	Maryland Ambulance Safety Task Force **February 16, 2017 (Thursday)** **10:00 AM – 12:00 Noon** **Room 212 @ MIEMSS** **653 W. Pratt Street Baltimore, MD 21201**	
Meeting:	**Maryland Ambulance Safety Taskforce**	
Task Force Goals:	1. **Implement initial and periodic driver screening.** 2. **Ensure effective initial ambulance driver training and periodic refresher training.** 3. **Increase use of restraints in all seating positions of Ambulance and Fire vehicles.** 4. **Reduce the incidence of excessive ambulance speeds and routine use of "lights and sirens**". 5. **Improve monitoring of ambulance safety issues and enforcement of safety practices.** 6. **Continue the ongoing statewide forum for ambulance safety issues** Adopted 11/2013 at the Ambulance Safety Summit	
Attendees:		
Unable to Attend:		
	PROPOSED Agenda	
10:00	**Welcome and Introductions**	Cyndy Wright Johnson RN Lisa Chervon NRP
10:00	**Maryland Crash Data update** 1. 1999 – 2015 Maryland Crash data on Ambulance and Fire crashes 2. 2015 new elements and implications for report generation 3. Goal - Maryland Crash data dissemination - Formats for distribution – fact sheet, EMS news article, workshops - GIS mapping of one year of crashes - Infographic based upon NHTSA model specific data available - Other formats	National Study Center Cindy Burch MS

10:30	**Ambulance Restraint Use – Buckle Up Providers** 1. Johns Hopkins QI – Research Project on providers use of restraints in Pediatric Transport Team 2. Buckle Up Messaging to providers	Johns Hopkins PICU Transport Team Johns Hopkins University Engineering
11:00	**QIC Subcommittee – Fatal Crash Review** 1) Data Abstraction form – feedback on data elements 2) Crash reconstruction - MSP participation **3)** Status of 28 cases – ME reports/ Crash reports	Cyndy Wright Johnson RN Cindy Burch MS
11:10	**Best Practice examples and documents – Priorities** 1. Driver screening & frequency of rescreening / reporting 2. Driver training – ambulance specific initial & refresher 3. Other protocols / policies	Committee
11:20	**Assessment of Task Force Progress to date** **Next Steps**	Committee
11:50	**New/ Old Business** EMS Care 2017 Presentation – best practices and innovations	Committee
2017 Meeting	~~**February 16th 2017 (Thursday)**~~ **June 8th 2017 (Thursday)** **October 19th 2017 (Thursday)** **Subcommittee / Work group meetings**	Committee

State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

Donald L. DeVries, Jr., Esq.
Chairman
Emergency Medical Services Board

410-706-5074
FAX: 410-706-4768

Ambulance Safety Taskforce
Meeting Notes

February 16, 2017

Attendees
Steve Mroczek – MSFA / Oxford VFD; Tim Delehanty – MFRI; Bryan Ebling – Caroline County EMS; Eric Henderson – LifeStar / Hopkins; Brian Ashby - MedStar Transport; Linda Dousa – MSFA / Harford EMS; Bill Dousa – MSFA / Harford EMS; Cory Skidmore – Hart to Heart; Mark Scarboro – STAR; Cynthia Burch – NSC; Chris Corea – MSP; Soraya Bailey – JHU Mechanical Engineering; Oludunsin Samuel–Ojo – JHU Mechanical Engineering; Yadel Okorie – JHU Mechanical Engineering; Eric Trauter – Hart to Heart; Phil Hurlock – MIEMSS; Jim Brown – MIEMSS; Brittany Spies – MIEMSS; Lisa Chervon – MIEMSS;
Cyndy Wright Johnson – MIEMSS; Barbara Goff - MIEMSS

Welcome and Introductions
Ms. Wright Johnson and Ms. Chervon welcomed everyone and introductions were made.

Maryland Crash Data – Update
Ms. Burch gave an overview of emergency vehicle (fire apparatus and ambulances) crash data from 1999 – 2015 and reported that all Maryland law enforcement is utilizing the automated crash reporting system designed and made available through the Maryland State Police (MSP).

