

2010 Military Health System Conference Winning papers on Patient Safety Innovations

Sharing Knowledge: Achieving Breakthrough Performance

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27 Jan 2010



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2010 Military Health System Conference

Achieving Patient Safety in Obstetrics: An Obstetric Safety Team Initiative

Sharing Knowledge: Achieving Breakthrough Performance
CDR R. Lee Biggs, MC, USN
January 27, 2010



Naval Hospital Guam

Background



Background



- Maternal-Fetal mortality in Summer '07 & Spring '08
 - Root Cause Analysis (RCA)
 - Common threads:
 - Communication Failures
 - Training Deficiencies
 - Provider Clinical Error

- Command-directed working group established
 - Obstetrics Safety Training Assessment Team (OSTAT)
 - Obstetrics, Family Practice, Pediatrics, Nursing, Risk Mgt

Background (The Dilemma)



- Change and learning from adverse events is not easy in Obstetrics
- Creating cultures of safety requires major changes in behavior
- “At risk” behavior or “shortcuts” occur because the system supports the behavior
- Individual, professional autonomy creates a barrier to progress in the patient safety arena

Practices Which Weaken Defenses



- The need to be in multiple places at once
- High volume
- Poor sign-out practices
- Inadequate protocols for consultation, referral, or transfer
- Agreeing to patient requests that are fundamentally unsafe
- Off-site monitoring of high risk situations
- Hierarchy and the lack of teamwork regarding safety issues
- Inadequate backup
- Human factors impairing vigilance

Plan



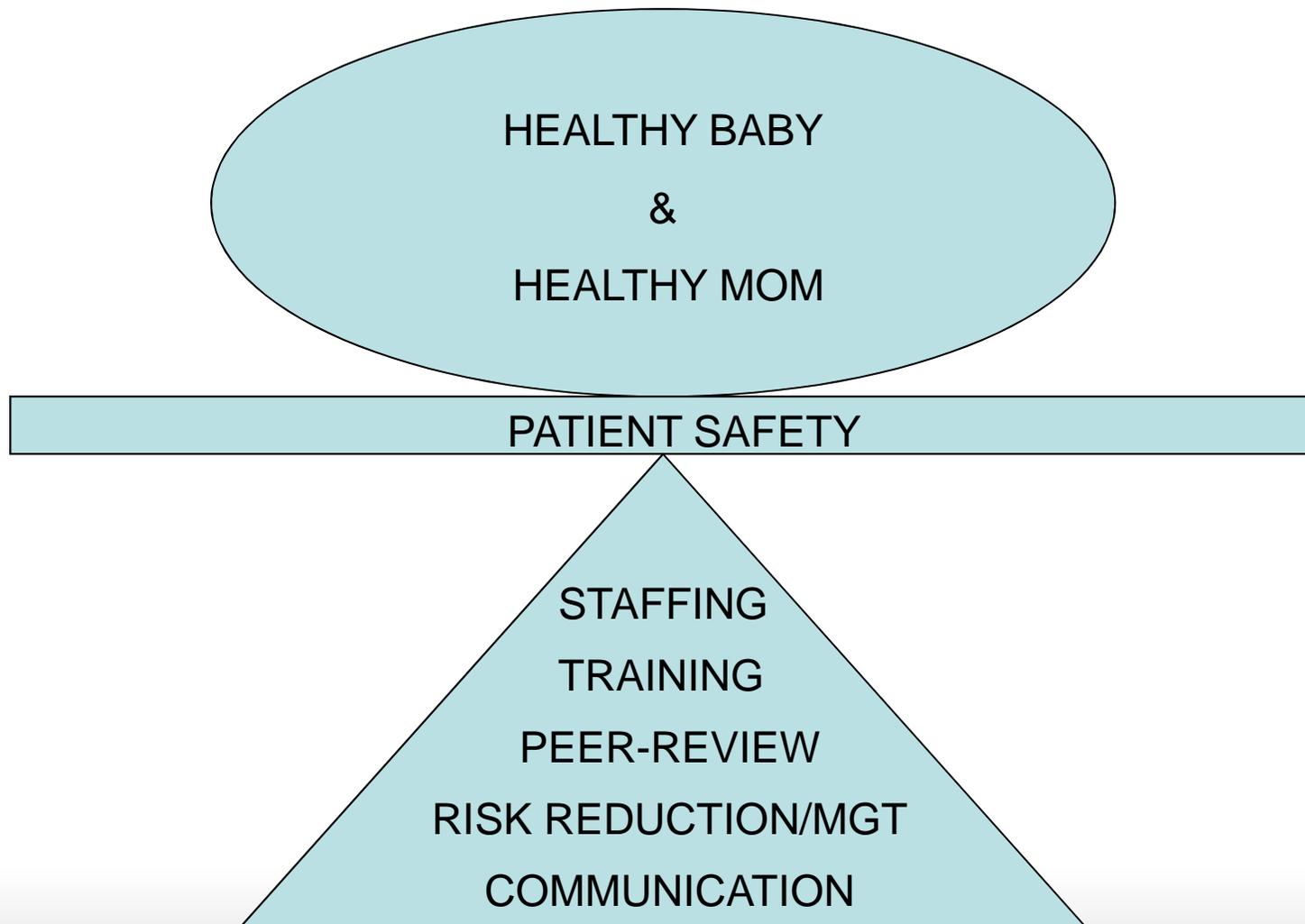
- Achieve well-supported maternal-newborn care
 - Identify weaknesses
 - Challenge previously held notions
 - Cultivate team-centered care
 - Develop realistic, sustainable training
 - Eliminate risks to maintain highest level of patient care
 - Build solution which adapts to change

Focus Areas

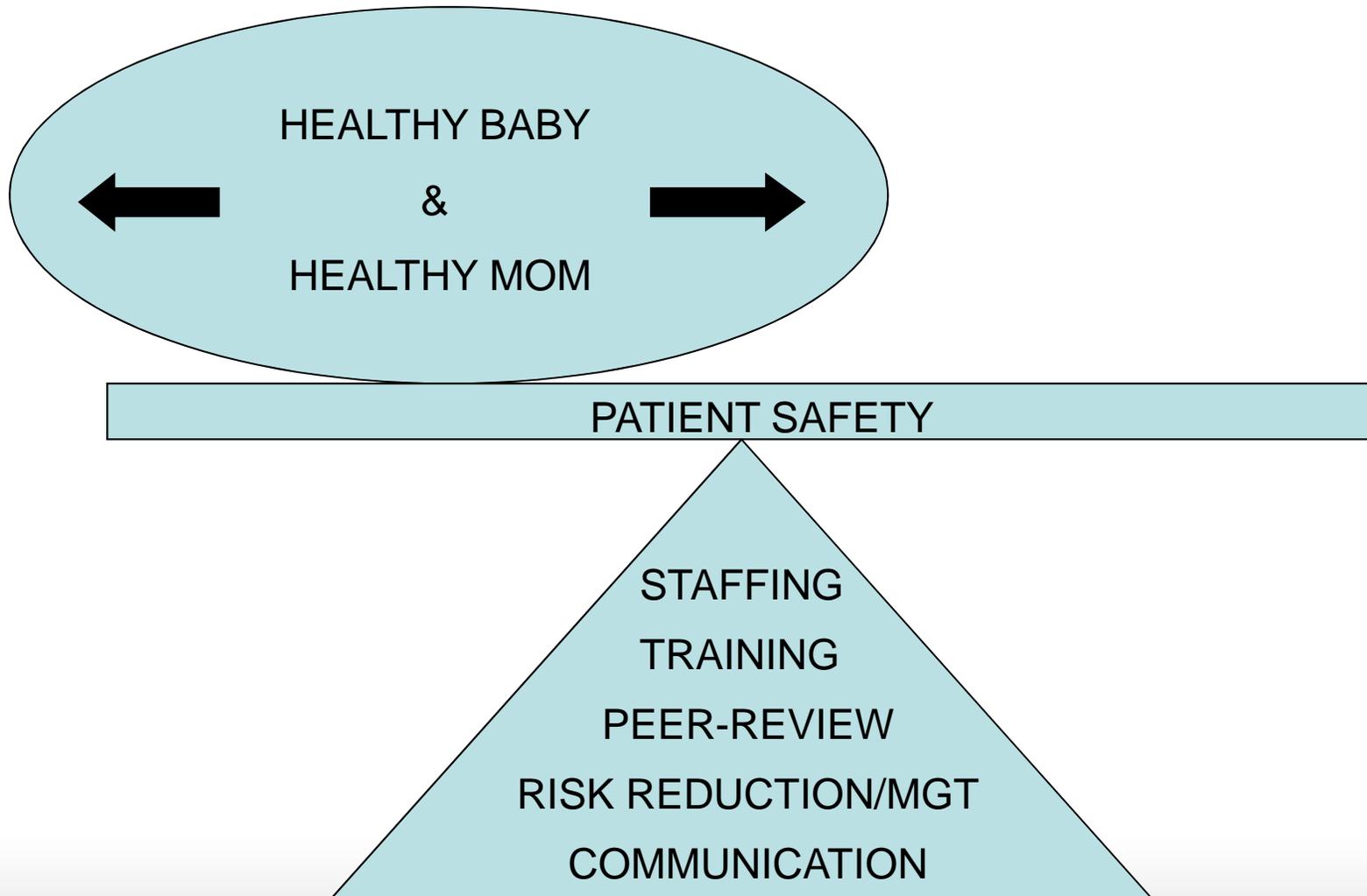


- Communication
- Training
- Peer Support
- Risk Management
- Staffing

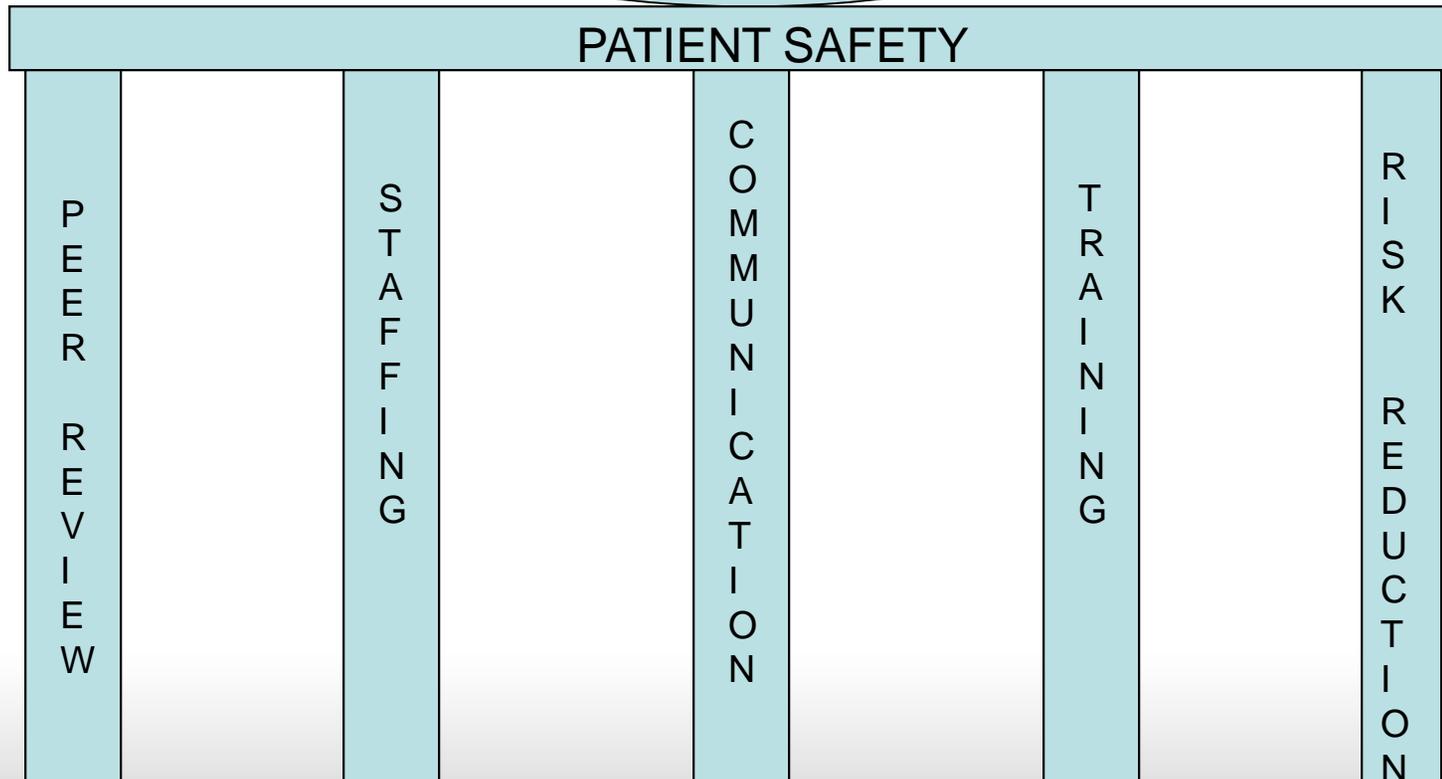
OB Model (Pre-OSTAT)



