the statewide QI plan itself will be a continuously developing and continuously improving plan.

The Department encourages collaboration among PEHSC, regional councils, EMS services, EMS practitioners, PSAPs, trauma centers, and other stakeholders to establish resources for best practices at each level of QI included in this statewide plan.

For quality improvement processes to work, it is essential that the process be non-punitive. The process must also be inclusive of every level of individual within the system, and it must make every individual feel welcome and important in the process. The system individuals must believe that the process will lead to system improvement and ultimately to improved patient care.

EMS quality improvement occurs at several levels, and the system is responsible for improving the quality at all levels. QI is important at each of these levels, and the QI responsibilities at each level are defined below:

I. EMS Office, Pennsylvania Department of Health

The Department will assure that EMS QI occurs throughout the EMS system in the Commonwealth of Pennsylvania. The Department will assure that every region effectively participates in the QI process. Additionally, the EMS Office will use QI processes to improve the quality of services that it provides to organizations that interact with the Office.

During the 2002-2003 year, the EMS Office will:

- ❑ Establish an EMS Office QI Committee. This committee will be chaired by the Commonwealth Emergency Medical Director and will assess areas for improvement in services provided by the EMS Office. The committee will be composed of internal EMS Office personnel and external representatives. The external committee membership will include an individual representing PEHSC, PTSF, and regional councils.

- ❑ Explore QI resources for training individuals responsible for EMS QI. In the past, the Office sponsored the NHTSA QI Training Course for regional QI coordinators and regional representatives. The EMS Office will convene a meeting of regional QI representatives to investigate best practices related to the anonymous error reporting system.
- ❑ Assure that every region has met their 2002-2003 QI responsibilities.
- ❑ Establish a statewide QI plan for the 2003-2004 year, with annual expectations for each level of the EMS system.
- ❑ Assess the service that the EMS Office provides to its users.
- ❑ The EMS Office may coordinate QI projects that can be used by all regional councils, EMS providers, or medical command facilities within the Commonwealth.

II. EMS Regional Councils

During 2002-2003, each regional EMS council will complete the following:

- ❑ Establish a Regional Quality Improvement Committee that meets at least quarterly and includes all levels of EMS services. The committee must include representatives from First Responder providers, BLS ambulance providers, ALS ambulance providers, service medical directors, and medical command physicians. Committees are encouraged to include representatives from PSAP/ Emergency Medical Dispatch providers, non-EMS AED providers (e.g. police or industrial AED providers), receiving facility/ hospitals, regional trauma centers, and other appropriate organizations.
- ❑ Establish an anonymous regional EMS safety incident/event reporting system. The airline industry has had tremendous success with systems for the anonymous reporting of safety incidents. Airline personnel are so comfortable with this system that they often report their own safety incidents. Since many EMS safety incidents are related to system problems and not to individuals, it is ideal to attain this level of reporting comfort so that causes of safety incidents can be investigated and the potential for repeated safety incidents can be reduced. This system will include:
 - ❑ An anonymous mechanism for the reporting of EMS clinical safety incidents and a procedure for immediate blinding of any safety incident that has not been anonymously reported.
 - ❑ This safety incident reporting mechanism must be separate from the existing complaint investigation procedure. The reporting system must include a mechanism to clearly inform individuals filing reports that this is not the system that should be used to file an official complaint against an EMS provider or practitioner, and should advise individuals of the mechanism for filing an official complaint to be investigated.
 - ❑ It is important that the anonymous regional safety incident reporting system include the important events that become complaints. For this reason, the region will submit an anonymous safety incident report into the system for each complaint that is related to an safety incident.
 - ❑ For the purpose of this reporting system, an safety incident will be defined as any event or action that leads to or has the potential to lead to a worsened patient outcome related to the event or action. These can be safety incidents related to systems, operations, device or equipment failures, drug administration, or any aspect of patient care.

