

U.S. Department of Defense

Patient Safety Program

PARTNERING FOR A NEW LEVEL OF CARE



SPRING 2010

A QUARTERLY NEWSLETTER TO ASSIST THE MILITARY HEALTH SYSTEM IMPROVE PATIENT SAFETY

PATIENT SAFETY AWARENESS WEEK ACROSS THE MHS

DoD PSP Talks the Talk of Safer Healthcare Every Day

This year, Patient Safety Awareness Week, with its theme of “Let’s Talk: Healthy Conversations for Safer Healthcare”, presented an opportunity for the Patient Safety Program to highlight its many on-going safety-related conversations. Providers across the Military Health System (MHS) are encouraged daily to join the Patient Safety Learning Center, a community Wiki (web portal), and to participate in the monthly Learning Action Network Webinars, where patient safety best practices, lessons and success stories are shared.

Across the MHS where patient safety is a shared responsibility among leaders, providers and patients alike, Military Treatment Facilities (MTFs) supported Patient Safety Awareness Week. As always, their shout out to patient safety was loud and clear:

Brooke Army Medical Center (BAMC)

BAMC staff distributed educational materials and hospital information to patients at a Patient Safety Fair on March 10th. All week staff was reminded of patient safety through quizzes, notices and videos. BAMC keeps the patient safety conversation going year-round by actively encouraging the reporting of patient safety events and by awarding a quarterly TEAM contribution award.

31st MDG, Aviano AFB

Patient safety events spanned Awareness Week at Aviano Air Force Base. Monday through Thursday patient safety Information tables were set up in the Atrium, a Medical Do No Harm Room was in operation, training was offered on the Medical Obstetric Emergency Simulator (MOES) and staff was encouraged to join in patient safety challenges and quizzes. In keeping with the overarching DoD patient safety commitment to communication and teamwork, the week ended fittingly with a TeamSTEPPS™ training session.

Carl R. Darnall Army Medical Center, Fort Hood, Texas

Darnall AMC celebrated Patient Safety Awareness Week by devoting a stand-down day to its second annual Culture of Patient Safety Symposium. Doctors, dentists, nurses, administrators and students discussed teamwork, changing the patient safety culture, and the importance of leadership guidance. Speakers included Heidi King, MS, FACHE, Deputy Director, DoD Patient Safety Program, Director, Patient Safety Solutions Center and keynoter Lt. Col. (Ret.) John J. Nance, JD, author of “Why Hospitals Should Fly: the Ultimate Flight Plan to Patient Safety and Quality Care”.



Pictured l to r: Pam Scott, Nursing Services PI Coordinator; Marcus Caruthers, Clinical Risk Management Asst.; LTC Boykins Russell, Deputy Chief, Hospital Education; Paula Lochhead, PI Specialist; Pat Turner, Dept. of Med. PI Coordinator.



MOES training session team at Aviano.



Darnall AMC staff attend the Culture of Patient Safety Symposium.

ONE MISSION, ONE TEAM

Director's Corner

I would like to take this opportunity to extend a special thank you to Dr. Geoffrey Rake, who is retiring at the end of March after serving since 2003 as the Director, Patient Safety Analysis Center. Dr. Rake previously served for twenty-nine years as a physician in the U.S. Air Force. His years of service and dedication, and his contributions to improve patient safety and the quality of care within the Military Health System, have been nothing short of spectacular. His leadership has been instrumental in assisting to guide this program from its infancy to its current state. Dr. Rake's vision has helped drive a call to action for reduced medical errors and recognition of the patient safety movement throughout the DoD. On behalf of my staff and former Directors of the DoD Patient Safety Program, we wish Dr. Rake all the best as he transitions into another phase of his life.



During the week of March 7th - 13th, hospitals and clinics throughout the Military health System participated in National Patient Safety Awareness Week. Facilities hosted a number of activities to raise awareness of patient safety among staff, educate their patients on ways to become involved in their own health care, and foster partnership activities between hospitals and their patient communities. These initiatives were extremely successful in continuing to drive home the message to engage and improve communication amongst all members of the healthcare team. I personally thank all who were involved in supporting Patient Safety Awareness Week. These efforts demonstrated your commitment to providing a safer patient care environment.