The Balance Point



The Goal



Communication



- Establish central daily turnover
- Two challenge rule re-defined
- Improved provider-provider communication
- Clinical decisions respecting staffing and ward census

Training



- Previous MBU Training, didactic only
 - No drills, limited in-service

- New focus: department & hospital-wide drills
 - Urgent Cesarean Delivery, Hemorrhage, Shoulder Dystocia, Seizures, Infant distress
 - Mobile Obstetric Emergency Simulator (MOES)

- RN Training
 - Customized Pipeline Training
 - WestPac Alliance (Guam, Okinawa, Yokosuka) Regional Training

- Staff Training
 - Instructor status attained and courses established locally

Peer Support/Review



- Implement 360° Peer Review Process
- Monthly Chart Review
- High-risk management with Okinawa MFM
- Improved FP consultation/co-management

Risk Management



- High-risk clinical procedures given practice guidelines
 - TOLAC (Trial of Labor After Cesarean Delivery)
 - Elective/Social Inductions
 - Multiple Gestation
 - Operative Vaginal Delivery
- OB and FP in-house when a patient is admitted in labor
- Collect data to protect and provide basis for management decisions

Staffing



- Experienced mother-baby RNs must be home grown
- Limited local civilian RN pool
- Navy-wide shortage
- Clinical decisions must respect staffing restraints



Methods

- Effectiveness would be assessed through significant reduction in Maternal-Fetal morbidity and mortality

- Pre-OSTAT Baseline Comparison
 - June 2007 through May 2008
 - 420 Total Deliveries

- OSTAT Implementation (OSTAT +1 yr)
 - June 2008 through May 2009
 - 435 Total Deliveries

Methods



- 10 Obstetric specific outcomes
 - Birth Trauma (3rd, 4th degree lacerations)
 - Preterm Delivery
 - Postpartum Hemorrhage
 - Fetal Death/IUFD
 - APGARS < 6 min at 5 min
 - Multiple Gestation Deliveries
 - Shoulder Dystocia
 - Urgent Cesarean Deliveries
 - Medical Evacuation
 - Cesarean Delivery Rate

Methods



- Data was collected retrospectively by an obstetric data quality nurse who was blinded and was not a member of the study team.
- All data was collected from obstetric delivery logs.
- Statistical analysis was performed using Student t test (two-tailed) and Chi Square where appropriate.
 - P value of $< .05$ was considered significant

Results



Measure	Pre-OSTAT	OSTAT +1	% Change	P-Value
Birth Trauma (3 rd /4 [°] lacerations)	40	11	73%	< .001
Preterm Delivery	18	6	66%	.016
Postpartum Hemorrhage	54	19	65%	< .001
Fetal Death/IUFD	6	4	33%	.560
APGARs < 6 at 5 minutes	25	15	40%	.132
Twin Deliveries	8	1	88%	.014
Shoulder Dystocia	14	10	29%	.459
Urgent Cesarean Delivery	22	5	80%	<.001
MEDEVAC	15	9	40%	.248
Cesarean Deliveries	127	121		

Conclusions



- Drifting from basic philosophies compromises the delivery of safe maternal-newborn care.
- Change is not solitary, is difficult, is met with skepticism, and requires constant re-tuning and enforcement.
- A lack of resources or personnel should not be considered a deterrent to sweeping change.
- Low-tech, low-cost, back-to-basics approach universally adaptable
- Patient safety programs can be clinically as well as statistically significant.

2010 Military Health System Conference

TeamSTEPPS: Change and Learning in an Ambulatory Care Setting

Sharing Knowledge: Achieving Breakthrough Performance

Sharon A. Takiguchi, RN, MS, APRN, ABD, Patient Safety Program Manager

January 2010



15th MDG Hickam Air Force Base
Commander Debra L. Munsell, Colonel, USAF, NC

TEAMSTEPPS INITIATIVE



- TeamSTEPPS Training – an education program that advocates a team approach to **CREATE A SAFE PATIENT** environment and **REDUCE MEDICAL ERRORS.**¹
- TeamSTEPPS Training - developed by DoD and AHRQ (2006) constructed from evidence based and best practices studies.²

¹King et al., 2006; ²Clancy & Tornberg, 2006

PURPOSE



- **Short-term**

1. Implement teamwork training
1. Increase reporting of Near-miss and Actual events reporting

PURPOSE Continued...



Long-Term implement the following tools:

1. Huddles
2. SBAR
3. Timeout Checklist
4. Standard Handoff format
5. Simplified Event Reporting Tool

THEORETICAL FRAMEWORK



CHANGE THEORY

Lewin & Gold (1948) and Schein (2004)

Change the behavior of groups in organizations over time using a “unfreezing-moving-refreezing model.”

- **Unfreezing** entails developing motivation and preparing for change.
- **Moving** involves restructuring individuals’ perspectives.
- **Refreezing** necessitates reinforcing and integrating the change

THEORETICAL FRAMEWORK

CONTINUED...



ADULT LEARNING THEORY

Knowles (1973)

- ❖ Learning is a process by which behavior is changed, shaped or controlled.
- ❖ Adult learning theory (androgogy) differs from the learning of children (pedagogy).
- ❖ Pedagogy focuses on subject oriented learning with teacher as active partner & learner passive.
- ❖ Androgogy emphasizes self-direction, use of past experiences and organizing learning around real life problems (problem oriented).



UNFREEZING

Develop motivation and prepare for change

1. Avid leadership commitment to change.
2. Attendance of multi-disciplinary group at AHRQ/DoD sponsored TeamSTEPPS training.
3. Completion of needs assessment at 15th MDG which serves 13,200 patients.
4. Modules of Overview, Leadership and Communication chosen and modified to meet the needs of the facility.
5. Planning committee/leadership determined the featured tools, handouts and evaluation format.

DESIGN CONTINUED...



MOVING

- ❖ Training schedule set-up with department specific classes and calendar sent out to all staff.
- ❖ 2 hour classes held from January to April 2009.
- ❖ Commanders attended training first to show commitment to the program.
- ❖ MDG Commander came to classes for a few minutes to emphasize importance of the training.

RESULTS



KNOWLEDGE ACQUISITION

- ❑ 240 (99%) members of 15th MDG attended training.
- ❑ Learners completed a 10 question Pre- and Post-test.
- ❑ Figure 1 shows comparison results of Pre- and Post-test.

RESULTS CONTINUED...

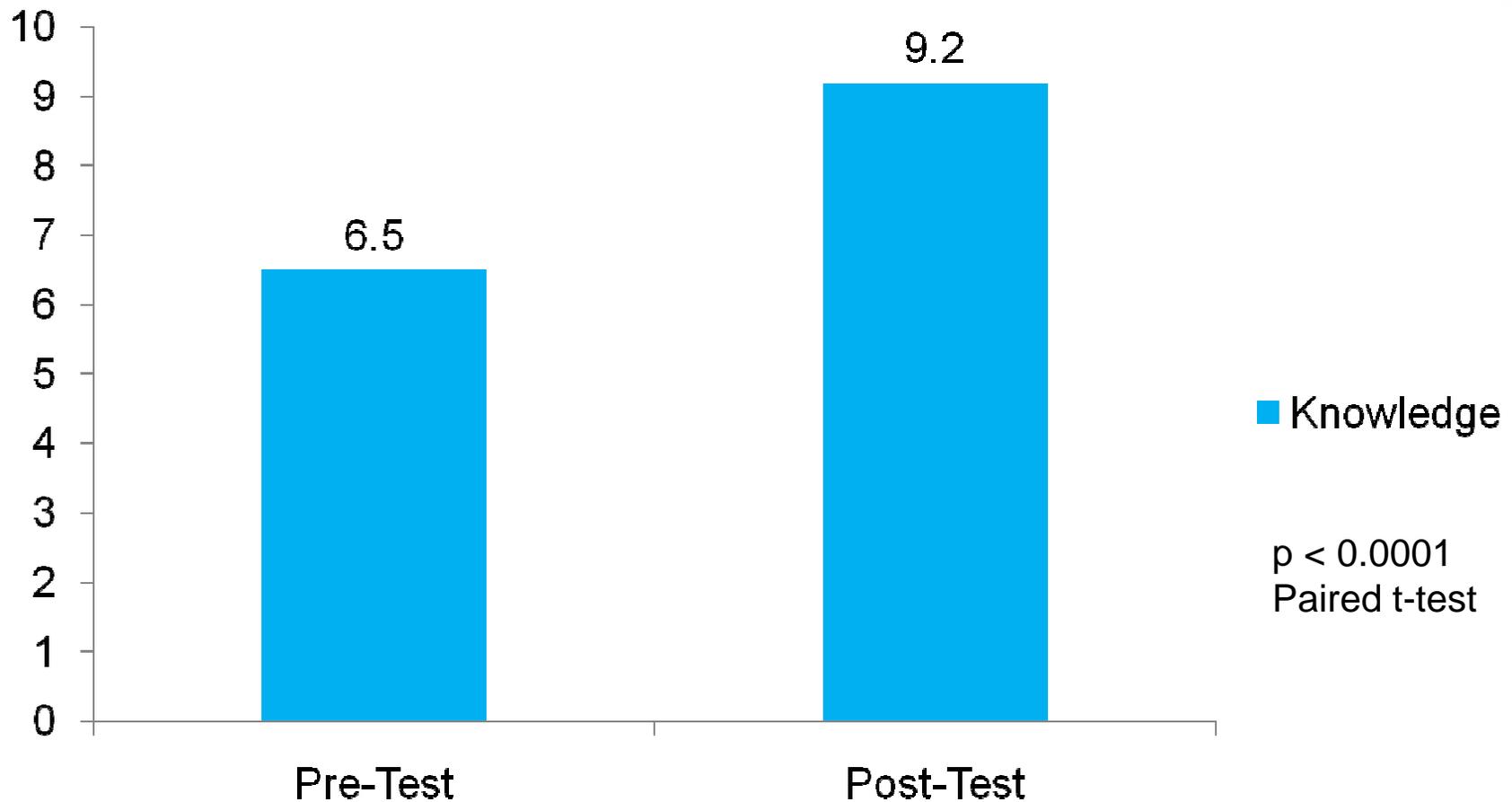


Figure 1. Knowledge of TeamSTEPPS before and after Training (Rating on 10 point scale).

RESULTS CONTINUED...



TRAINING SESSION EVALUATION

- ❑ Learners completed a 10 question evaluation of the 2 hour class.
- ❑ The evaluation tool used a Likert scale of 1 (strongly disagree) to 5 (strongly agree).
- ❑ The ratings indicated positive results with all elements receiving a **ratings of 4.61 to 4.78.**
- ❑ Two learner's comments summed it up:
 - 1) **“A smooth moving, easy to understand with lots of information class. Thanks.”**
 - 2) **“Great training – actually learned something.”**

RESULTS CONTINUED...



EVENT REPORT

- The number of event reports 6 months before and 6 months after completion of classes were quantified.
- Comparing the average number of events per month showed a significant increase ($p=0.04$).
- Figure 2 shows the graph of the comparison.

RESULTS CONTINUED...

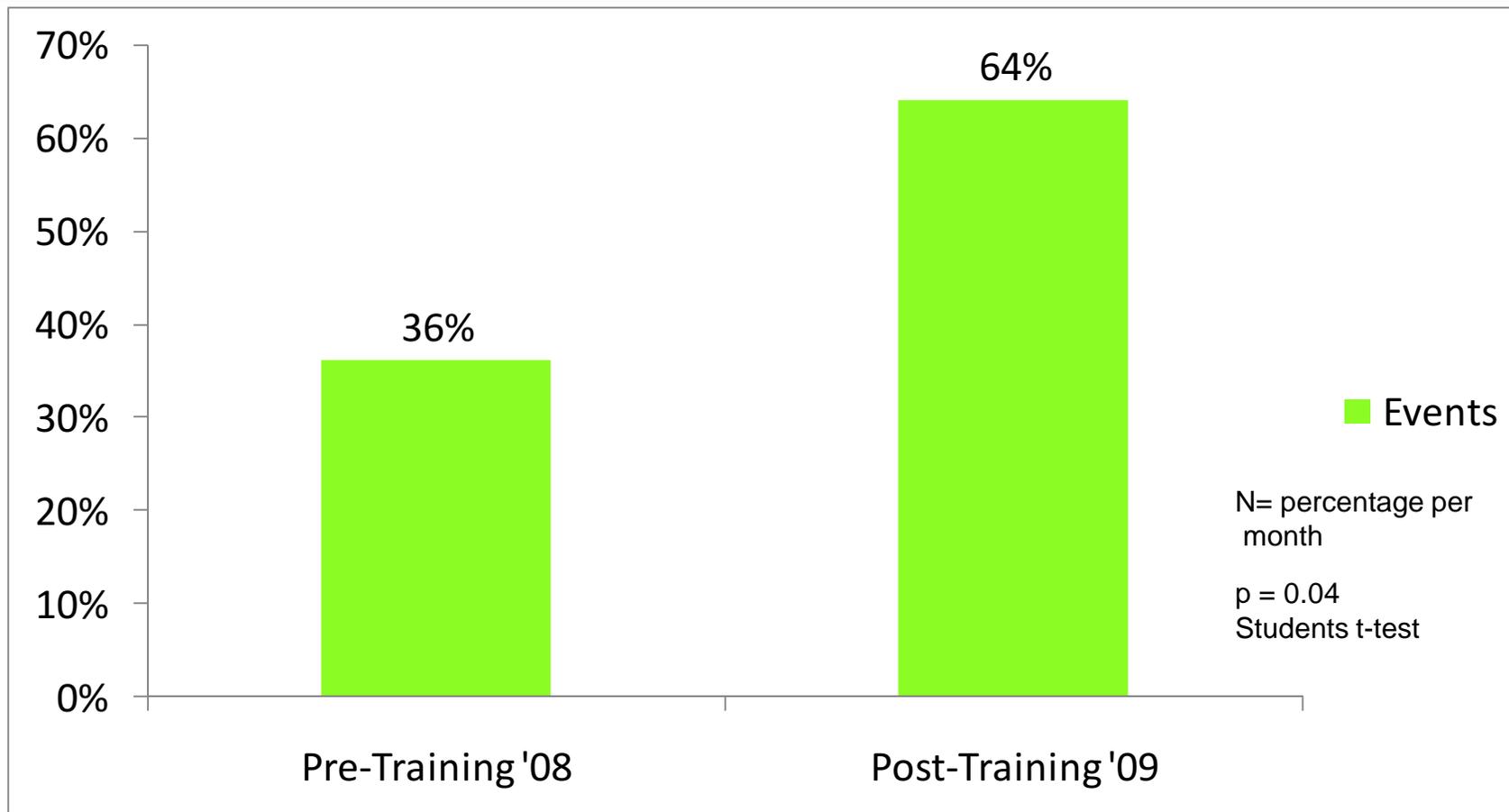


Figure 2. Event Reporting 6 months before and after TeamSTEPPS Training.

