JOHNSON COUNTY EMS SYSTEM
MEDICAL DIRECTOR

Monthly Newsletter

2021/09

Prepared By:
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VERGE

VERGE ONLINE REPORTING PLATFORM

Verge is the online reporting platform the Johnson County EMS System is currently using to report and track patient safety events that occur in the system. Your department should have a VERGE icon downloaded on your station computers and maybe even your toughbooks. If you haven't seen the VERGE icon on any of your department's computers, I would encourage you to reach out to your leadership to inquire about it.

WHAT SHOULD BE REPORTED?

EMS System agencies are expected to report the following Patient Safety Events (PSE) to the Office of the Medical Director (OMD) using Verge as soon as reasonably possible after an event:

- Harm or potential harm (ex. Near Miss/Close call) to patient or clinician during the course of patient care
- Unsafe condition/environment: any circumstance that increases the probability of a PSE
- Medication errors (including errors of omission, ex. failure to give medication when indicated)
- Clinician actions outside of protocol
- Clinician action that exceeds local scope of practice as determined by credentialing category
- Medical device/Equipment failures that occur during patient care
- Hospital/Outside Healthcare provider/Public Complaint regarding patient care provided
- Agency leadership discretion
- Medical Director discretion

PREVENTABILITY

Each case that is entered will have a preventability assigned. If it is a NEAR MISS, we will not assign a preventability as it was already prevented. The next section will discuss NEAR MISSES.

The preventability internal metrics are below:

- Almost certainly could have been prevented
- Likely could have been prevented
- Likely could NOT have been prevented
- Almost certainly could NOT have been prevented

VERGE

PATIENT SAFETY EVENT/NEAR MISS

NEAR MISS

Near Miss (Close Call) events that do not reach the patient will be categorized by reasons that prevented the near miss (close call) from reaching the patient:

- Fail-safe designed in the process and/or safeguard worked effectively
- Provider or healthcare team member who made the error noticed and recovered from this error (avoiding any possibility of it reaching the patient)
- Spontaneous action by a provider or healthcare team member prevented the event from reaching the patient
- Action by the patient's family member/friend/bystander prevented the event from reaching the patient
- Unknown

CASE CONCLUSION

Each case will have a case conclusion. A single case could have multiple issues, therefore a case may have multiple conclusions. The case conclusions are below:

- Accept outcome*
- Assist clinician*
- At-risk behavior*
- Consider disciplinary sanction*
- Human error*
- Repetitive at-risk behavior*
- Repetitive human error*
- Reckless*
- Support clinician for decision to violate rule*
- Support clinician in decision*
- Commend clinician
- Support clinician
- System issue (education)
- System issue (equipment)
- System issue (team communication/dynamics)

JUST CULTURE OUTCOMES

HOW IS THIS BENEFITING YOU?

As a result of VERGE entries, we have been able to send out potential patient safety alerts and potential provider safety alerts to the system.

We have been able to identify educational needs for the system as well. Dr. Jacobsen has put out a video on cardiac arrest metrics, education on Sodium bicarbonate and Calcium chloride administration, peri-arrest specific issues (manual bp, stay and play), and many other topics we will be addressing in skills and simulation.

There has also been system issue changes. Recently we made a change to start carrying Sodium Bicarbonate in the medical bags and have increased the number of Calcium chloride and Sodium Bicarbonate carried on the ambulances.

There have been hospital diversion issues addressed and investigated as well as hospital/EMS relationship issues identified and remedied.

Reporting DOES make a difference.
I encourage you to continue reporting events so we can continue to grow and improve together and provide the best care we can to the community we serve.

Please take a peek at the next page to see our VERGE data for the system so far!

