SECOND QUARTER 2013

E.V.E.N.T.
Near Miss Report

Welcome!

Welcome to the EMS Voluntary Event Notification Tool (E.V.E.N.T.)!

This is an aggregate report of the near miss events reported to E.V.E.N.T. for the second quarter of 2013 (April 2013 through June 2013). We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of Emergency Medical Services (EMS). It collects data submitted anonymously by EMS practitioners. The data collected will be used to develop policies, procedures and training programs to improve the safe delivery of EMS. A similar system used by airline pilots has led to important airline system improvements based upon pilot reported "near miss" situations and errors.

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool. The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

This is the aggregate Near Miss E.V.E.N.T. summary report for Second Quarter 2013.

PROVIDED BY:

The Center for Leadership, Innovation, and Research in EMS (CLIR)

IN PARTNERSHIP WITH:

Table 1: Near Miss Events Quarterly

	2010-2011	2012	2013
Jan - Mar		1	3
Apr - Jun	1		3
Jul - Sep	1	8	
Oct - Dec		10	
Total	2	19	6

As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

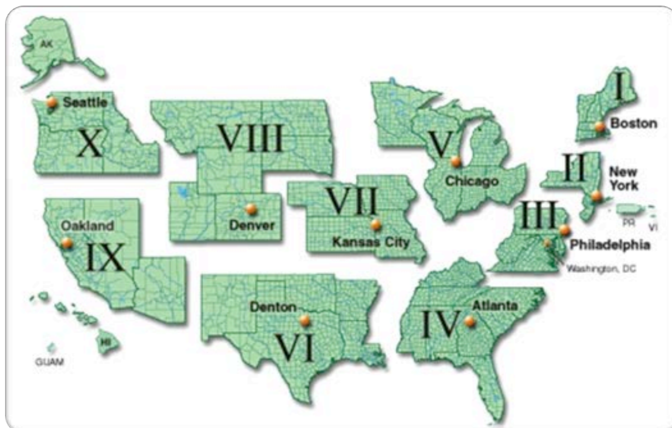
When an anonymous EVENT report is submitted, our team is notified by email. In the United States, the anonymous event report is shared with the state EMS office of the state in which the event was reported to have occurred. The state name in the report is then removed and the record is shared through our Google Group and kept for this summary report. Canadian records have the Province name removed, and then the reports are shared through the Paramedic Chiefs of Canada, and kept for inclusion in aggregate reports.

Figure 1: Near Miss Events by State (United States of America)

5
4
3
2
1
0

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming

Figure 1.1 FEMA Region Map of United States



Near Miss Events by FEMA Region

This period's US near miss event reports were in FEMA regions 2, 3, 4 and 9 (does not match the total number of reports because two were in Canada).

Figure 1.1 Notes: Map includes all Ten FEMA Regions as determined by Department of Homeland Security.

Alabama Emergency Medical Technicians Association

American College of
Emergency Physicians
ADVANCING EMERGENCY CARE

CAA
HEP

CECBEMS

CoAEMSP

HGH EMS
RESCUE

IEMSA
IOWA EMERGENCY MEDICAL SERVICES

NAED
National Academies of Emergency Dispatch

NAEMSP

NAEMT

NASEMSO

NATIONAL
EMS
MANAGEMENT
ASSOCIATION

National
EMS
Memorial
Service

NOSORH
national organization of state offices of rural health

National Registry of
Emergency Medical Technicians
THE NATION'S EMS CERTIFICATION

NATIONAL VOLUNTEER FIRE COUNCIL
ORG. 1976
Supporting Those Who Serve

DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES

VOLUNTEER AMBULANCE & RESCUE
NEW YORK STATE
ASSOCIATION INC.

North Central
EMS Institute

NORTH DAKOTA
EMS
EMS ASSOCIATION

Oregon
EMS Association
www.oregonems.org

PENNSYLVANIA EMERGENCY
HEALTH SERVICES COUNCIL
Your Voice In EMS.