RESULTS CONTINUED...



HUDDLES

- ❑ The TeamSTEPPS Program advocates huddles to improve communication and cohesion of a group with the end result of less harm and higher quality of care to patients.
- ❑ Figure 3 illustrates the breakdown of huddles per week.
- ❑ Further coaching needed to increase use of Huddles.

RESULTS CONTINUED...

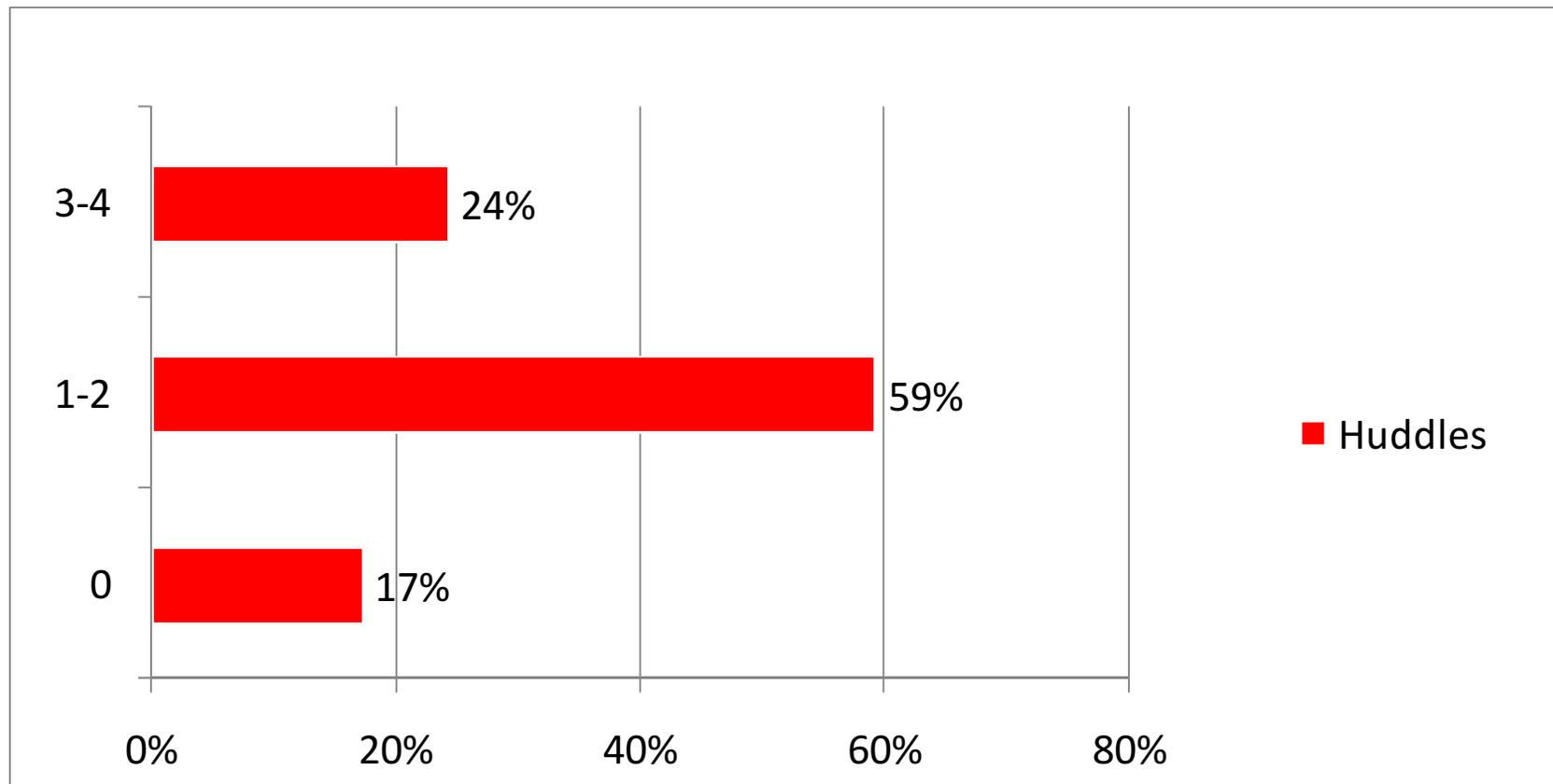


Figure 3. Percentage of staff using Huddles 0 to 4 times per week.

RESULTS CONTINUED...



- Table 1. Barriers encountered in carrying out huddles.
 - Different duty hours and schedules
 - Time
 - Extra duties pulling staff away from their unit
 - Leave
 - Meetings
 - Operational tempo
 - Staff personalities
 - Staff support
 - Workload

RESULTS CONTINUED...



SBAR

- **59%** of the members of the 15th MDG reported using SBAR (Situation, Background, Assessment, Request/Recommendation) weekly.
- During the Training with the use of **Androgogy** principles of learner involvement, members huddled and used SBAR to practice reporting on an actual incident that occurred in the facility.

STRATEGIES



Figure 4. TeamSTEPPS Learners Huddling to SBAR an actual past incident during Training.

RESULTS CONTINUED...



HANDOFF FORMAT

Survey follow-up showed:

- Only **30%** of the handoffs to emergency room and referrals used the standard SBAR format.

TIMEOUT CHECKLIST

Survey follow-up showed:

- Only **69%** of the procedures were found to show the utilization of the Procedure Timeout Checklist.

RESULTS CONTINUED...

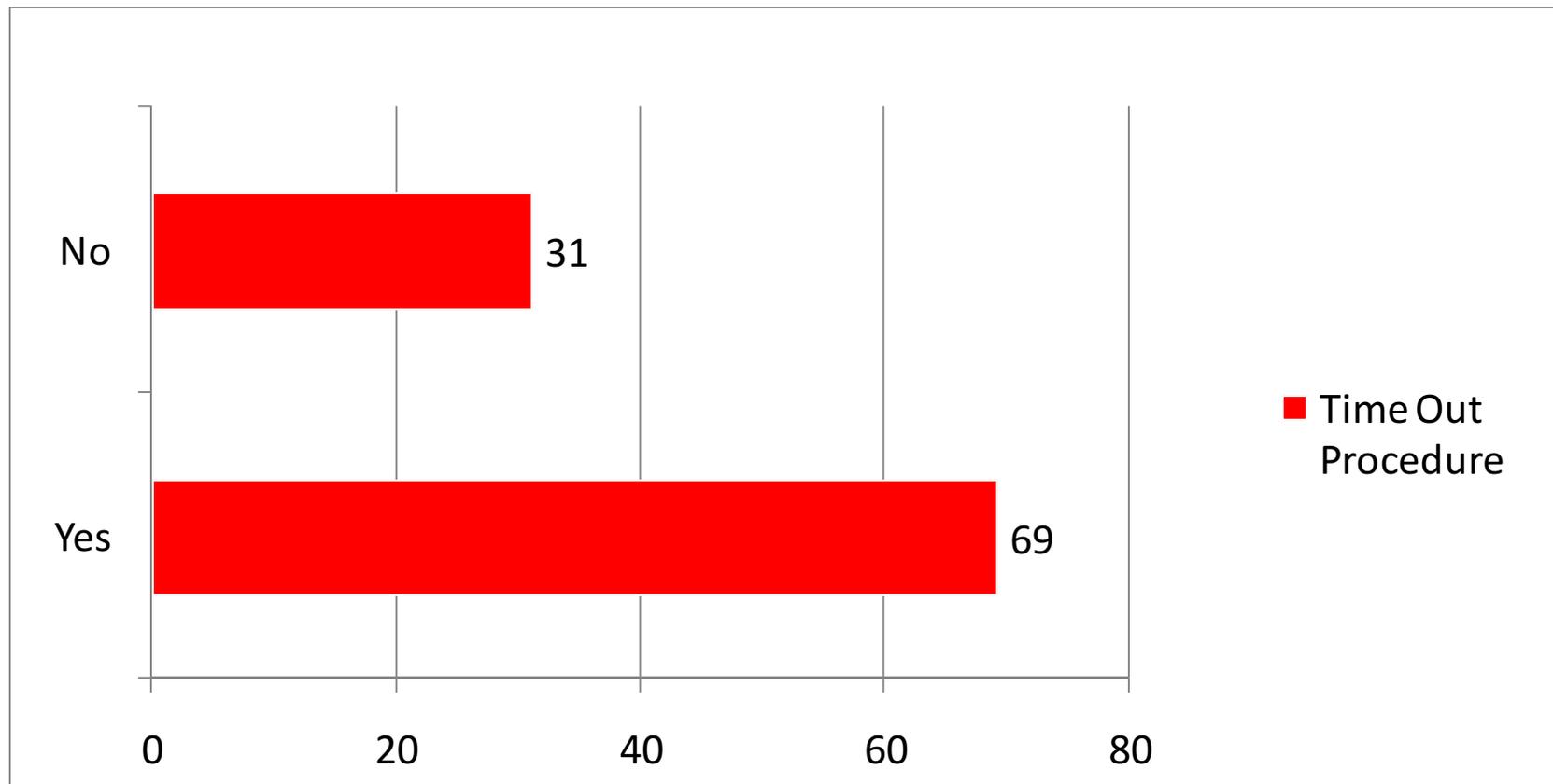


Figure 5. Percentage of time the clinical area is carrying out Time-out Procedure.



FEEDBACK TO 15TH MDG MEMBERS

😊 15th MDG members received feedback with our **SAMMY SAFETY NEWSLETTER** and other reminders (e.g. Cookies with TeamSTEPPS messages at Christmas, Patient Safety Awareness on Pencils & pens, etc.)

STRATEGIES

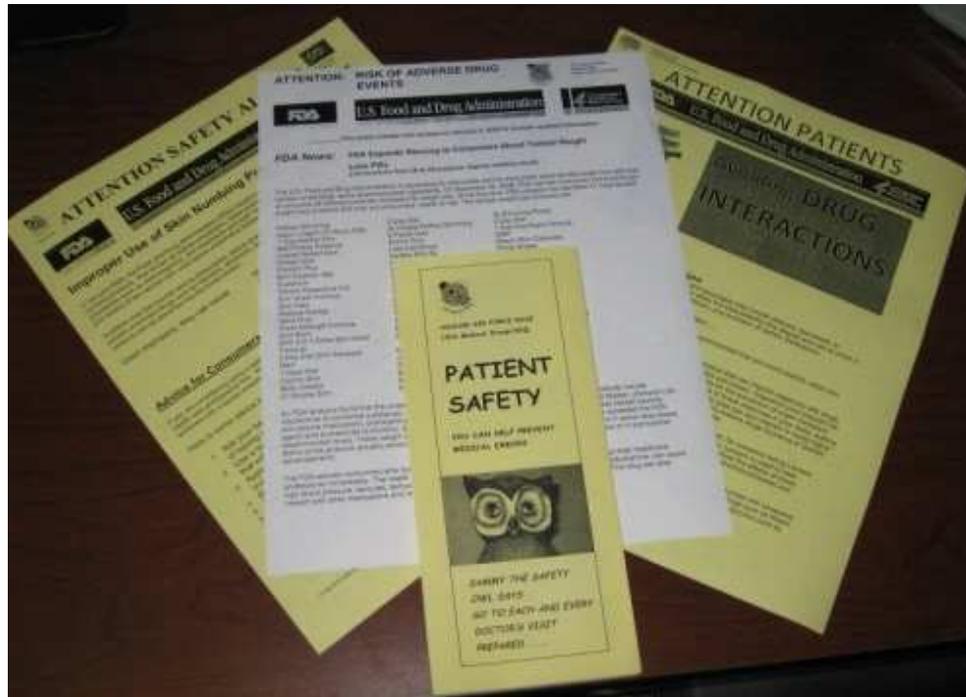


Figure 6. Newsletter and Fliers used to feedback to members of 15th MDG Patient Safety Audits and facts to support patient safety.