Ms. Burch said that data is collected on emergency and non-emergency vehicles and include body type, seat belt usage and seating layout. She gave an overview of ambulance crash data involving fatalities and injuries running emergency and non-emergency including injuries to others outside of the ambulance i.e. another vehicle or pedestrian and county of occurrence.

Ms. Wright Johnson reminded the committee that Baltimore City has the highest crash rated since they have the most hospitals. The data reports where a crash occurs, not the agency that owns the ambulance/ fire vehicle. Ms. Burch said population and number of highways also play a role in the numbers of crashes.

A discussion regarding property damage crashes reporting i.e. when and to what entity the report should be sent ensued.

The Model Minimum Uniform Crash Criteria Guideline (MMUCC) a minimum, standardized data set for describing motor vehicle crashes and the vehicles, persons and environment involved was discussed. The Guideline is designed to generate the information necessary to improve highway safety within each state and nationally. NHTSA and GHSA developed a methodology for mapping the data collected on crash reports and the data entered and maintained on crash databases to the data elements and attributes in the MMUCC Guideline. This methodology is intended to standardize how States compare both their crash reports and their crash databases to MMUCC. There may be an opportunity to include the standard ambulance seating positions into the Maryland FARS reports.

Quality Improvement Project:
One of the projects related to ambulance safety and data is to have a small interdisciplinary group review the 28 deaths that have occurred in the past 12 years of data collection. This review will be done through the MIEMSS Pediatric QIC so that the information remains protected. Today the committee reviewed the form and data elements one last time. Ms. Wright Johnson and Ms. Burch will update the Data Abstraction Form based on today's discussion. The National Study Center will begin to pull the crash investigations and autopsies for these cases.

Ambulance Restraint Use – Buckle Up Providers
The Johns Hopkins University Mechanical Engineering Students have partnered with the Pediatric Transport Team at Johns Hopkins Children's Center to study the restraint use and behaviors of EMS and hospital staff during transport calls. This two year project's goal was to develop a system that will increase seatbelt usage and safety. The students provided a demonstration of the "pouch seating design" for use in the back of an ambulance. The seats will send a notification/report daily via the internet if a provider was not seated and belted. The second year technology is integrated in to the seat and not as obvious to those responding to a call. At this time the daily reports are part of research and design and not used in the performance evaluation at JHCC. Educational programs continue to encourage seat belt use every time.

Actions: the equipment within the pediatric transport ambulances has been rearranged based upon year one data. The hope that is by collocating the most frequently used equipment close to the provider the use of seat belts during transports will increase. Second year data will help provide insight.

Questions arose regarding "Drive Cams" monitoring activities in the cab of the ambulance; five and 35 day reporting i.e. cell phone use and any legal issues. There is a great deal of variation at this time between companies and enforcement.

Task Force Goals
Recommended changes to the goals:

1. Implement initial and periodic driver screening. > Recommend and promote initial and periodic driver screening.
2. Ensure effective initial ambulance driver training and periodic refresher training. > Recommend effective initial and periodic refresher training and identify gaps.
3. Increase use of restraints in all seating positions of Ambulance and Fire vehicles. > Promote increased use of restraints in all seating positions of Ambulance and Fire vehicles.
4. Reduce the incidence of excessive ambulance speeds and routine use of "lights and sirens".
5. Improve monitoring of ambulance safety issues and enforcement of safety practices. > Monitor ambulance safety issues and enforcement of safety practices.
6. Continue the ongoing statewide forum for ambulance safety issues.

Best Practice Examples and Documents
Mr. Ebling said he would like to develop a survey on best practices and would like to form a small group of four to five people to assist with the questions. The goal is to assess statewide current practices to identify gaps. Mr. Ebling will reach out to Chief Frankel.

Meeting notes from the October 2016 meeting were approved for posting.

The next meeting will be held on June 8, 2017 at 10m at MIEMSS in room 212