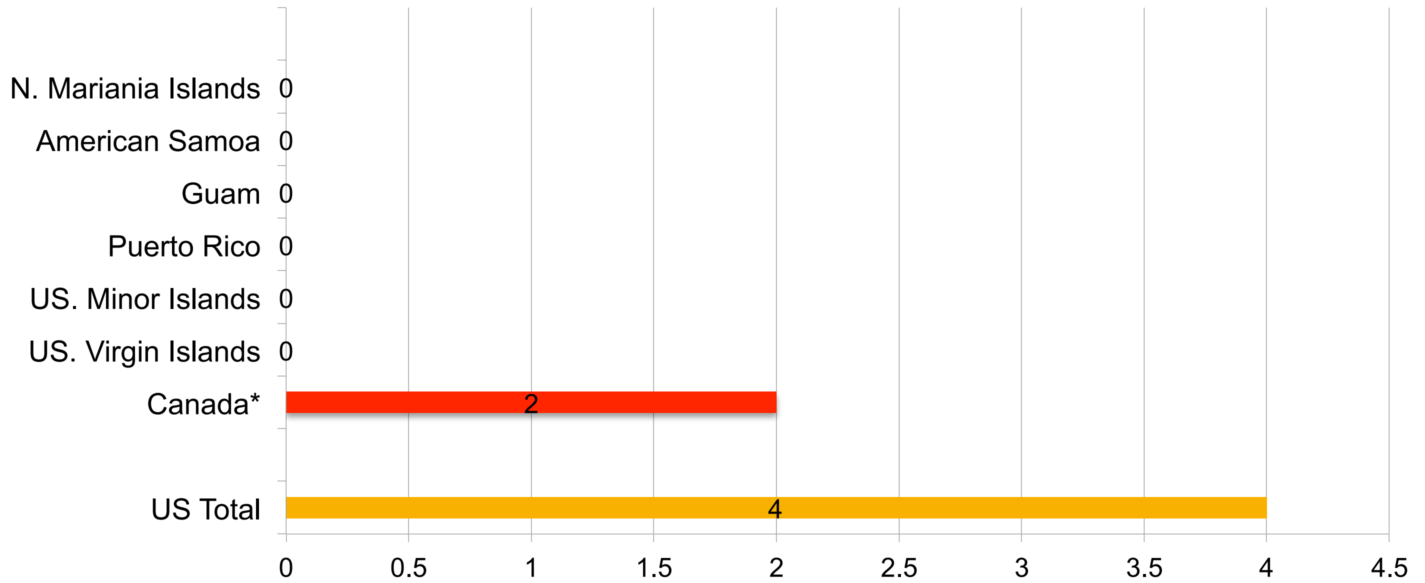
PAAW
PROFESSIONAL AMBULANCE
ASSOCIATION OF WISCONSIN

SOUTH CAROLINA
EMS ASSOCIATION

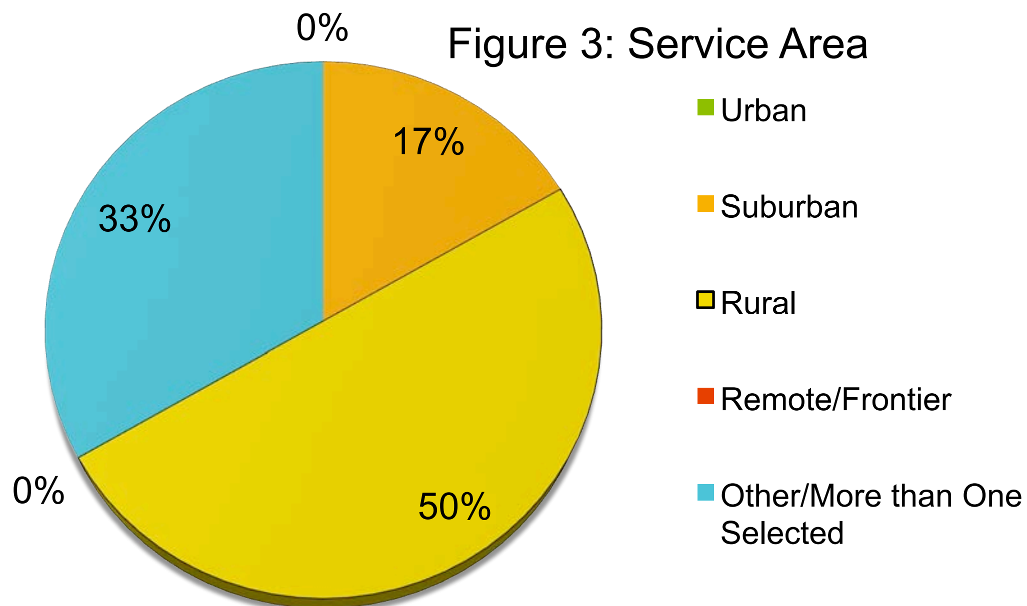
VFIS
A Division of Glatfelter Insurance Group

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

Figure 2: Quarterly Near Misses in Canada and U.S. Territories



Quarterly Frequency of Near Miss Events Across Agency Characteristics



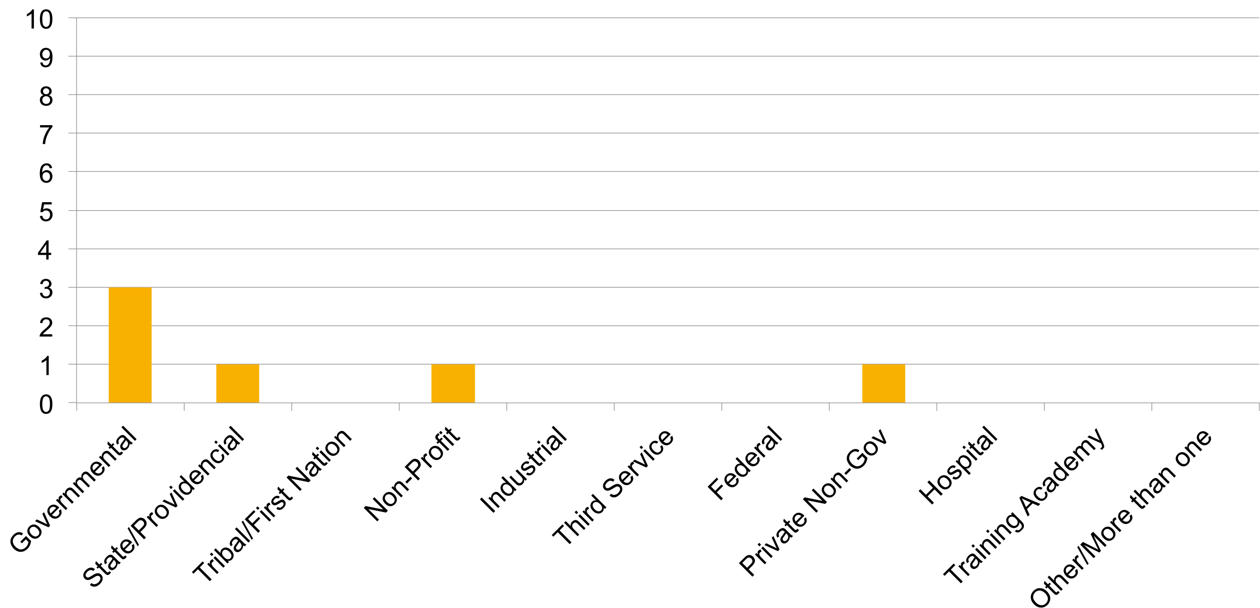


Figure 4: Frequency of NME by Agency Ownership
10
9
8
7
6
5
4
3
2
1
0
Governmental
State/Providencial
Tribal/First Nation
Non-Profit
Industrial
Third Service
Federal
Private Non-Gov
Hospital
Training Academy
Other/More than one