CONCLUSION



1. TeamSTEPPS Training helped further the culture of safety at the 15th MDG.
2. TeamSTEPPS Training accomplished the short-term goals (increased knowledge and reporting of errors) using Change and Learning Theory.
3. TeamSTEPPS Training demonstrated some success rates and some challenges for implementation of tools.
4. The program help identify barriers and other deficits for future problem solving.

FUTURE



- 1. Follow-up with chart audits on Handoff format and Timeout checklist.**
- 2. Develop more creative ways to overcome barriers identified by staff.**
- 3. Continue to explore the principles of Change and Learning Theory to enhance Patient Safety in the outpatient Setting.**

2010 Military Health System Conference

Prevention of Errors Related to Anticoagulants Prescribed in an In-Patient Setting

Sharing Knowledge: Achieving Breakthrough Performance

TEQUILA E. LANGHAM, RN, MSN, OCN, CMSRN

27 JANUARY 2010



BACKGROUND



■ National Patient Safety Goal 3E

■ “Reduce the likelihood of patient harm associated with the use of anticoagulant therapy”¹

- Warfarin (Coumadin®)
- Enoxaparin (Lovenox®)
- Fondaparinux (Arixtra®)
- Unfractionated Heparin
 - Subcutaneous
 - Infusion drip

Anticoagulants



¹The Joint Commission, 2009 Hospital Accreditation Standards, NPSG.03.05.01

BACKGROUND (cont'd)

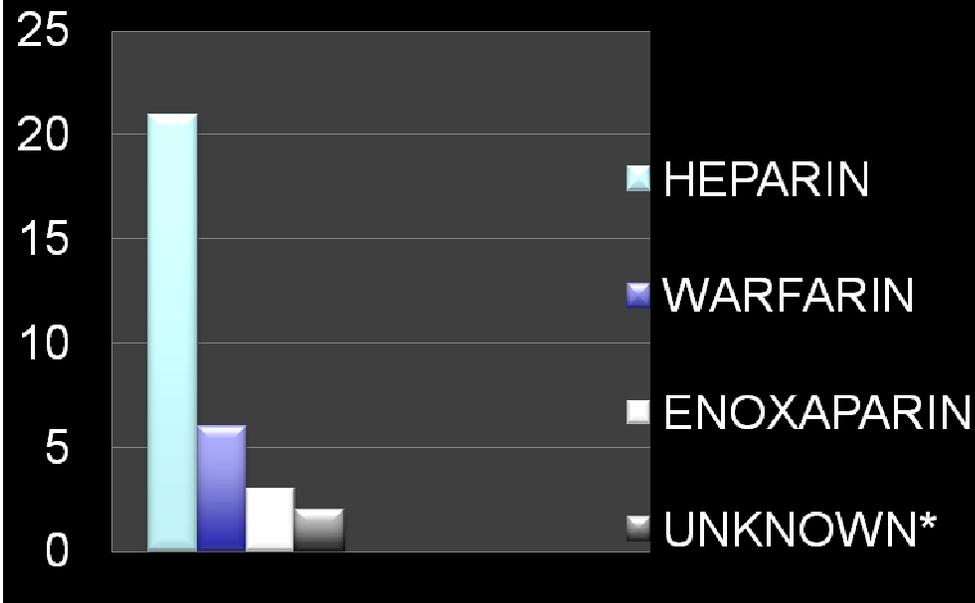


- Anticoagulants have been identified as one of the top five drug types associated with patient safety incidents in the United States ⁽¹⁾
- Anticoagulant medications are top five drug types associated with patient safety incidents in the United States ⁽²⁾

HISTORICAL EVIDENCE



Number of reported Sentinel Events related to Anticoagulants (1997-2007) 3



*One event affected three patients

Outcomes (34* Pts)

- Deaths: 28
- Loss of function: 6

Settings

- Hospital: 29
- ER: 1
- Long Term Care: 2

Cause of Event

- Wrong drug: 3
- Wrong dose: 7
- Improper monitoring: 9
- Pump malfunction error: 5
- Given without order: 2

BAMC ANTICOAGULATION THERAPY INITIATIVE



- **Command Directed**
 - Oversight: Cardiology Section of the Department of Medicine
- **Standardized order sets created for anticoagulation therapy**
- **Medications:**
 - Unfractionated Heparin
 - Warfarin (Coumadin®)
 - Enoxaparin (Lovenox®)
 - Fondaparinux (Arixtra®)

BAMC ANTICOAGULATION ORDER SET



Order Entry - Essentris

File Edit View Env Admin Status Boards FlowSheets Notes Orders Summary Screens IPIOTS Tools Web Links Help OE Options Order Entry

Essentris

Unsign'd DC'd Pending DC

Renew Order	Priority	V/O	Start Time	Stop Time	ENT	SIGN	MD	ACK	REVIEW	VERIFY
X1	Routine		0300 14 Dec 2009		SSP	SSP				
Stable	Routine		0300 14 Dec 2009		SSP	SSP				
General Surgery Team A	Routine		0300 14 Dec 2009		SSP	SSP				

Intern Pager: 513-7589

Name	Freq	Comment	Priority	V/O
Inpatient Admission 2 West		1. Injury:none 2: Attending:LeVoyer 3. Contact Precautions:none 4. Diagnosis:SBO 5. Admitting Svc:	Routine	
Inpatient Admission 2 West		1. Injury:none 2: Attending:LeVoyer 3. Contact Precautions:none 4. Diagnosis:SBO 5. Admitting Svc: Gen Surg Team A	Routine	
Inpatient Admission 2 West		1. Injury:none 2: Attending:LeVoyer 3. Contact Precautions:none 4. Diagnosis:SBO 5. Admitting Svc: Gen Surg Team A	Routine	

Name	Freq	Priority	MD	Comment	ENT	SIGN	ACK	REVIEW	V/O	Start Time	Stop Time
Diet Order: NPO	AC	Routine		NPO;	SSP	SSP	MLP			0300 14 Dec 2009	

Name	Volume (ml)	Rate (ml/hr)	Comment	V/O	Start Time	Stop Time	ENT	SIGN	MD	ACK	REV
D5.45NS+ 20meqKCL	1000	110	continuous maintenance IVF		0300 14 Dec 2009		SSP	SSP	SHIMU		

Name	Freq	Priority	MD	Comment	ENT	SIGN	ACK	REVIEW	V/O	Start Time	Stop Time
CBC PNL (BAMC)	QAMLABS	Routine			SSP	SSP	MLP			0300 14 Dec 2009	
CHEM7 CA MG PO4	QAMLABS	Routine			SSP	SSP	MLP			0300 14 Dec 2009	
LFTS, Amylase Lipase	QAMLABS	Routine			SSP	SSP	MLP			0300 14 Dec 2009	

Name	Dose	Route	Freq	Comment	Priority	V/O	Start Time
HEPARIN (PORK) *Mandatory: Activate Anticoagulation Order Set*	5000 UNITS	SQ	BID	DVT Prophylaxis	Routine		0300 14
PANTOPRAZOLE (PROTONIX) {40MG INJ}	40 MG	IV	Daily	thanks	Routine		0300 14
CEPACOL (OR SUB)	1 EA	PO	Q2HRS PRN		Routine		0600 14
diphenhydramINE	25-50 MG	IV	QHS PRN	insomnia	Routine		2200 14
SODIUM PHOS 0 MEQ	15 mmol	IV	X1	For Phos of 2.3 - Electrolyte Replacement	Routine		1100 15

Active Orders / Orders Without ACK / Orders Without COSIGN

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Start Inboxes - Microsoft Outlook FW: System skill Fair (UN... Microsoft PowerPoint - ... Order Entry - Essentris 1:31 PM

DVT Prophylaxis

Alert statement

BAMC ANTICOAGULATION THERAPY INITIATIVE (cont'd)



- **Multidiscipline Approach:**
 - Prescribers: Providers
 - Administrators: Nursing
 - Dispensers: Pharmacy
 - Monitors: Patient Safety/Nursing
 - Others
 - Coumadin Clinic Staff
 - Nutritionist
 - Laboratory Services



- **Components of Program**

- **Patient Teaching**

- Three consults are generated with each Anticoagulation Order Set:
 - Inpatient Clinical Pharmacy
 - Coumadin® Clinic (Coumadin® orders)
 - Nutritional Services (Coumadin® orders)

BAMC ANTICOAGULATION PROGRAM (cont'd)



■ **Laboratory Tests:**

- Admission Labs: Waste: largest impediment to improved performance Variation: enemy of continuous quality.
- Renal Function Panel w/ GFR; Coags, Anti-Xa (heparin drip); CBC; LFT; B-HCG (when indicated); and urinalysis
- Daily Labs: Coags, Anti-Xa (when applicable), CBC

BAMC ANTICOAGULATION PROGRAM

(cont'd)



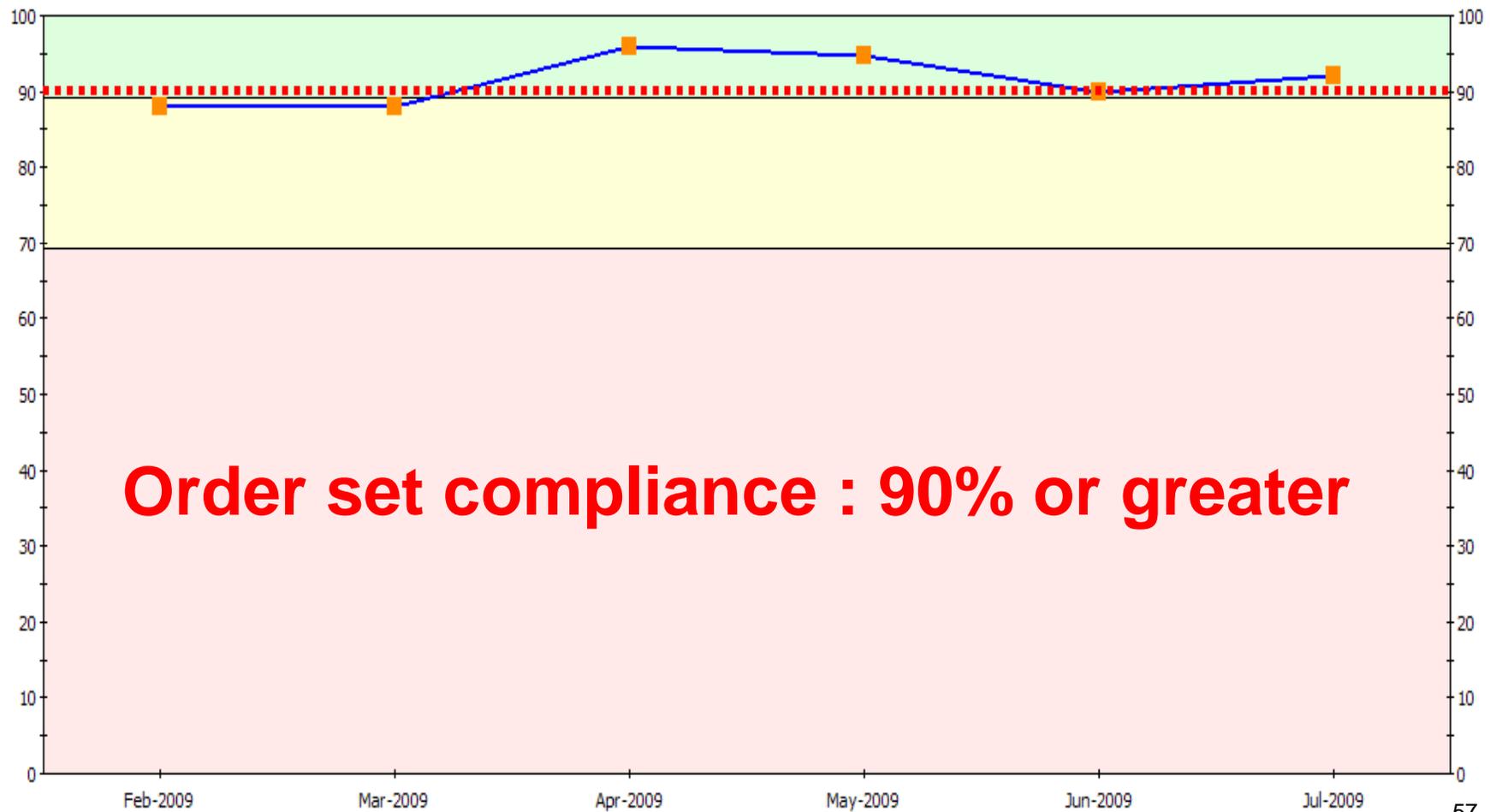
- Nursing obtains height and weight on admission
- Nursing alert MD when certain lab parameters are obtained:
 - INR greater than 3.5
 - Baseline platelets less than 100,000 or drops below 50% of Pt's baseline
 - Positive B-HCG