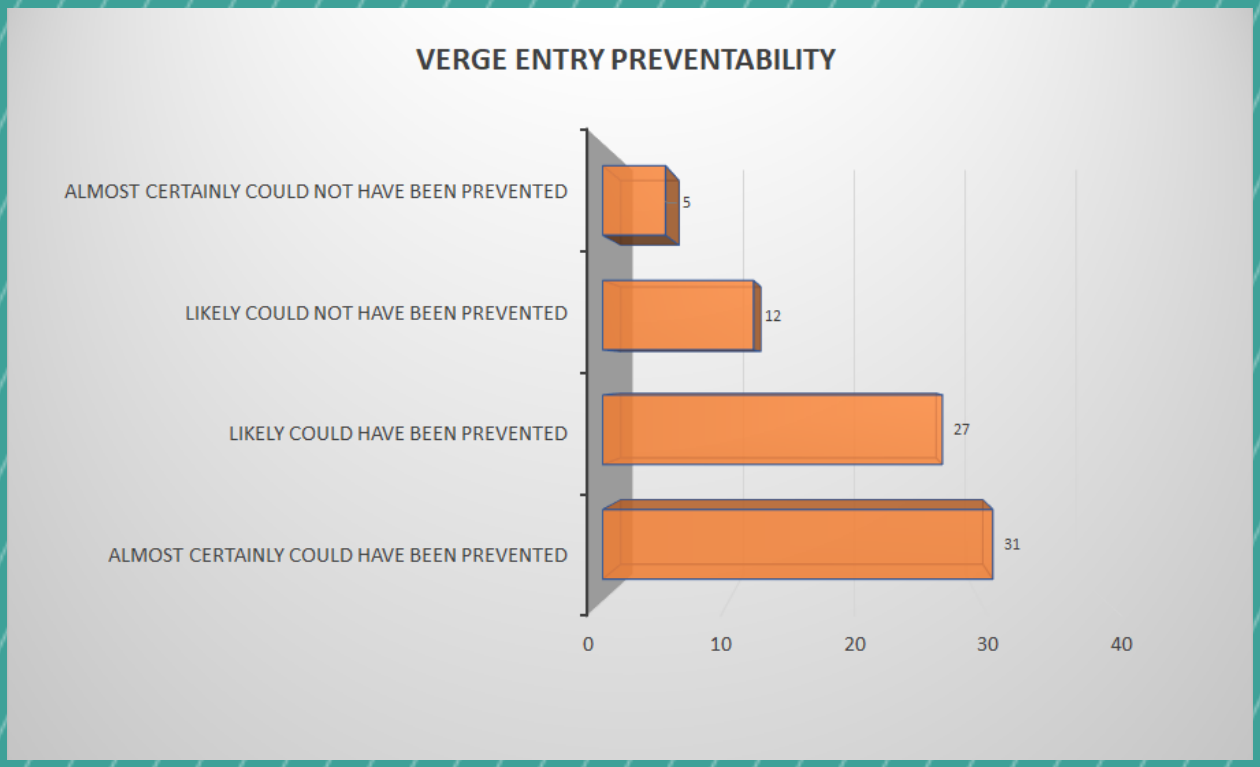
NUMBER OF EVENTS REPORTED IN VERGE

131

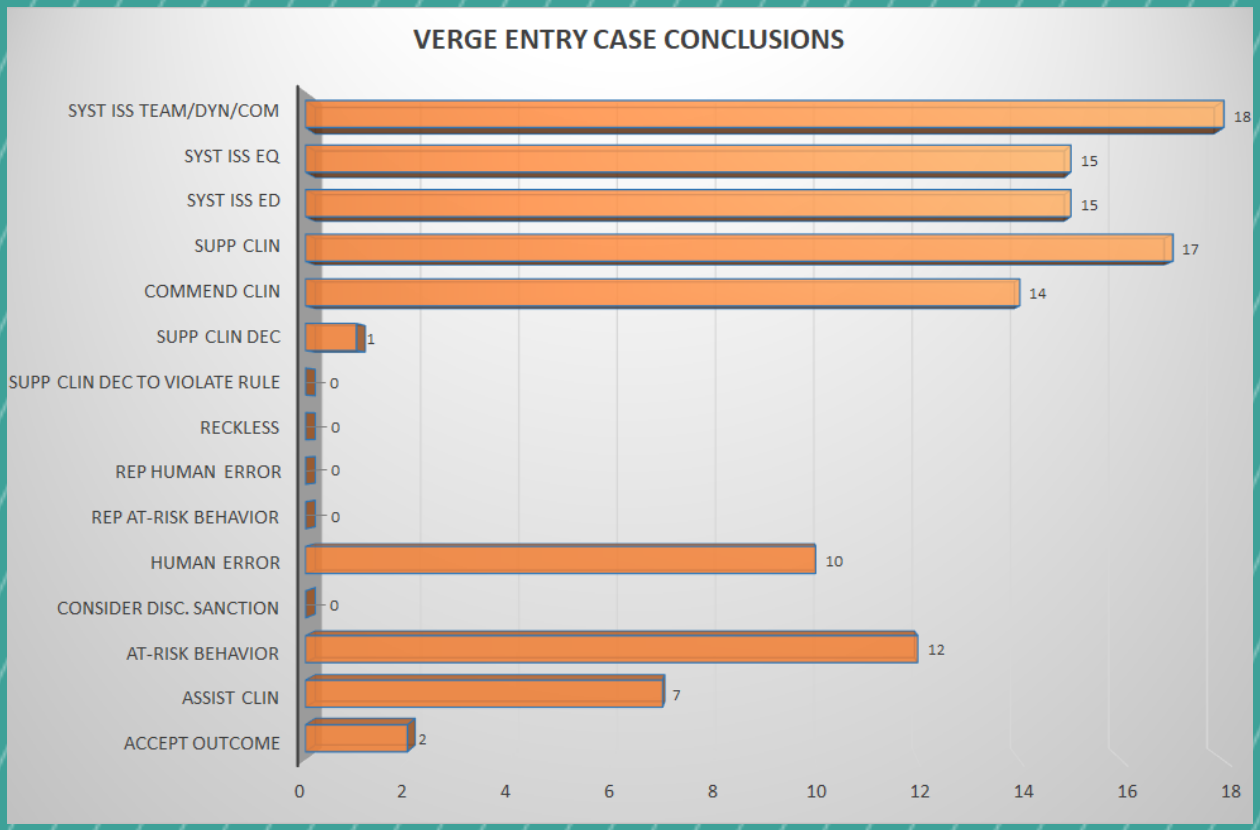
NUMBER OF NEAR MISSES REPORTED IN VERGE

9

PREVENTABILITY



CASE CONCLUSIONS



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QUESTIONS?

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A copy of this newsletter can be found online at:
jcemsmd.com