

### ***Medical Simulation: Practicing to Be Expert Teams***

An expert panel from across the MHS presented didactic information and a series of interactive simulated exercises designed to introduce attendees to the effectiveness of simulation as it is used to promote team-based care.

The panel consisted of *Heidi King*, Deputy Director, DoD Patient Safety Program and Director, Patient Safety Solution Center; *Col. Deborah M. Burgess*, MD, USAF; LTC *Shad Deering*, MD, USA, Director, Andersen Simulation Center; *Gil Muniz*, PhD, Chief Operating Officer, National Capital Simulation Center, and *LTC Donald Robinson*, Director, DoD Patient Safety Program.

Col. Burgess emphasized the importance of practice-based learning. To achieve true breakthrough performance, training must transfer to the work environment. That is what simulation-based training aims to accomplish.

LTC Deering explained the use of simulation exercises in the service of team-training – where the emphasis is not simply on technical proficiency, but equally on how participants function as a team. Attendees received a TeamSTEPPS® Pocket Guide, and a brief overview of TeamSTEPPS strategies. They then watched three simulated exercises, and evaluated and discussed the effectiveness of teamwork in each.





***Front-Line Perspectives for Advancing the Culture of Safety:  
Battlefield to Bedside***



Leaders from the front-line of patient safety in the MHS shared the latest initiatives, innovations and insights. Representing a wide range of command experience, the panelists included *LTC Donald W. Robinson*, DO, USA, Director, DoD Patient Safety Program; *Michael Datena*, RPh, MPA, Program Analyst, DoD Patient Safety Program; *MG Patricia D. Horoho*, MSN, MS, USA and *COL Peter G. Napolitano*, MD, USA.

MG Horoho explained the theories of normalization of deviancy, structural secrecy and practical drift. Left unrecognized and unchecked, these can lead to system failure. She shared recommendations based on her extensive personal command experience for combating these at the facility leadership level.

Battlefield insight was provided by COL Napolitano. He described his successful efforts to introduce TeamSTEPPS® in Iraq during his 2008 deployment. Calling the 86<sup>th</sup> CSH in Baghdad “where the rubber meets the road”, COL Napolitano recounted his personal

experiences and the dramatic difference the familiar teamwork tools made to improve safety in the combat zone.

The overarching patient safety initiatives currently available to all MHS providers were outlined by Michael Datena. He underscored the importance of the Patient Safety Reporting system, TeamSTEPPS and the Patient Safety Learning Center – all tools to enhance the learning environment and keep our patients safer.

Advancing the culture of safety remains a high-level priority for the DoD Patient Safety Program (PSP). LTC Robinson described the many ways the PSP seeks to strengthen the culture of safety across the MHS: the annual Patient Safety Awards, the Tri-Service Culture Survey, and a newly introduced Commanders’ Forum, an interactive platform where facility commanders can collaborate and network. The first Forum is planned for February 2010. All commanders were urged to take part.



***A Commander's Perspective:  
Leadership to Improve Patient  
Safety and Quality***

Less a panel discussion than a conversation, *CAPT Bruce L. Gillingham*, MD, USN, Commander Naval Hospital Jacksonville and *LTC Donald W. Robinson*, DO, USA, Director, DoD Patient Safety Program shared their perspectives on how leadership can impact patient safety and quality in MHS facilities.

CAPT Gillingham outlined a list of “safety essentials” – effective communication, psychological

safety, rapid feedback, output metrics, accountability and teamwork -- all of which can exist only when they are supported by actively engaged leadership. He shared his vision of the leader’s role – to set the tone, foster mindfulness, encourage anticipation, and champion the imagination. Based on his experience as hospital commander, he offered suggestions to personnel for engaging their leaders, as well as suggestions to leaders for integrating patient safety into their facilities’ cultures (safety walk-rounds, quality council, integrating strategic plan with quality goals).





### ***2009 DoD Patient Safety Awards***

The DoD Patient Safety Awards were presented at the beginning of the morning plenary sessions to a full auditorium of Conference attendees. *Dr. Jack Smith*, Acting Chief Medical Officer for TRICARE Management Activity presented the Patient Safety Awards to facility commanders or deputy commanders. In introducing the awardees, Dr. Smith offered the congratulations and appreciation of the entire MHS to these patient safety innovators and their staff who work every day to, he said, “put care back in healthcare.”

On Wednesday, January 27<sup>th</sup>, the award winning initiatives were presented in detail at a Conference break-out session. Moderated by *LTC Donald W. Robinson*, Director, Patient Safety Program, the project managers described the origins, processes, metrics and recommendations of each submission.

Below are the *2009 Patient Safety Award project managers at the MHS Conference break-out session with DoD Patient Safety Program leaders. Pictured back row, l to r: Tequila E. Langham, RN, MSN, OCN, CMSRN, Brooke AMC; David T. Bolesh, Rn, MSN, Patient Safety Manager, Kenner AHC; Shelley Drake, Patient Safety Manager, 99<sup>th</sup> MDG, Nellis AFB; CDR R. Lee Biggs, MC, USN; LTC Donald Robinson, Director, DoD Patient Safety Program; front row, l to r: Heidi B. King, MS, Deputy Director, DoD Patient Safety Program.)*





### ***Patient Safety Program Exhibit***

The DoD Patient Safety Program (PSP) maintained a presence in the MHS Conference Exhibition Hall, where it was visited by attendees from around the United States and abroad. Located in the MHS Pavilion, an area specially designated for military health agencies, the Patient Safety Program (PSP) kiosk was staffed by PSP personnel. Visitors to the PSP booth could review information on the array of patient safety tools available, and could scroll through computers featuring links to Program on-line learning sites. Take-away handouts described the Patient Safety Reporting System and the Patient Safety Learning Center.