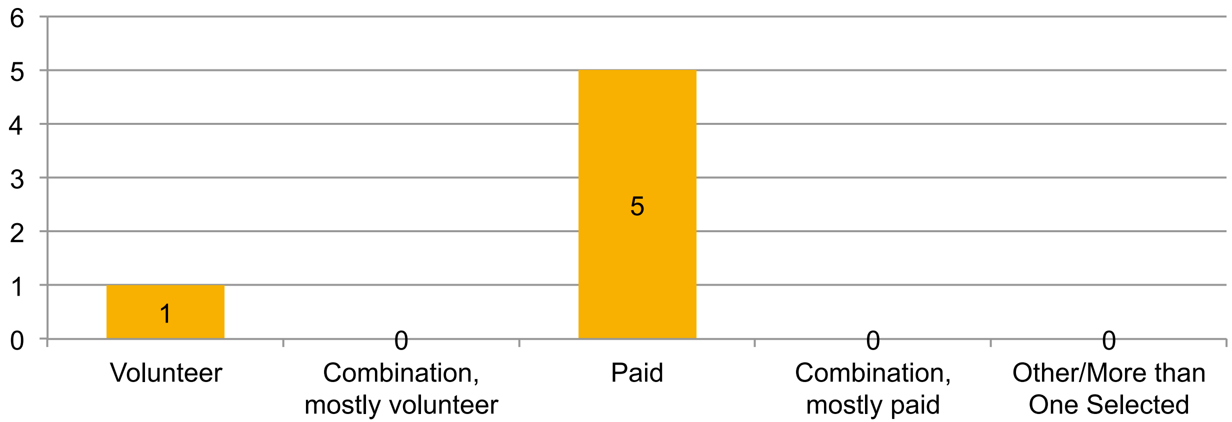


Figure 5: Department Type
6
5
4
3
2
1
0
1
0
5
0
0
Volunteer
Combination, mostly volunteer
Paid
Combination, mostly paid
Other/More than One Selected

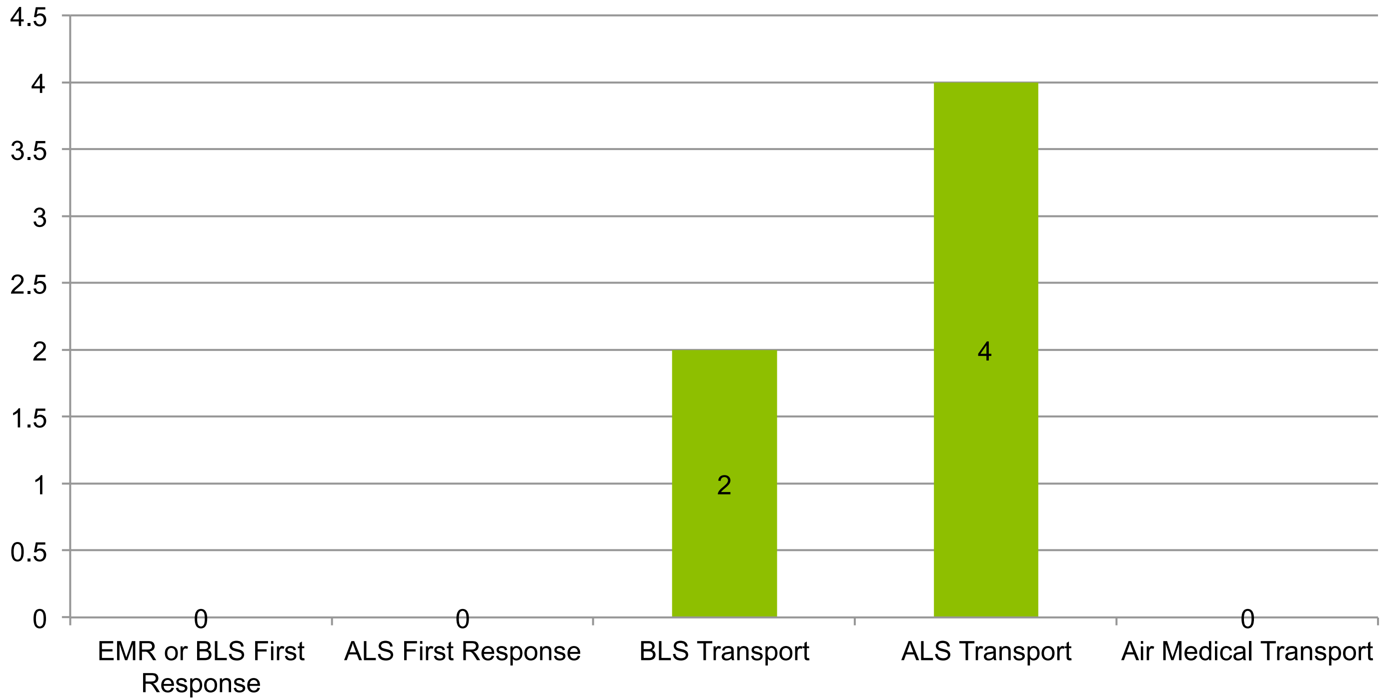


Figure 6: Level of Organization
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
0
0
2
4
0
EMR or BLS First Response
ALS First Response
BLS Transport
ALS Transport
Air Medical Transport