Measures Of Compliance with the Anticoagulation Order Set



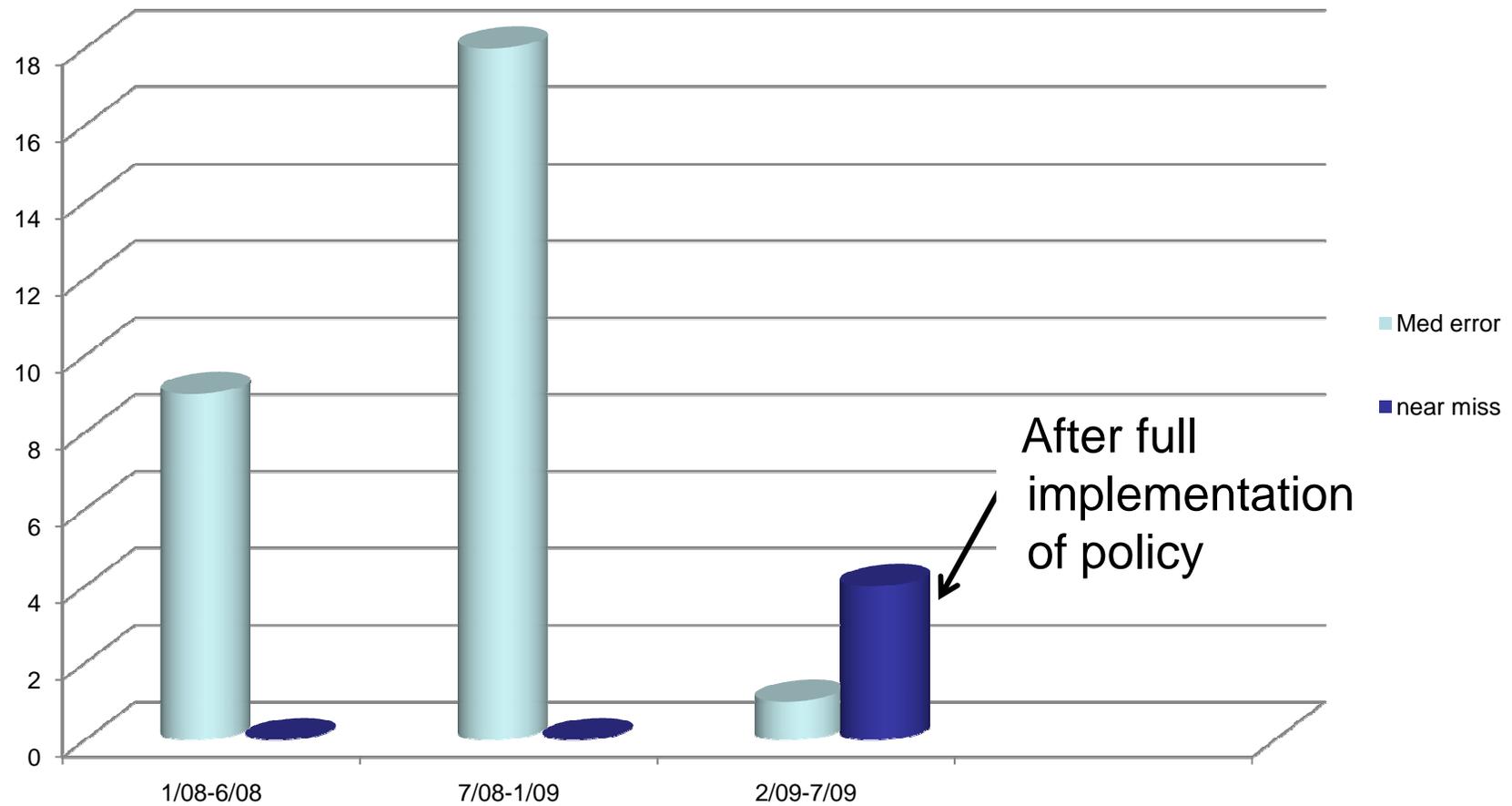
Anticoagulation Compliance

—■ % of compliance anticoagulation orders

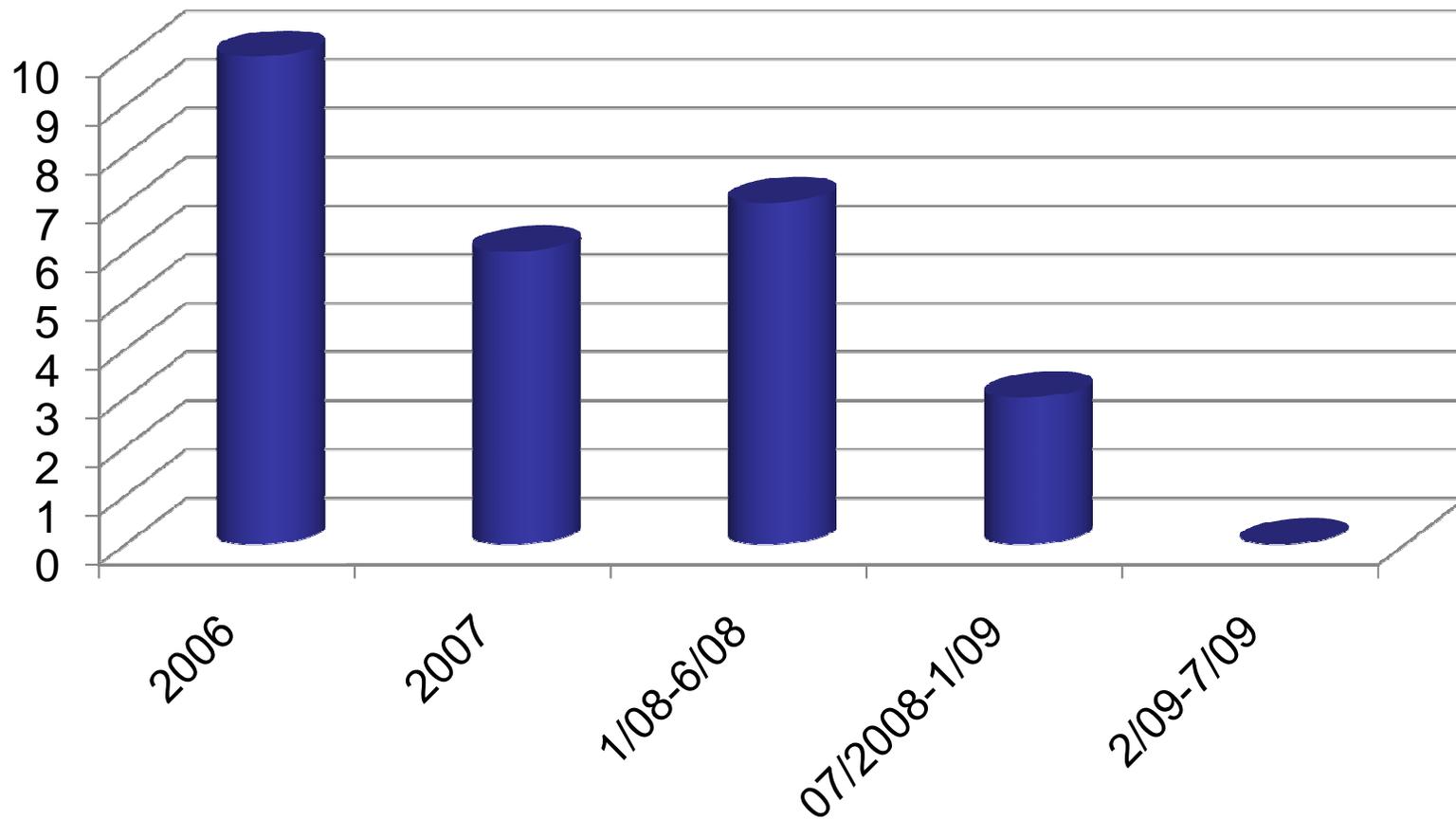


Order set compliance : 90% or greater

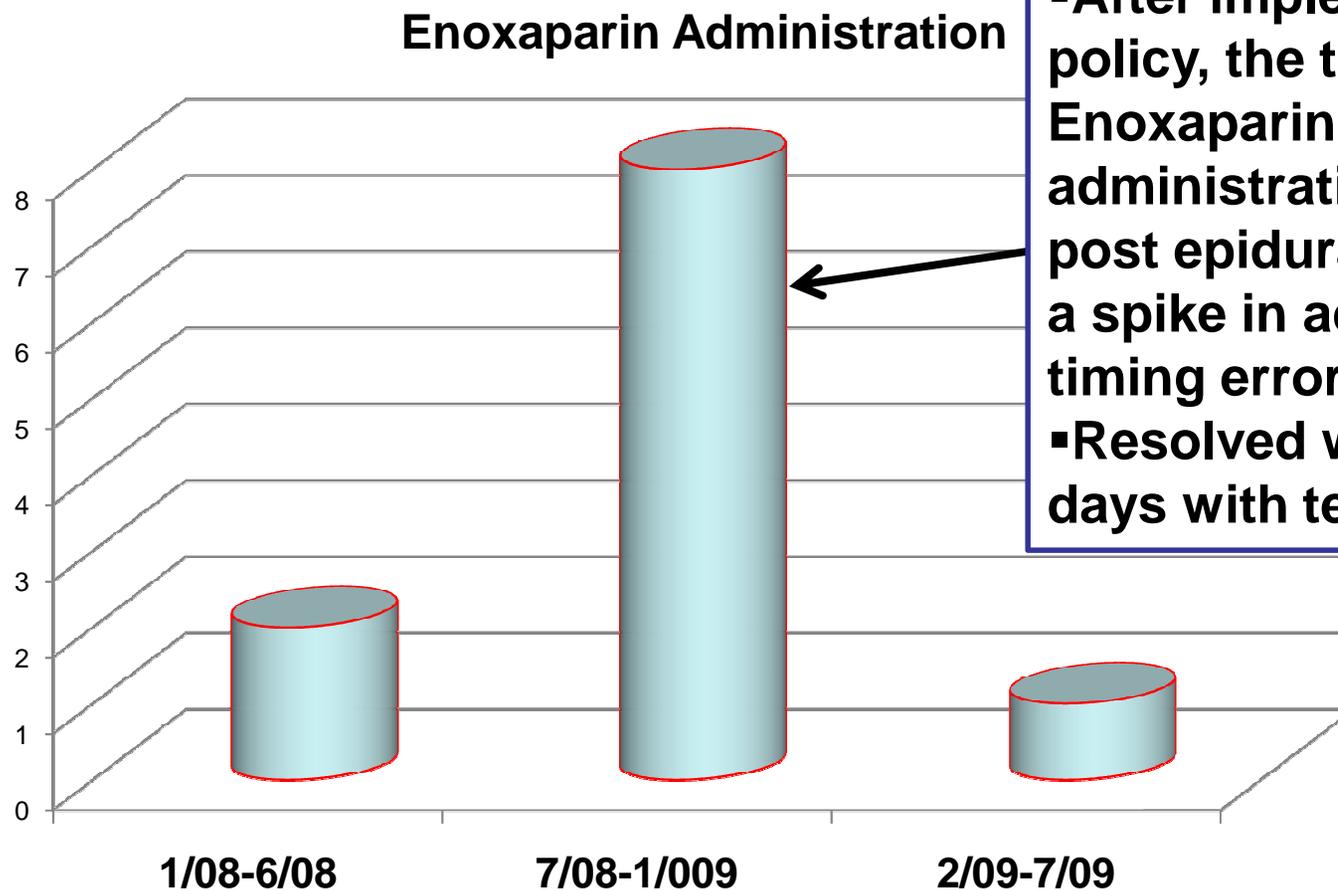
Medication Error Rate



Heparin Related Errors



Enoxaparin Administration Errors



- After implementation of policy, the timing of Enoxaparin administration changed post epidural leading to a spike in administration timing error
- Resolved within 30 days with teaching

Summary



- **Standardized inpatient pathway with:**
 - Basic initial labs & daily appropriate labs
 - Clinical pharmacy consult (drug-drug interaction review)
 - Nutritional services consult (food-drug interaction)
 - All anticoagulant products were standardized by pharmacy with pre-mixed doses to minimize medication related errors

Summary (cont'd)



- All lab abnormalities were monitored by nursing staff as well as pharmacy and were reported back to ordering provider
- **Discharged patients:**
 - Provided with a drug dose summary
 - All patients new to Warfarin were seen in Anticoagulation Clinic within 72 hours post discharge from hospital

Conclusion



- Our innovative and progressive program will allow for an increasing number of beneficiaries to receive:
 - Top-quality anticoagulation care with:
 - Minimal incidence of anticoagulation related errors
 - Substantial cost savings to the health care system
- Additionally, the multidisciplinary approach will allow for greater unit team building, increased staff member job satisfaction, and better patient care

Brooke Army Medical Center Team Members



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ACKNOWLEDGEMENTS



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COL Jean M. Dailey, RN, MSN, ANC