I would like to remind all facilities of the new DoD Patient Safety Reporting System (PSR). This Web-based tool will soon be used throughout the DoD to report both medication- and non-medication-related events. It is currently being piloted in nine Military Treatment Facilities (MTFs) with an expected deployment to all facilities in the summer of 2010. PSR will help create a safer environment for patients.

Remember to visit the new Patient Safety Program website at <http://dodpatientsafety.usuhs.mil> and the Patient Safety Learning Center to share lessons learned and to communicate with your colleagues.

DONALD W. ROBINSON, LTC, MC, Director, DoD Patient Safety

THANKS AND FAREWELL TO GEOFFREY RAKE, MD Patient Safety Analysis Center Leader Retires

Dr. Geoffrey Rake, Director of the Patient Safety Analysis Center since 2003, is retiring after thirty-five years of service to the Department of Defense (DoD).

Under his leadership dramatic advances and dynamic changes have enhanced the Center's ability to aggregate incoming events, provide analysis, and create publications that share knowledge. Among the most significant changes he has helped to usher in is the current deployment of Datix®, a revolutionary web based event reporting system. Datix combines the now disparate medication and non-medication reporting systems into a single system. In Dr. Rake's words, "Datix is a game changer for DoD. We expect to see an explosion of new information on patient safety events."

He has far surpassed his initial goals of improved reporting of events, making patient safety more supportive, and shifting to a more outcome oriented focus. Reporting of events has more than doubled during his tenure. Dozens of new educational offerings and publications have been sent to the field. Completing the trio of goals has been a significant reduction (by half) in harmful events.

Dr. Rake has been a leader in collaborating with external agencies to further patient safety advances. He was pivotal in the Army's development of a Pharmacovigilance Center which will help the Food and Drug Administration redefine post marketing drug surveillance for our nation. He was directly responsible for ground breaking data sharing agreements with the Veteran's Administration and the Food and Drug Administration. Patient safety across the nation will benefit from these agreements for years to come. He collaborated with the Agency for Healthcare Research and Quality to stand up patient safety organizations nationwide in response to the congressional Patient Safety Act of 2005.

Dr. Rake and his wife, Jo, will be moving to Austin, Texas to enjoy retirement and their new grandson. Dr. Rake will be deeply missed by the DoD Patient Safety Program, and most especially by the staff of the Patient Safety Analysis Center, who have had the pleasure of working directly under his exemplary leadership.



Dr. Geoffrey Rake, Director Patient Safety Analysis Center and his Center staff.

THE PATIENT SAFETY REPORTING SYSTEM

A New Tool To Improve Safe Care Delivery

As we now serve 9.6 million TRICARE beneficiaries, it is up to all of us in the Military Health System (MHS) to do everything we can to provide our patients with a safe and positive experience. We can do this by continuing to cultivate a culture of teamwork and learning more about the ways we can enhance patient safety.

The DoD Patient Safety Program fosters a culture of trust and transparency through communication, coordination and teamwork. We are pleased to introduce a powerful new tool that will help us continue to improve the safe delivery of care to our beneficiaries: the DoD Patient Safety Reporting System (PSR).

What is PSR?

PSR is a Web-based tool that enables enterprise-wide reporting of both medication- and non-medication-related patient safety events, including near misses. An anonymous, secure confidential and easy-to-use online tool, PSR will help foster conversations around safety trends and how to improve care.

Through event reporting we can identify threats to patient safety and seize opportunities for improvement.

Who uses PSR?

All facility staff with a CAC card will use PSR to report events. All patient safety event types, from potential adverse events, near misses, actual events to sentinel events, can be reported. You will have the option of reporting anonymously or including your name with the report if you wish confirmation of your report and to receive feedback.