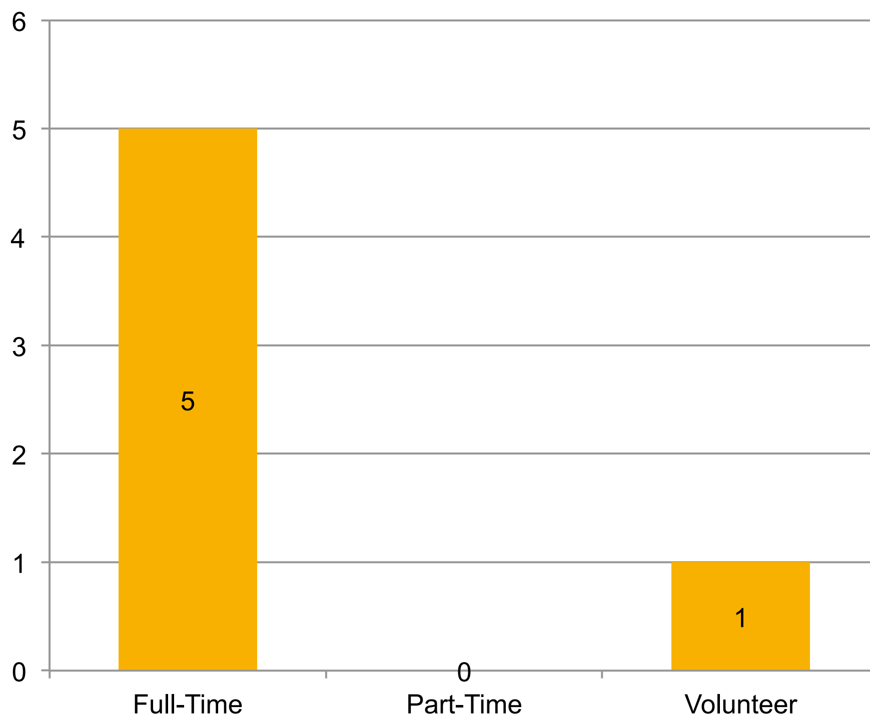


Figure 7: Employment
6
5
4
3
2
1
0
5
0
1
Full-Time
Part-Time
Volunteer

Figure 8: Annual Responses of NME Agency

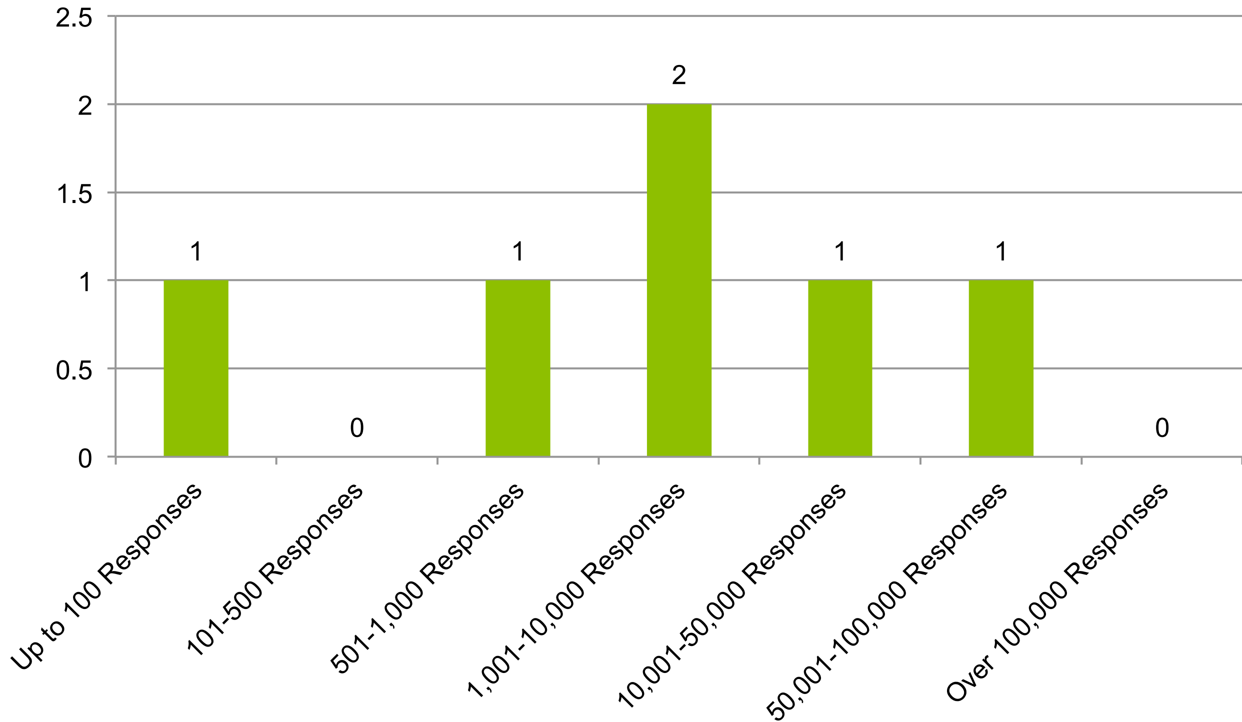


Figure 9: Near Miss Event Setting

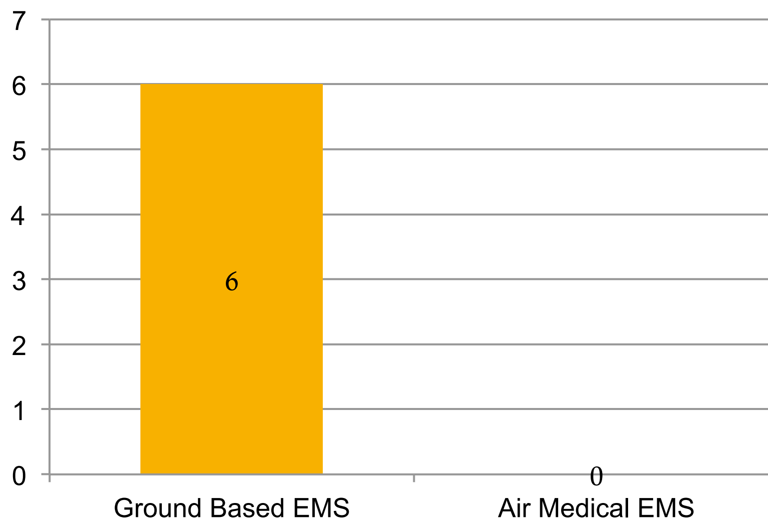


Figure 10: NME Occurrence During EMS Response Timeline

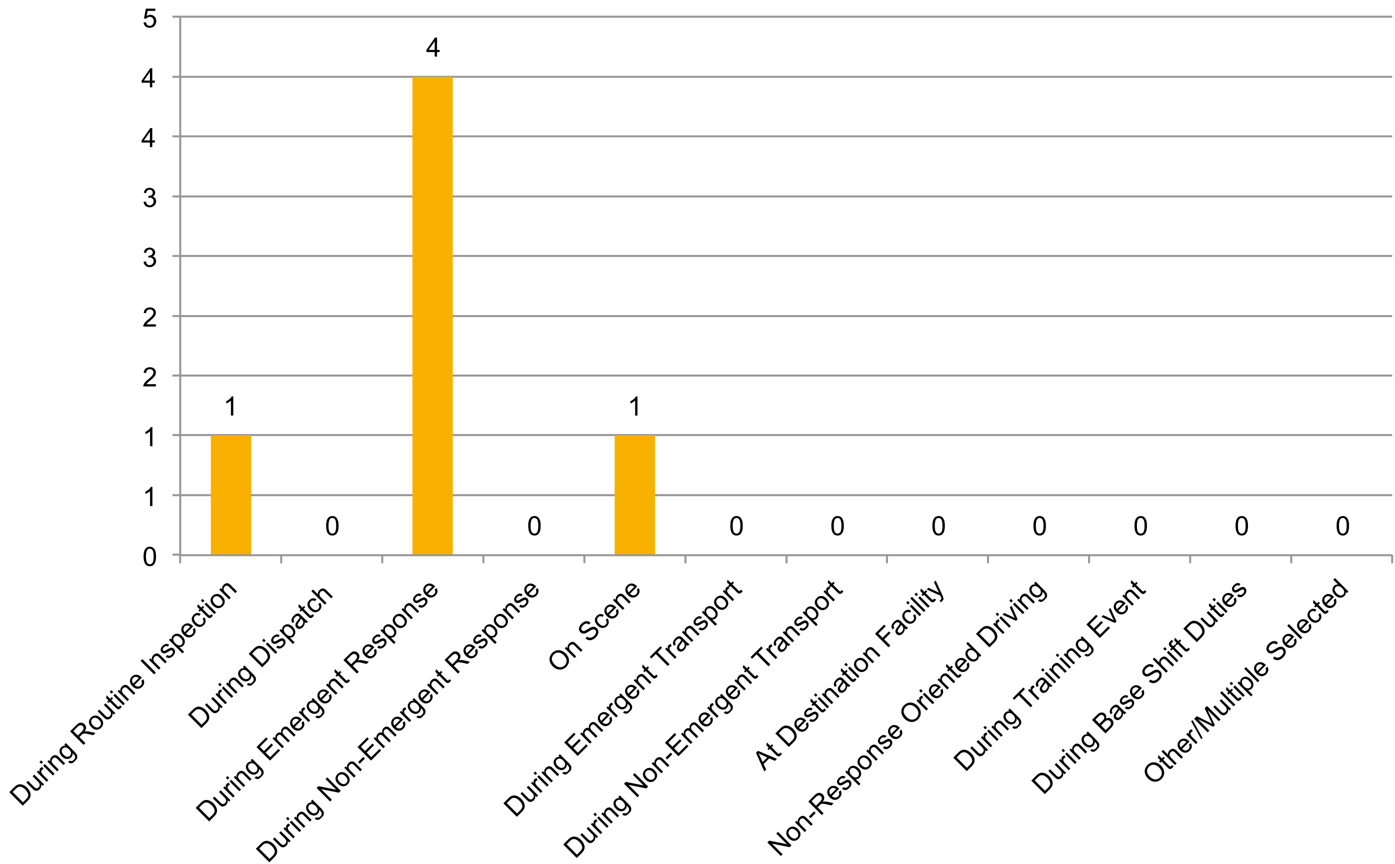


Figure 11: Year Reported Near Miss Event Occurred