COL Thirsa Martinez, PharmD, MS, USA

LTC Mary Jo K. Rohrer, MD, MC, USA

Ms Robin A. Canuela, RN, MSN

REFERENCE



1. The Joint Commission: High-alert medications and patient safety. *Sentinel Event Alert # 11*, November 19, 1999. Available online: http://www.jointcommission.org/SentinelEventAlert/se_a_41.htm (accessed 12/19/08)
2. Fanikos, J., et al: Medication errors associated with anticoagulant therapy in the hospital. *American Journal of Cardiology*, 2004, 94: 532-535
3. The Joint Commission: Preventing errors relating to commonly used anticoagulants. *Sentinel Event Alert # 41*, September 24, 2008. Available online: http://www.jointcommission.org/SentinelEventAlert/se_a_41.htm (accessed 12/19/09)

2010 Military Health System Conference

Eliminating Unauthorized Abbreviations from CHCS/AHLTA

Sharing Knowledge: Achieving Breakthrough Performance

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Health Clinic

27 January 2010



U.S. Army

Background



- 2003 TJC (then JCAHO) Patient Safety Goal
 - “Standard abbreviations ... a list of abbreviations ... not to use”
- 2005 TJC approved alternate approach for DoD
 - Allowed “U” & “QD” in CPOE in CHCS
- 2008 KAHC decided to eliminate “QD” from CPOE in CHCS/AHLTA
 - Go beyond just meeting the standard

KAHC Command Group



Initial Efforts: 2004 - 2008



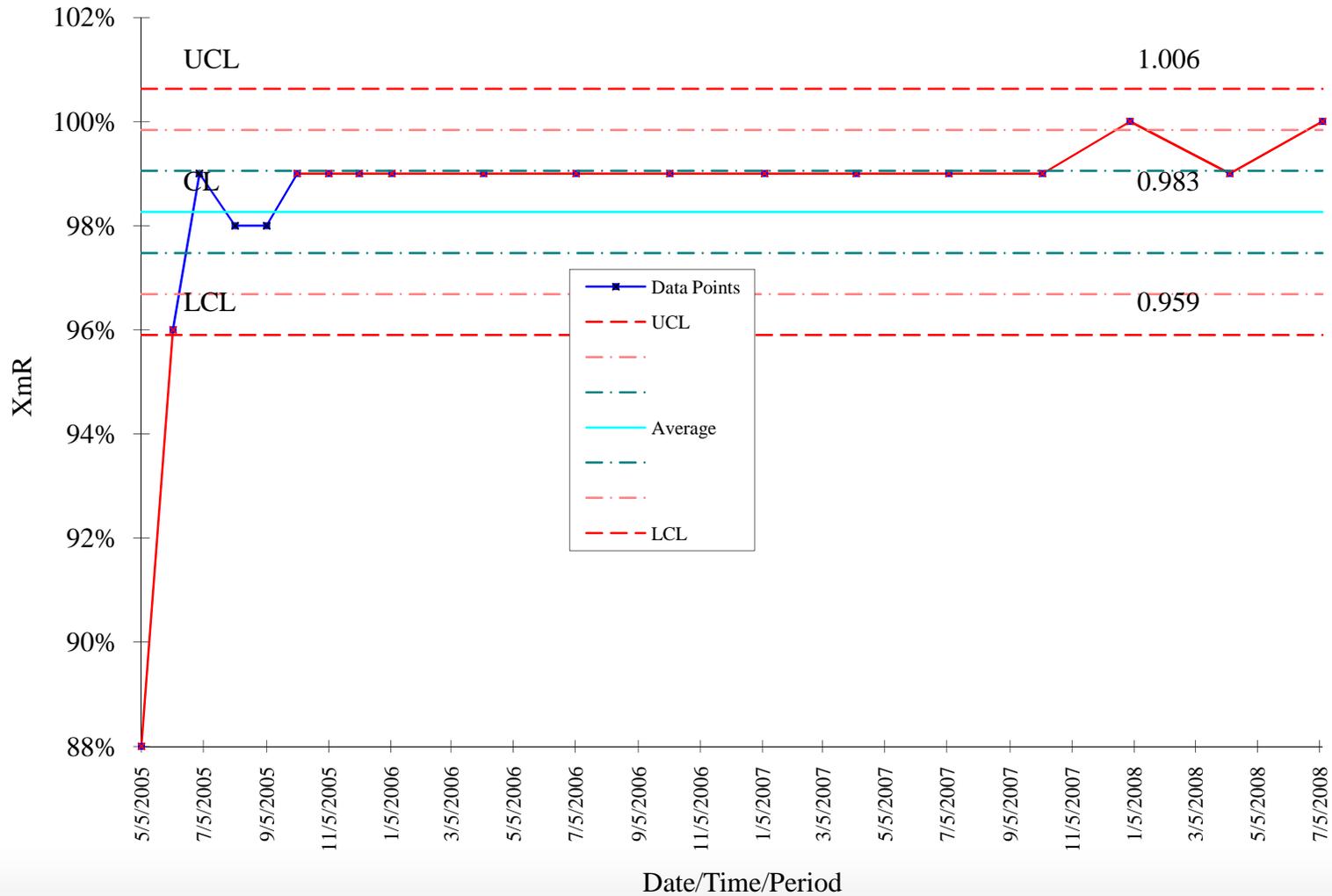
- Printed Forms – 100%
 - Removed all DNUA from all forms
 - 642 local forms: 3 contained DNUA
 - Sustain by reviewing all new forms for DNUA

- Eliminate DNUA from outpatient records
 - Initially audits of paper records
 - Then AHLTA “free text” entries

Initial Efforts: 2004 - 2008



Do-Not-Use Abbreviations Compliance



KAHC Providers



Initial Efforts: 2004-2008

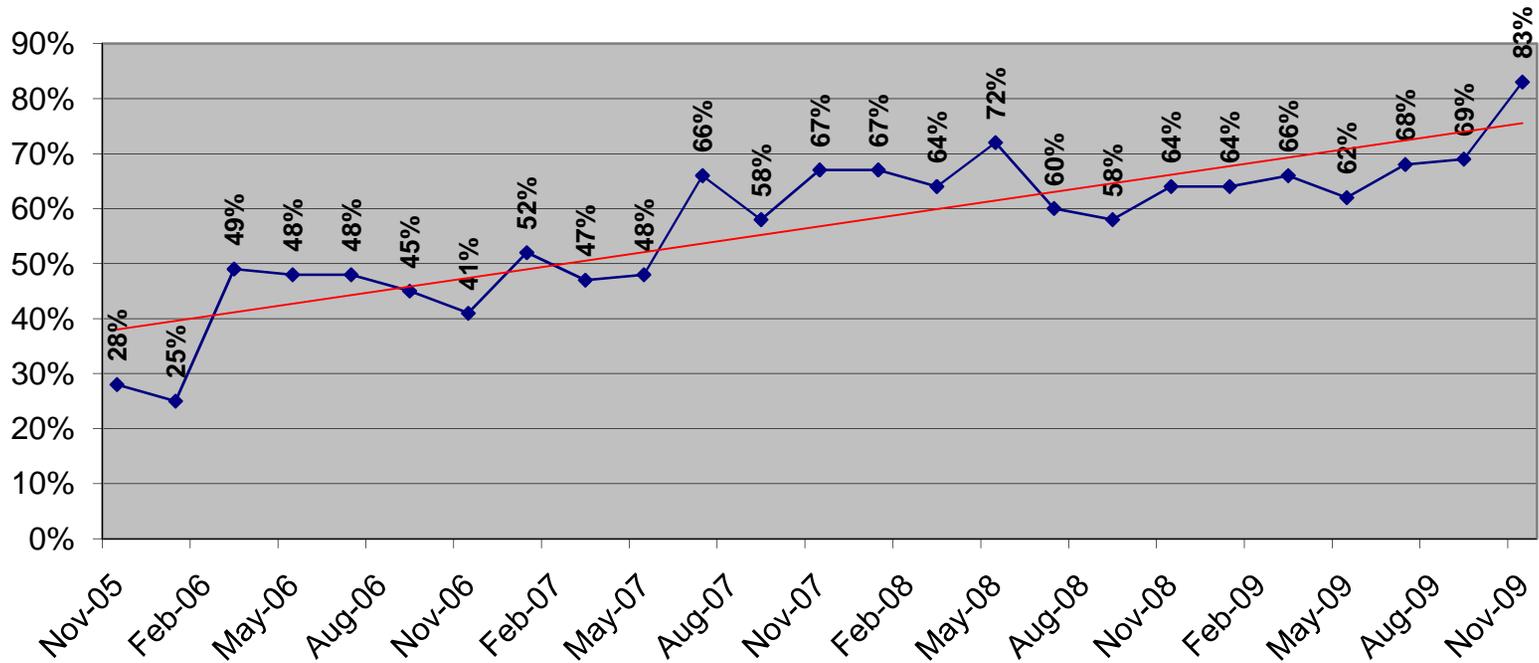


- Non-MTF Sources of DNUA
 - 40% of prescriptions were from outside providers
 - Most were handwritten
- 1,200 letters to TRICARE network providers
 - Signed by Commander & HealthNet VP
- Every-other-month audits (150-350 Rx per)
 - Second letter if DNUA used
 - Tracked individual providers

Initial Efforts: 2004 - 2008



Do-Not-Use Abbreviations: External Providers



KAHC Pharmacy Staff



Remove QD from CHCS

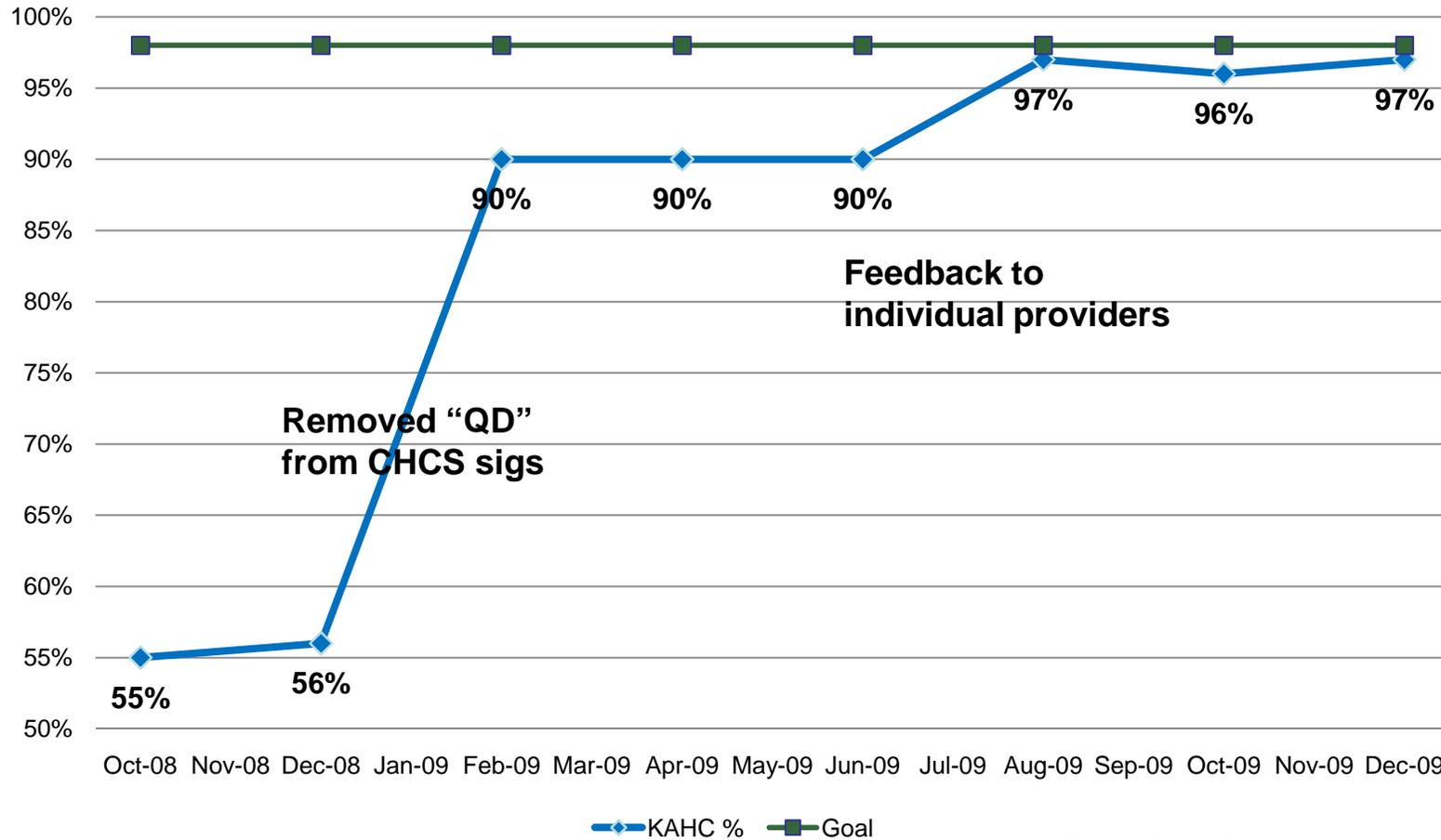


- 2008 Initiative started
- Pharmacy identified QD in preloaded sigs
 - Changed all to “daily”, “HS”, etc
- Audit all providers
 - Every-other-month
 - Feedback to providers & clinics
- Hidden QDs
 - Individual provider order sets
 - Copied Rx rewrites
 - Individual providers contacted