- ❑ A mechanism to summarize the reported errors into an annual report for submission to the EMS Office.
- ❑ A plan to use the safety incident summaries to guide the region's QI projects and training/ continuing education sessions focused on reducing frequent safety incidents.
- ❑ A method of marketing the regional EMS safety incident reporting system to the BLS and ALS practitioners and the nursing and physician staff in receiving facility emergency departments.
- ❑ The region's safety incident reporting system should become operative by 7/1/03.
- ❑ Each regional Council will assure that every ALS ambulance service and ALS air ambulance service is performing regular QI as required by this statewide QI plan and the EMS Act and its rules and regulations.
- ❑ Each regional Council will assure that every medical command facility is performing regular QI as required by this statewide QI plan and the EMS Act and its rules and regulations.
- ❑ Each regional QI committee will develop and perform a QI project on a regional level. The results of this project and a plan for improvement will be reported to the EMS Office QI Committee.
- ❑ The regional QI committee may coordinate QI projects that can be used by all EMS provider services or medical command facilities within the region.
- ❑ Provide resources to assist EMS services in the performance of QI.
- ❑ Complete a satisfaction assessment of the services that the regional council provides to individuals and entities that interact with the regional council.
- ❑ Explore regional QI resources for training individuals responsible for QI.
- ❑ The regional council must assure that the identities of EMS providers, EMS practitioners, and patients are protected during each phase of the QI process.

III. ALS Ambulance and ALS Air Ambulance Services

The EMS Act and its rules and regulations require that each ALS Provider completes regular QI to maintain a license to provide ALS services. ALS services should consider performing their QI activities in conjunction with the local receiving hospital(s). Knowledge of patient outcome is essential to good EMS QI, and there may be increased peer review protection for projects that are done within the structure of the hospital system.

During 2002-2003, each ALS ambulance service and ALS Air ambulance service must:

- ❑ Have a structured formal system for developing, completing and analyzing regular assessments of the quality of patient care provided by that service.
- ❑ Include the ALS service medical director in its QI activities.
- ❑ Show evidence of completing at least two quality improvement projects, including final summaries and improvement plans. The summary/improvement plan of each QI project must be submitted to the regional council.
- ❑ Educate all personnel to the regional safety incident reporting system.

IV. Medical Command Facilities:

The EMS Act and its rules and regulations require that each medical command facility complete regular QI to maintain approval as a medical command facility.

During 2002-2003, each medical command facility must:

- ❑ Have a structured formal system for developing, completing and analyzing regular assessments of the quality of patient care provided by that facility.
- ❑ Include the medical command facility medical director in its QI activities.
- ❑ Show evidence of completing at least two quality improvement projects, including final summaries and improvement plans. The summary/improvement plan of each QI project must be submitted to the regional council.
- ❑ Educate all personnel to the regional safety incident reporting system.

V. BLS Services

The concepts of QI are essential to improving the clinical service provided by BLS services. BLS services are encouraged to develop a QI process, establish a QI committee, assess the services they provide to their users, include a service medical director and hospital resources in service QI, interact with other levels of providers to improve the quality and efficiency of patient care, and perform QI projects. In future years, these will be required as part of the statewide QI plan.

VI. First Responder Services

The concepts of QI are essential to improving the clinical service provided by First Responder services. First Responder services are encouraged to develop a QI process, establish a QI committee, assess the services they provide to their users, include a service medical director and hospital resources in service QI, interact with other levels of providers to improve the quality and efficiency of patient care, and perform QI projects. In future years, these will be required as part of the statewide QI plan.

VII. Emergency Medical Dispatch providers

Although the Department of Health does not have any authority to require QI at the level of the dispatch center, EMD providers are the first link in the EMS system. EMS system QI is incomplete without assessing the pre-arrival instructions and dispatch modes for the purpose of improving the clinical outcome of EMS patients. Regions and EMS services are encouraged to communicate with dispatch centers to work toward relationships that foster cooperative efforts to improve the quality of patient care and efficiency of the use of EMS resources.

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