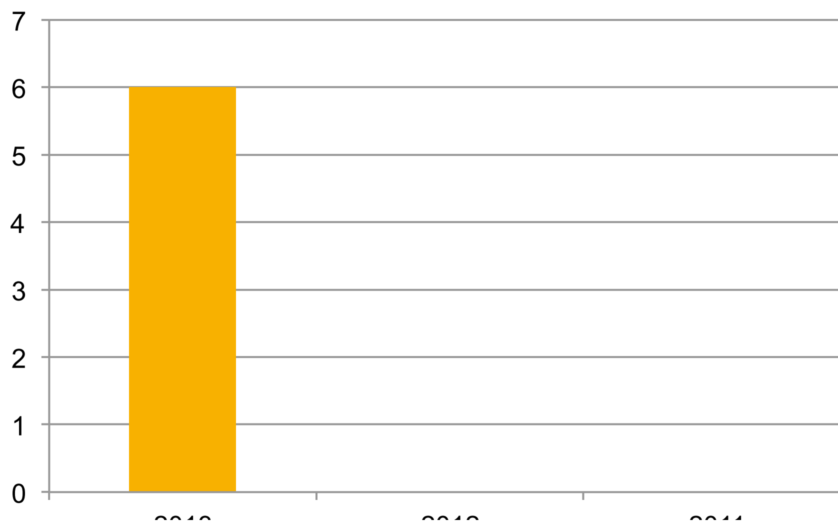


Figure 12: Month of Reported Near Miss Event

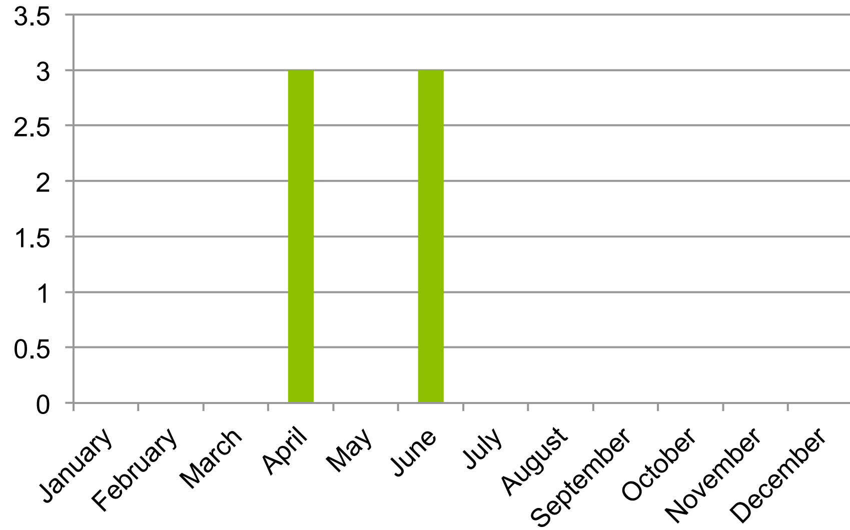


Figure 13: Time of Reported NME

1.2
1
0.8
0.6
0.4
0.2
0

0001-0100 0101-0200 0201-0300 0301-0400 0401-0500 0501-0600 0601-0700 0701-0800 0801-0900 0901-1000 1001-1100 1101-1200 1201-1300 1301-1400 1401-1500 1501-1600 1601-1700 1701-1800 1801-1900 1901-2000 2001-2100 2101-2200 2201-2300 2301-2400