Remove QD from CHCS



KAHC Compliance with removing "QD" from CHCS RXs



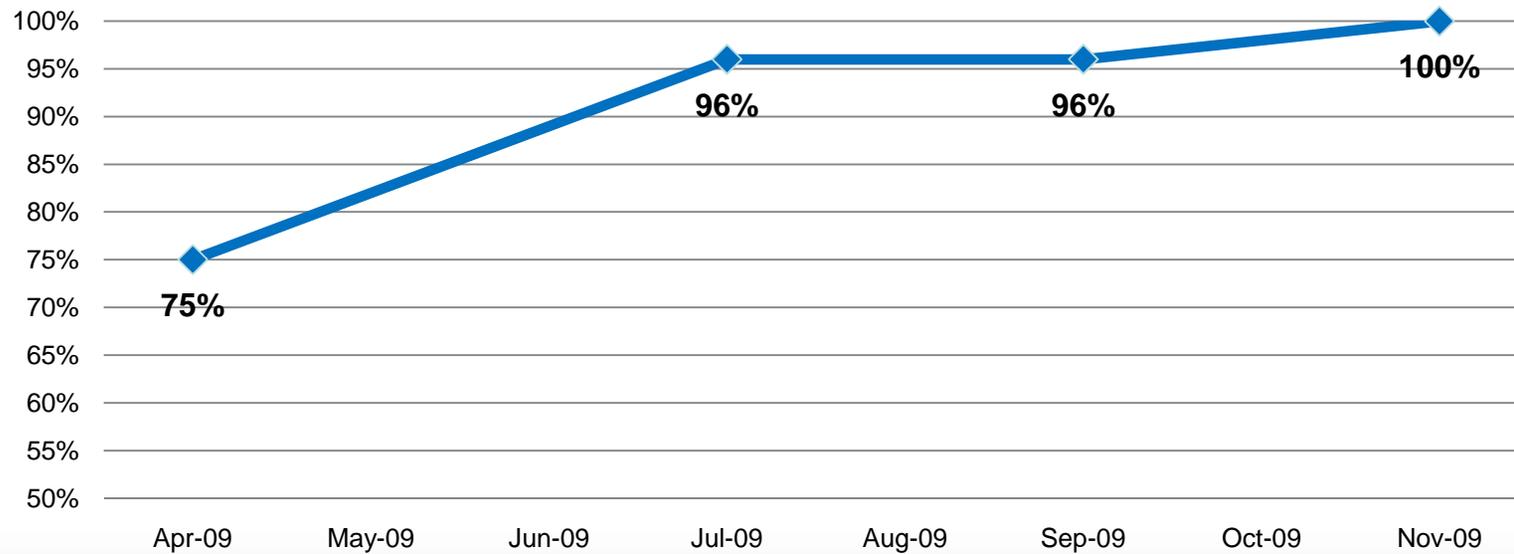
Goal = 98%

Removing QD from CHCS



- Pharmacy entered "QD"
 - Entered "QD" as written on outside Rx
 - Baseline 75% compliance
 - Quickly increased to 100%

Pharmacy Entered "QD" in CHCS



KAHC Active Duty Clinic Staff

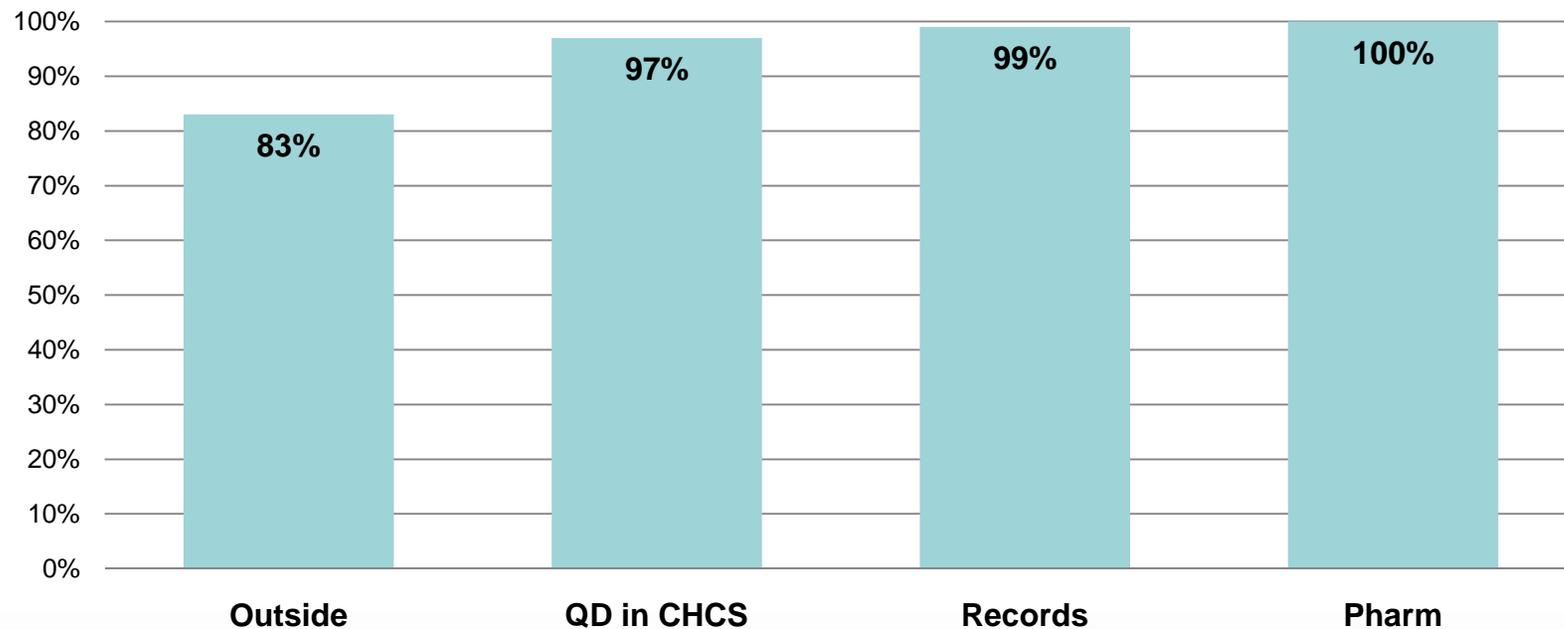


Current Compliance



- All KAHC DNUA sources
 - 95% compliance (if equally weighted)
 - Multidisciplinary collaboration & cooperation

All KAHC Sources



What now?



- Sustain the Gain
 - Continue audits
 - Individual & management feedback
 - Reports to Command
 - New provider & staff orientation/training
- Continuous Improvement
 - System fixes to CHCS/AHLTA
 - System-wide DNUA purge
 - Decimals in AHLTA Immunization screen

Because it is the right thing to do!



Questions



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Advancing Patient Safety to the Bedside

Creating a Culture of Safety and Quality

Sharing Knowledge: Achieving Breakthrough Performance

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27 Jan 2010



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Nellis AFB, NV

PRESENTATION VERSION

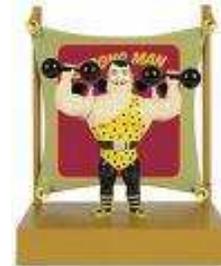
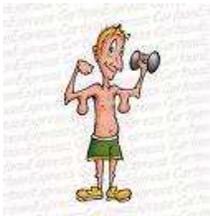
DoD Tri-Service Culture Survey



- Request for MTF interview led to project
 - Required in-depth analysis of PSP

- Analysis highlighted strengths

- Analysis revealed weaknesses



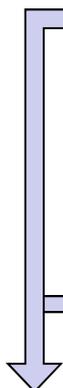
- Project: use survey results to guide PSP enhancements
 - Survey is research-based with tools to collect valid metrics

Survey Results: PSP Strengths



- Improvement in all areas between 2006-08

Patient Safety Culture Area	% Positives		Difference	Change
	2006	2008		
1. Overall Perceptions of Patient Safety	63	69	+6	↑
2. Frequency of Events Reported	60	63	+3	↑
3. Supervisor Expectations & Actions Promoting Pt Safety	73	77	+4	↑
4. Organizational Learning – Continuous Improvement	68	73	+5	↑
5. Teamwork Within Work Area	72	77	+5	↑
6. Communication Openness	58	62	+4	↑
7. Feedback and Communication About Error	65	70	+5	↑
8. Nonpunitive Response to Error	43	47	+4	↑
9. Staffing	41	50	+9	↑
10. Management Support for Patient Safety	72	75	+3	↑
11. Teamwork Across Work Areas	52	55	+3	↑
12. Handoffs and Transitions	41	46	+5	↑
Work Area/Unit Patient Safety Grade	75	84	+9	↑
Reported Events in Past 12 Months (Converted from negative to positive)	30	35	+5	↑



Low scores became focus of project

The '*Emperor's New Clothes*' of PS

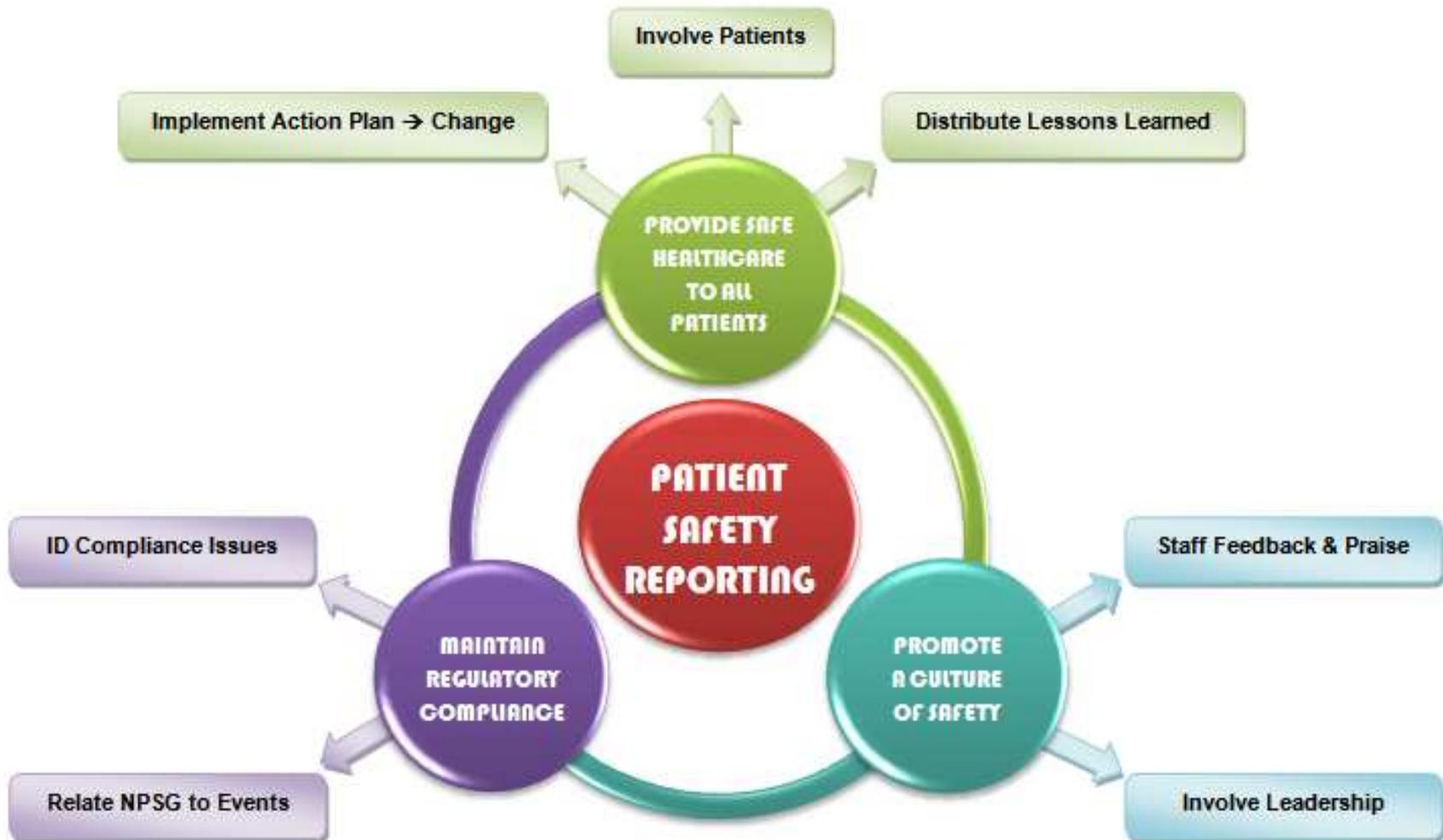


- **Myth:** We created a Nonpunitive Culture of Safety

It is difficult to claim a nonpunitive culture of safety when more than half of the staff believes their mistakes are held against them.