Patient Safety Managers and the Event Handler (or reviewer) whom they select will use PSR to manage and conduct an investigation after receiving a reported event.

Each data field within PSR provides an intuitive structure that efficiently guides event reporting and investigation. PSR will help you report events more easily, facilitate standardization of data and ensure completeness of reports. It will capture an unprecedented level of detail and richness of data in which Facilities, Services and the MHS can track, trend and take action.

Key Features

Causal and Contributing Factors list: provides the ability to identify the circumstances or factors which influenced the occurrence, or risk, of a patient safety event. Identifying causal factors will help us understand how and why an event occurred to implement direct and effective corrective actions that will protect future patients.

AHRQ Harm Scale: aligns with emerging U.S. and International Standards (AHRQ Common Formats). This scale will allow you to measure an event's impact on a patient's functional ability, including quality of life.



When will everyone start using PSR?

PSR will be piloted in nine Military Treatment Facilities (MTFs) beginning 29 March 2010 with full deployment planned for later this year.

Patient safety is a shared responsibility that hinges on communication and collaboration. As we move from a blame-oriented environment to one that thrives on learning from events and near-misses, you can help us capture information, identify ways to improve safety and most importantly, provide the best care possible to our patients.

For more information, visit <http://dodpatientsafety.usuhs.mil> or contact your Service POC:

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Why should we report events with PSR?

- **Get rid of the paper!**
- **Focus on capturing and learning from events and “near misses” rather “finding blame”**
- **PSR will help create a safer environment for patients.**

MHS CONFERENCE HIGHLIGHTS

A Roadmap to Breakthrough Performance

The Military Health System (MHS) aims to achieve “breakthrough performance” going forward. This year’s MHS Conference, January 25-28, 2010, convened national experts, MHS leaders, and service providers to share their knowledge on how to reach that goal. Donald Berwick M.D., MPP, Pres. and CEO, Institute for Healthcare Improvement discussed the need for healthcare to reach the “Quadruple Aim” – bringing readiness and coordination to the existing triple aim of population health, cost control and individual experience of care. RADM C.S. Hunter, Deputy Director, TRICARE Management Activity, outlined the MHS game plan for achieving the Quadruple Aim. Key-note speaker

Peter Pronovost, M.D., PhD, Johns Hopkins University, predicted a patient safety breakthrough when adaptive work (values, attitudes, beliefs) catches up to technical (scientific) work in the field.

The Department of Defense Patient Safety Program (DoD PSP) was an active participant in the conference. In its four break-out sessions, it shared initiatives and insights from the field on leadership engagement, creating a culture of patient safety and communication and collaboration through the use of medical simulation. Patient safety awardees, honored in the general session, detailed their projects.



Peter Pronovost, MD, PhD, Professor, Johns Hopkins University School of Medicine addresses Conference plenary session. Photo taken by Caroline Deutermann, MHS



A Commander's Perspective: Leadership to Implement Patient Safety and Quality. LTC Donald W. Robinson, DO, USA, Director, DoD Patient Safety Program and CAPT Bruce L. Gillingham, MD, USN, Commander Naval Hospital Jacksonville share their perspectives on how leadership can impact patient safety and quality in MHS facilities.



Medical Simulation: Practicing to be Expert Teams. Panel, from left, Heidi King, MS, FACHE, Deputy Director, DOD Patient Safety Program and Director, Patient Safety Solutions Center; COL Shad Deering, MD, USA, Director, Andersen Simulation Center; Col Deborah M. Burgess, MD, USAF; Gil Muniz, PhD, Chief Operating Officer, National Capital Simulation Center, and LTC Donald Robinson, Director, DoD Patient Safety Program.



Patient Safety Award project managers pose with PSP leaders following breakout session presentation. 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, 99th 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, FACHE, Deputy Director, DoD Patient Safety Program and Director, Patient Safety Solutions Center; Sharon Takiguchi, Patient Safety Manager, 15th Medical Group

PATIENT SAFETY PROGRAM NEWSLETTER

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