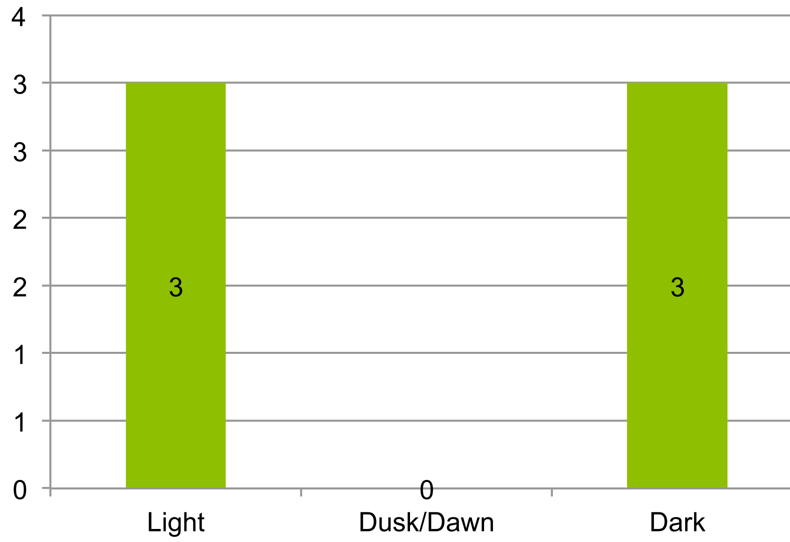


Figure 14: Environmental Visibility During Near Miss Event
4
3
3
2
2
1
1
0
3
0
3
Light
Dusk/Dawn
Dark

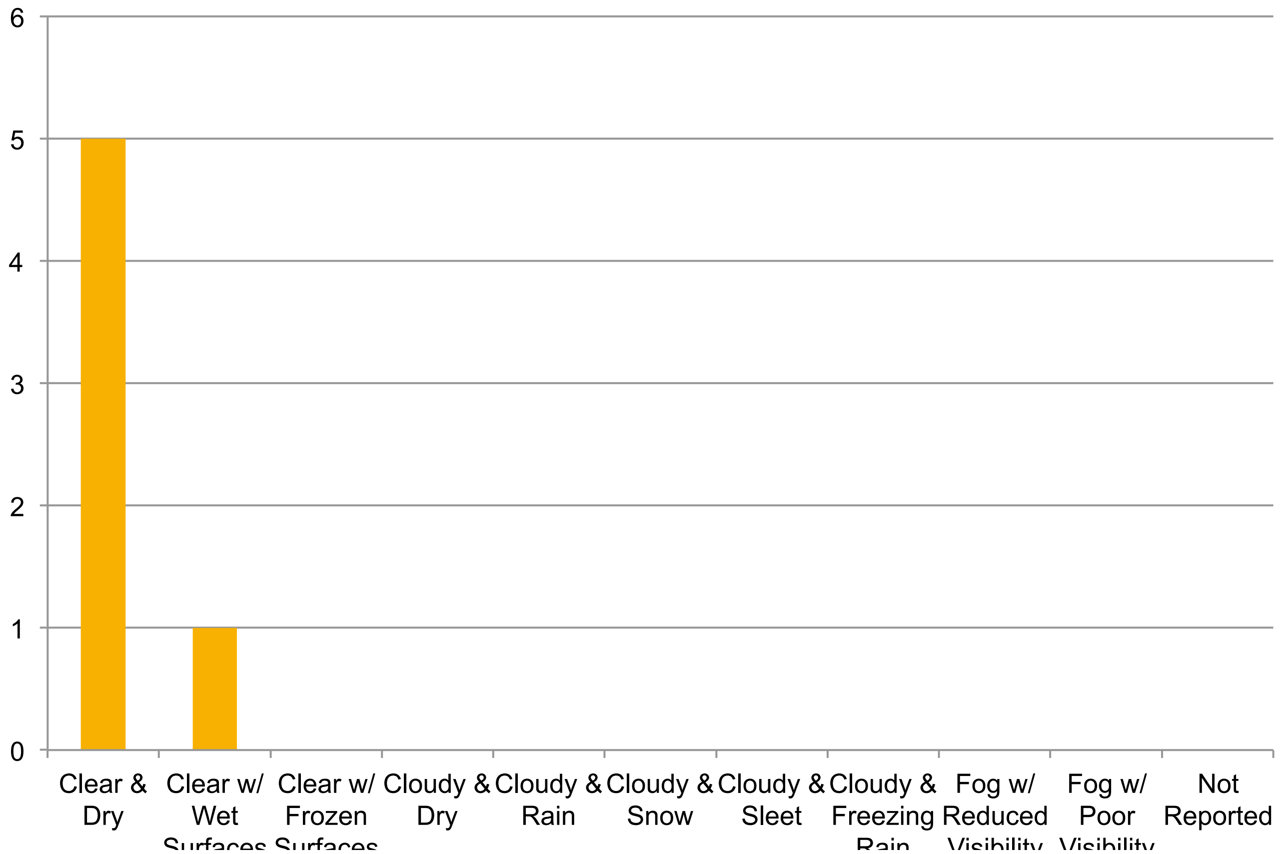


Figure 15: Weather During NME
6
5
4
3
2
1
0
Clear & Dry
Clear w/ Wet Surfaces
Clear w/ Frozen Surfaces
Cloudy & Dry
Cloudy & Rain
Cloudy & Snow
Cloudy & Sleet
Cloudy & Freezing Rain
Fog w/ Reduced Visibility
Fog w/ Poor Visibility
Not Reported

Table 2: Contributing Factors to Near Miss Events: As Reported by Providers

	Frequency		Frequency
Accountability	0	Situational Awareness	1
Command	0	SOP/SOG	0
Communication	1	Staffing	0
Decision Making	1	Task Allocation	0
Equipment	1	Teamwork	0
Fatigue	0	Training Issue	1
Distracted Driver/Pilot	0	Unknown	0
Horseplay	0	Weather	1
Human Error	2	Violent Patient	0
Individual Action	2	Violent Non-Patient	0
Procedure	1	Inadequate Lighting	1
Protocol	0	Other	0