99 MDG PSP Model



Project Hypothesis



- Increasing the number of staff who report PS events will enhance the nonpunitive culture of our MTF

- Is the fear of reprisal a hold-over from the healthcare culture before PS?



- Unless staff report, how can they know if reprisal occurs?

The Plan



- Increase PS event reporting



- Market the PSP

- Feedback
- Leadership's role
- Advertise "lessons learned"



- Conduct follow-up mini survey to prove hypothesis



Increasing PS Event Reporting



- Increased PS Work Group Reps from 12 - 30

- Utilized patient point-of-care surveys

- Monthly PS Reports reflect near misses/events

Compliance Tracker



FAMILY PRACTICE CLINIC 2009 NPSG COMPLIANCE TRACKER		JAN 09		
NPSG 1: Patient ID	METHOD	TOTAL	# CORRECT	PERCENT
Compare with computer screen/appointment	Observation	10	10	100%
Patient and chart	Observation	10	10	100%
Patient and lab tubes; label in pt presence	Observation	10	10	100%
NPSG 2: Communication	METHOD	TOTAL	# CORRECT	PERCENT
Do not use abbreviations: posted	Observation	10	10	100%
Do not use abbreviations: not used in medical records, AHLTA, CHCS or print media	Chart Audit	10	10	100%
Follow-up for handoff of patients seen in ED documented	Chart Audit/ED Referral Sheet	10	10	100%
NPSG 3: Safety of using medication	METHOD	TOTAL	# CORRECT	PERCENT
Label when removed from original container	Observation	10	10	100%
Label even if only one medication used	Observation	10	10	100%
label: name, strength, amount (if not obvious)	Observation	10	10	100%
Verify by 2 staff when med not given by preparer	Observation	10	10	100%
Label one container at a time	Observation	10	10	100%
Any unlabeled meds/solutions discarded	Observation	10	10	100%
Original container kept until procedure over	Observation	10	10	100%
NPSG 7: Reduce Risk of Infection	METHOD	TOTAL	# CORRECT	PERCENT
Comply with CDC hand hygiene guidelines	Observation	10	10	100%
Educate health-care associated infection strategies to patients/families w/infection	Chart Audit	10	10	100%
NPSG 8: Medication Reconciliation	METHOD	TOTAL	# CORRECT	PERCENT
Produce a list and validate with the patient; include OTC and herbals	Chart Audit	10	10	100%
Give a list to the patient	Chart Audit	10	10	100%
Provide copy of list to outside provider - if known	Chart Audit	10	10	100%

Selling Patient Safety



- What's in it for me?

- Feedback to reporters



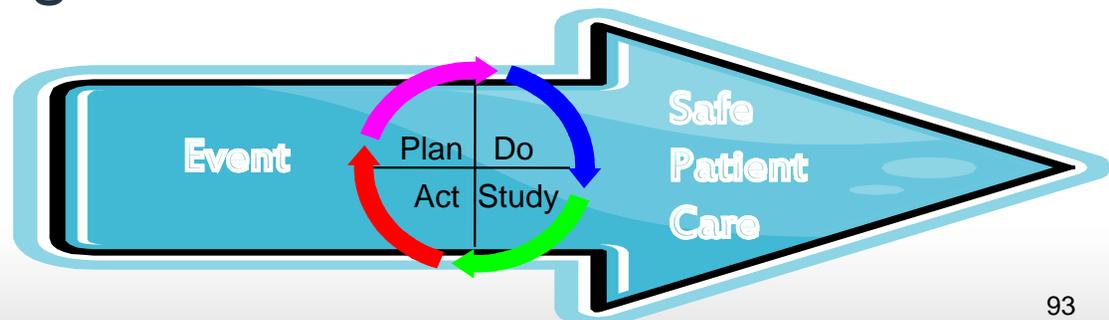
- Recognition by leadership

- OPR/EPR and award bullets



- Elimination of crazy-makers

- Real change occurs



Follow-up Survey



- Questions from original Tri-Service Survey

Choose the appropriate response for the following statements:	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
Staff feel like their mistakes are held against them.	<input type="checkbox"/>				
When an event is reported, it feels like the person is being written up, not the problem.	<input type="checkbox"/>				
Staff worry that mistakes they make are kept in their personnel file.	<input type="checkbox"/>				
How many near misses, errors, or harm events did you report during the past twelve months? Please note that reports may take many forms, e.g., laboratory check-sheets, medication errors entered into JAMRS, RCA actions not completed accurately, etc.					
None	1 to 2	3 to 5	6 to 10	11 to 20	21 or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Outcome of Project: Reporting



- PS Work Group NPSG observations/audits increased

MONTH	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
OBS	Baseline	129%	120%	105%	148%	224%	392%	434%

- Average pt surveys/mo
250 Pt Identification
215 Hand Hygiene
120 Medication Reconciliation
585 Total per month



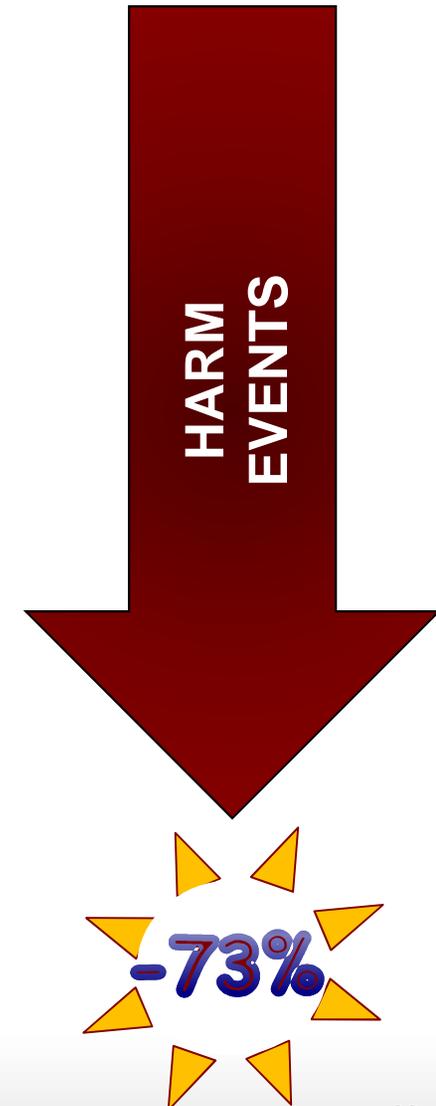
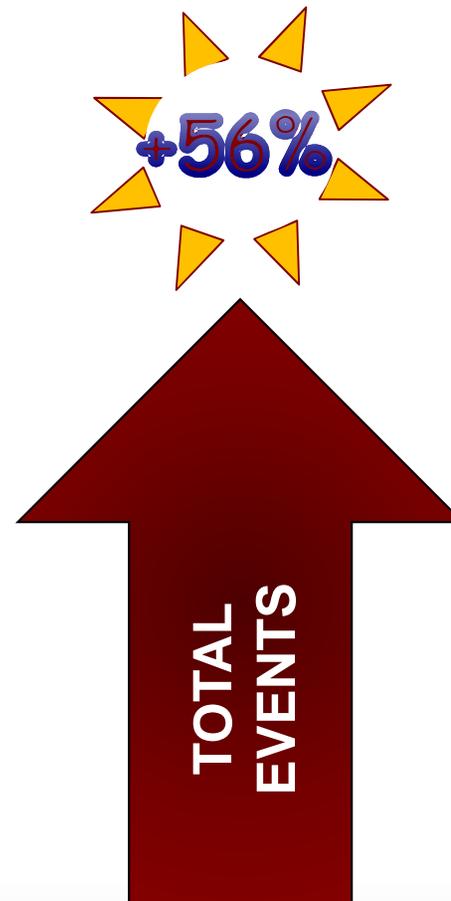
Outcome of Project: Reporting



- Average PS monthly reporting

TIME FRAME	2008	JAN-AUG 2009*
Average Total Errors/mo	Baseline	+56%
Average Near Misses/mo	Baseline	+71%
Average No Harm Errors/mo	Baseline	+10%
Average Harm Errors/mo	Baseline	-73%

* Time frame of project was Jan – Aug 2009

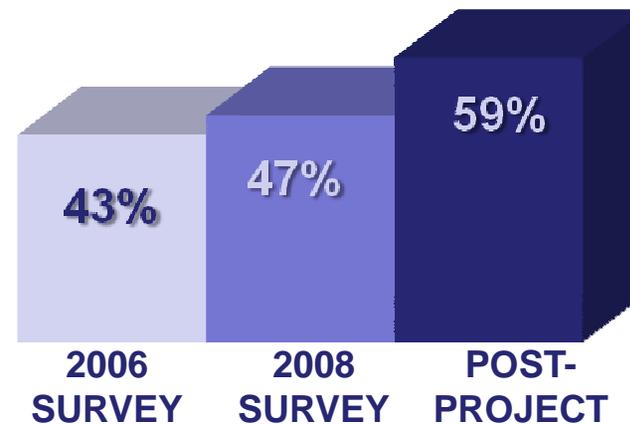


Outcome of Project: Marketing PS

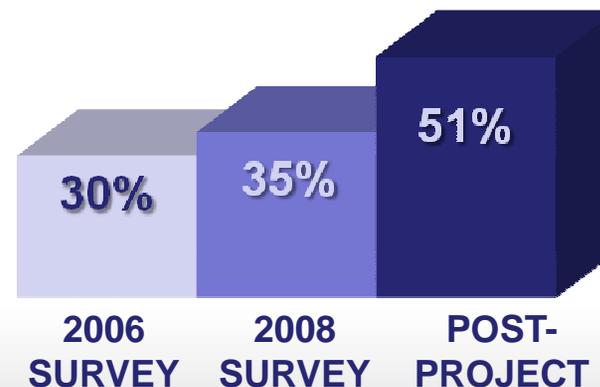


- Per repeat mini-survey:

- **STAFF WHO BELIEVE IN A NONPUNITIVE RESPONSE TO ERRORS**



- **STAFF WHO REPORT PS EVENTS**



Project Outcome



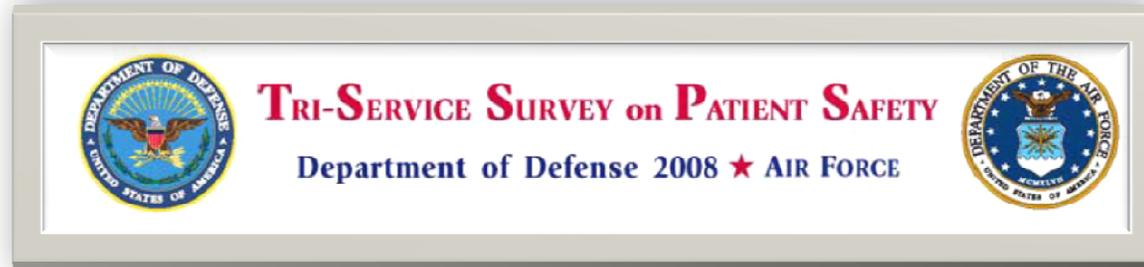
- Patient Safety Reporting Increased
- Nonpunitive Culture Enhanced
- MOST IMPORTANT RESULT:
 - Safer patient care delivered as evidenced by decreased patient harm
- The Joint Commission Survey in Oct 09

★ ZERO NPSG Findings! ★

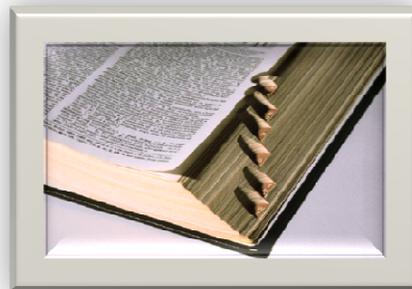
Recommendations



- Every MTF will benefit from a complete analysis of their survey results



- The survey can more clearly define “Event Reporting”.



Questions?



- Sample NPSG Trackers Available:
 - 99 Medical Group, Nellis AFB, NV
 - Shelley Drake
 - shelley.drake.ctr@nellis.af.mil

FAMILY PRACTICE CLINIC 2009 NPSG COMPLIANCE TRACKER				JAN 09							
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NPSG 7: Reduce Risk of Infection	METHOD	TOTAL	# CORRECT	PERCENT							
					MHC 2009 NPSG COMPLIANCE TRACKER W/RCA F-U						
					JAN 09						
					METHOD	TOTAL	# CORRECT	PERCENT			
					NPSG 15: Identify safety risks inherent in the patient population (note: applies to the psych unit and patients being treated for emotional or behavioral disorders)						
					Chart Audit	10	10	100%			
					The risk assessment includes identification of specific factors that may increase or decrease the risk for suicide.						
					PAST RCA METRICS			METHOD	TOTAL	# CORRECT	PERCENT
					Chart Audit	10	10	100%			
					Audit high risk log for inclusion of all inpatients until at least 2 visits after discharge						
					Chart Audit						
					Audit number of discharge notes received within 72 hrs of discharge from IP unit						
					Chart Audit						
					Audit IP unit's receipt of outpatient mental health record						
					Chart Audit						
					Audit of communication of risk status to patient's commander						
					Chart Audit	10	10	100%			