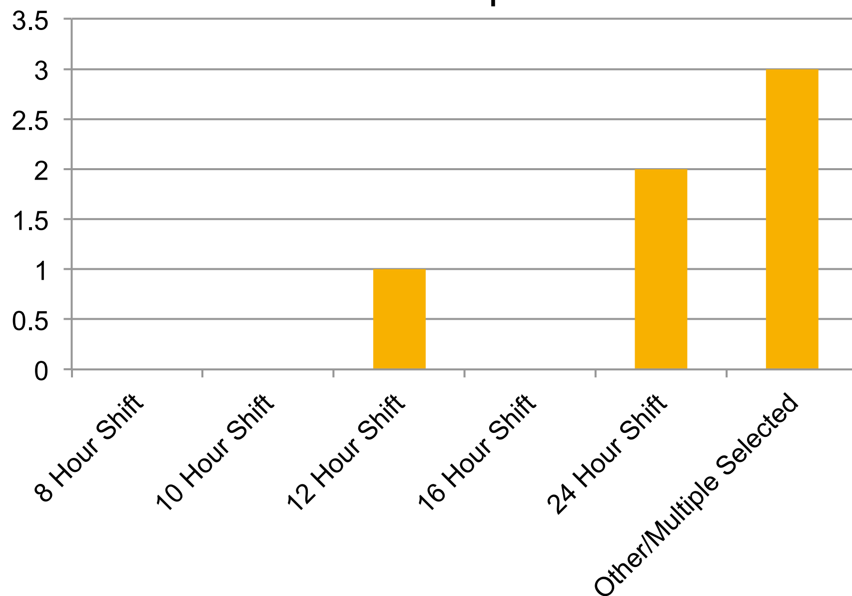
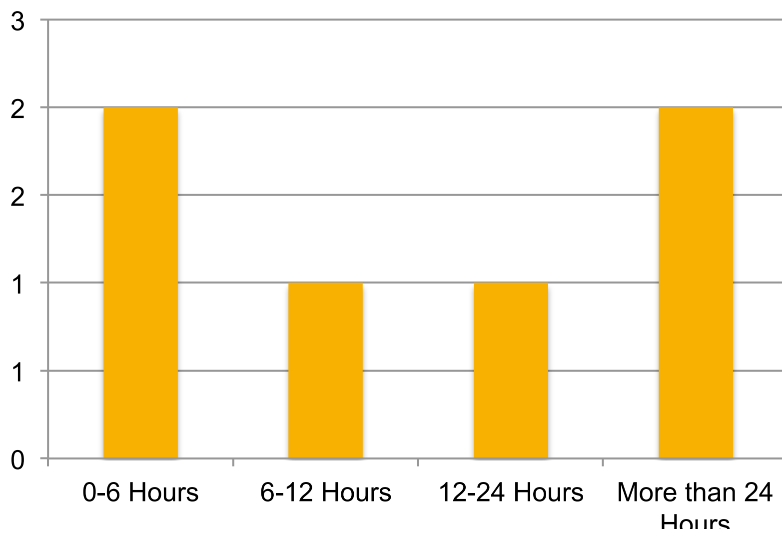


Figure 17: Hours into Shift at time of NME

2.5
2
1.5
1
0.5
0

0-4 Hours
5-8 Hours
9-12 Hours
13-16 Hours
17-20 Hours
21-24 Hours
More than 24 Hours

Figure 18: Time off before beginning of shift with NME



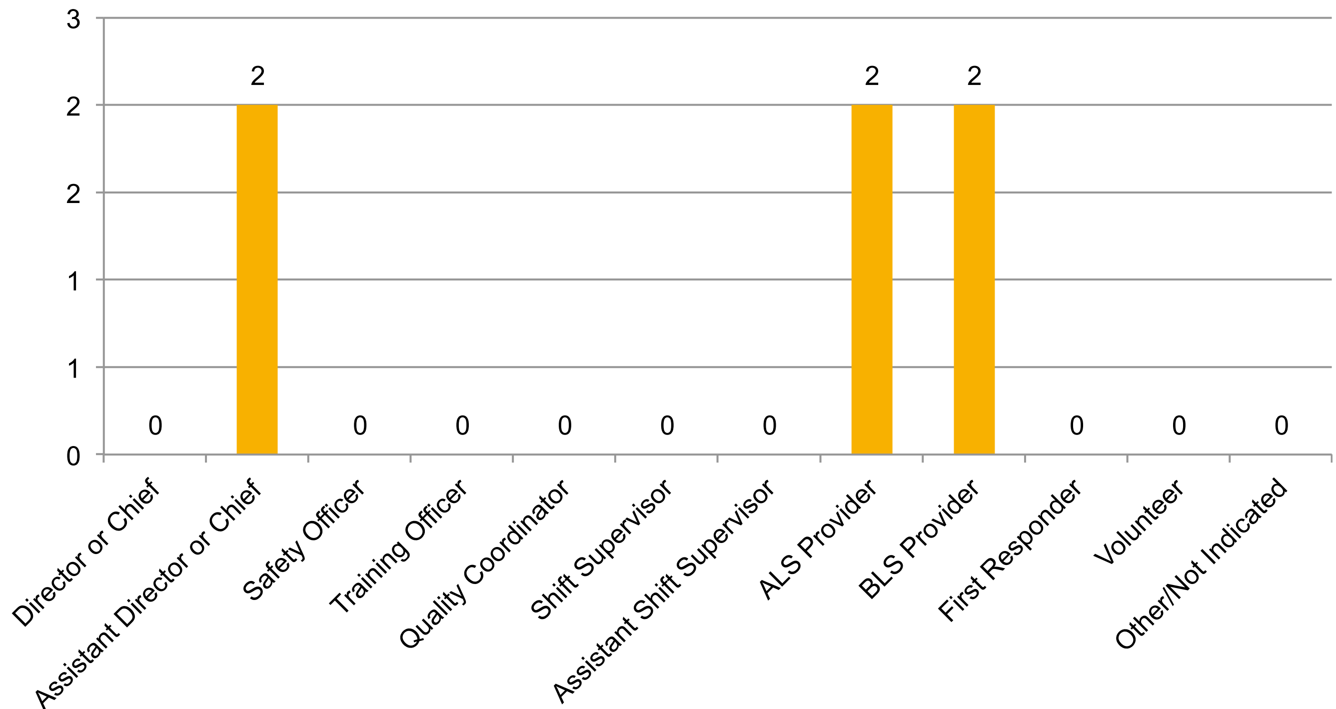


Figure 19: Rank of Provider in Near Miss Department
3
2
2
1
1
0
2
2
2
0
0
0
0
0
0
0
0
0
Director or Chief
Assistant Director or Chief
Safety Officer
Training Officer
Quality Coordinator
Shift Supervisor
Assistant Shift Supervisor
ALS Provider
BLS Provider
First Responder
Volunteer
Other/Not Indicated

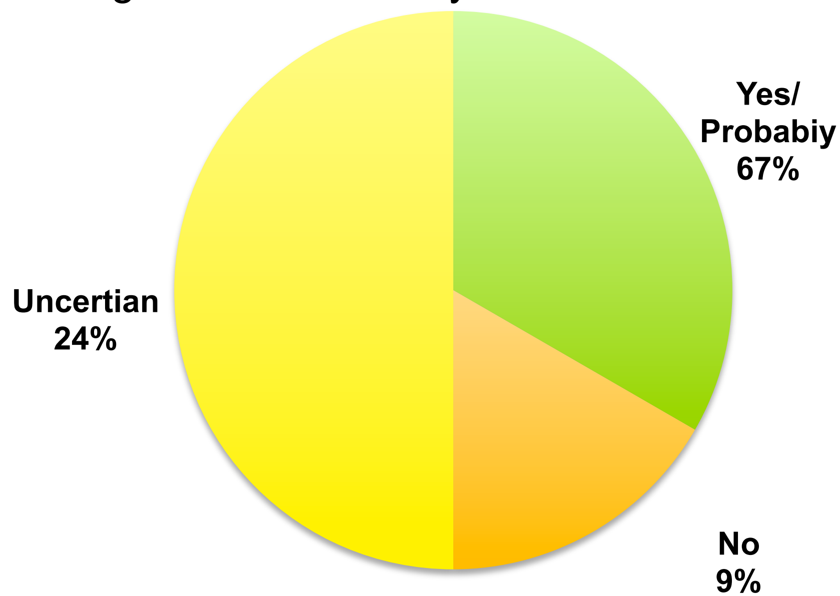


Figure 20: Probablity of Reoccurence
Yes/
Probabiy
67%
Uncertian
24%
No
9%

#	Description	Lessons Learned/System Change
1	We were responding to a routine lifting assistance call. It had stopped raining about 45 mins prior. Road and ground wet. Dark out. My partner ran off of the road on right side and went completely into ditch. Then when truck came out of ditch truck went up on 2 wheels and then back down on to 4 wheels and down into deep ditch on other side of road. Appropriate notifications made. If someone would have been in box of truck they would have most likely been killed due to not being in a seat belt and flying equipment as everything came out of every compartment.	Strap down all equipment. Use a better cabinet system to keep equipment and supplies in place.
2	The BLS crew responded to a residence for a medical alarm call, which according to dispatch information, there was no response from the resident to the call back. PD was not dispatched. An ALS crew and Engine Co. were also dispatched. The BLS crew and Engine arrived at the same time, followed by the ALS crew. After arriving at the scene, the BLS crew knocked on the front door and announced themselves as the Rescue crew. There was a large dog barking at the door, which was unlocked and slightly ajar. Lights were on in the house and the TV in the living room could be heard, but there was no response from the resident. The crew made entry after the dog showed no signs of aggression. The crew continued to call out "Rescue" as it made its way from the living room up the stairs to the bedroom where the light was on and another TV could be heard coming from that room. As the first crewmember started to enter the bedroom, an elderly male came out of the adjacent bathroom pointing a handgun at him. The crew member raised his hands mid-body with fingers up and palms out toward the resident, shouted "No-No - there is no need for that (referring to the weapon)" and backed away from the doorway while telling the resident why the crew was there. The second BLS crewmember, who was standing nearby, turned and motioned to the ALS crew behind him to get back. The occupant quickly placed the weapon on the bed and apologized. The crew observed that the trigger was not cocked. The occupant explained that he didn't realize he had activated his medical alarm and showed the crew that he placed it on the bedpost upside down, apparently depressing the activation button when he did so. The crew talked with the resident, who said he heard the crew shouting but did not understand what they were saying. He said he had a number of spinal column issues but was not having a medical emergency at that time. Before going back in service on scene, the crew talked to the resident and made friends with his energetic Weimaraner.	To ensure the resident knows an EMS crew is present, make an extra effort to communicate with the resident - shout loudly and often before and after making entry into the residence the name of your Department and ask a general question: e.g. "This is the XYZ Rescue Squad .... Did you call us? Does someone have a medical emergency?" Attempt to reduce or eliminate background noise within the residence in order to be heard by the patient (e.g. shut off a TV), as you attempt to locate the patient. Report the incident to dispatch, so that they have a record that there is a weapon at the residence, and that police should be dispatched on any future EMS calls. Dispatch should flag the residence as having a weapon and to dispatch PD on any calls where there is no response to call backs from either dispatch or a medical alarm company. (This was done the night of the incident). Brief the Rescue Squad about the incident to promote situational awareness and how members should respond to similar incidents.

#	Description	Lessons Learned/System Change
3	Patient reportedly had brief argument and felt chest pains weakness, fell to ground unconscious and was pulseless and apneic. First responders initiated CPR and used a state trooper's AED until ambulance arrived. Patient was successfully resuscitated and arrived at Hospital conscious and alert. Was later transported to Cardiac Center for additional treatment. Discharged home with pacemaker and AICD.	AED availability for non-medical situations. Traffic control, training events Making additional AED available on all EMS/ Fire apparatus.
4	While on an interstate the ambulance went to change lanes into the fast lane. A semi also decided to change lanes at the same time. As a result the ambulance had to rapidly change lanes to prevent an accident. This lead to the provider in the back of the ambulance to be thrown around. The provider didn't experience anything further than superficial injuries. The driver reported that without a rapid response to the situation the semi would have likely performed something similar to a PIT maneuver.	Between the providers that were involved with the incident a minimal amount of lane changes are to be conducted. Given the limited amount of time; approx. 1 mile, the ambulance will remain in the slow lane unless it is a code 3 response or there is no other option. Possible communication between those providing care and those driving to ensure no blind spots are missed and no near miss incidents occur.
5	Volunteer BLS crew was removing the patient from the back of their ambulance secured to the transport stretcher using the 5-point restraint system in order to transfer care to the ALS crew. Neither members of the BLS crew was familiar with the operation of the stretcher and caused the stretcher to tilt to one side and almost fall over.	More training required for the volunteer staff in the use of ambulance equipment.
6	Crewmember signed out drug box containing cardiac meds and placed on rear bumper of vehicle. Vehicle check begun and call assigned (emergency) before check completed. Crew responded without placing drug box in vehicle. Drug box lost in community. Steps taken to alert community through media, police, stakeholders. Event related to vehicle check process and practices.	Advise medics during training of specific steps that must be taken even during pre-shift check to safeguard against loss of medications or equipment. Enhanced training, consideration of 'best practices' document for vehicle check process to decrease likelihood of unexpected events should check be interrupted.