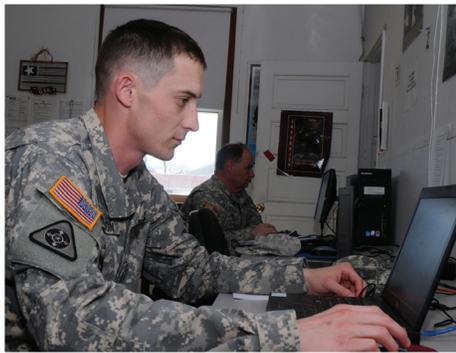


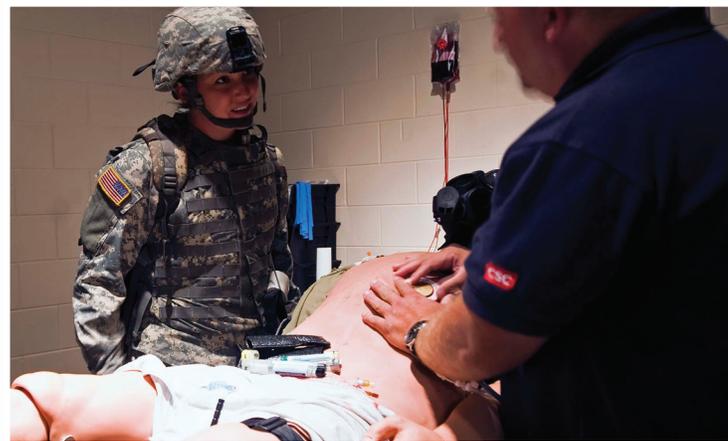


# Patient Safety Resource Guide

Department of Defense (DoD) Patient Safety Program (PSP)



*Partnering for a New Level of Care*



**Engaging, Educating  
and Equipping You with  
Products, Services  
and Solutions to Help  
Ensure the Safe Delivery  
of Care in the Military  
Health System (MHS)**





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INJECTION, USP

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*As a member of the patient safety community, we encourage you to use this Guide to explore the patient safety tools and resources that are readily available for use in your facilities. By taking advantage of these tools, working together and sharing leading practices with others, we are champions of change.*

—Lieutenant Colonel (P) Donald W. Robinson, M.D.,  
Director, Patient Safety Program

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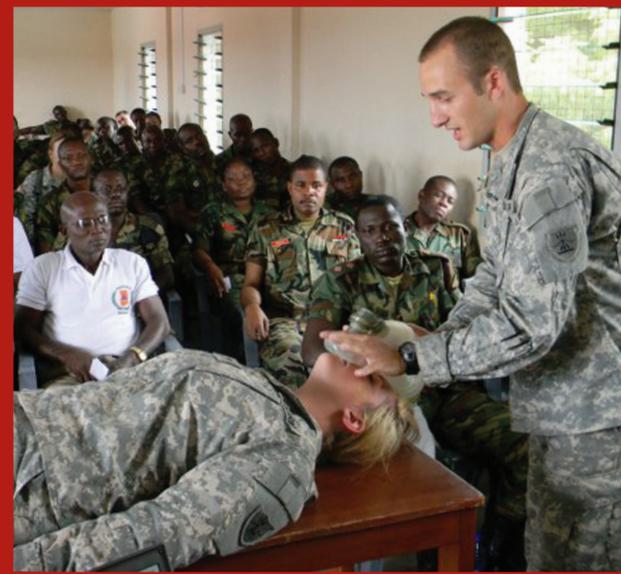
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## Getting to Know the DoD Patient Safety Program (PSP)

*We support the military mission by building organizational commitment and capacity to implement and sustain a culture of safety to protect the health of the patients entrusted to our care.*



### OUR MISSION

The **DoD PSP** was mandated by the Floyd D. Spence National Defense Authorization Act of 2001 in an effort to ensure the safe delivery of health care to 9.6 million TRICARE beneficiaries across the Military Health System (MHS).

Our mission is to promote a culture of safety to eliminate preventable patient harm by engaging, educating and equipping patient-care teams to institutionalize evidence-based safe practices.

We accomplish this mission by empowering health care professionals to make a difference for their patients through leadership engagement, training and education geared to varied professions and levels of personnel. In addition, we offer coaching, skill building, data interpretation, process improvement, risk assessment, task analysis and human factors consultation. By fostering a culture of patient safety through education and promoting trust and transparency, we can identify and mitigate risks to patients.

### IN OTHER WORDS...

- Engaging high-functioning teams focused on developing a culture of safety.
- Empowering providers with tools to enhance communications and teamwork.
- Activating patients in their health and health care.
- Making care safer for every patient in the MHS.





*We strive to get you the resources you need to provide high-quality, safe care to each patient, every time. This Guide serves as a collection of evidence-based tools you're already using, and introduces you to others you haven't yet discovered.*

—Heidi B. King, M.S.,  
Director, Patient Safety Solutions Center



## HOW PSP ALIGNS WITH BROADER MHS GOALS

The PSP equips Military Treatment Facilities (MTFs) with evidence-based products, solutions and capabilities to improve the safety and quality of care in the MHS. We provide these resources in support of the MHS Strategic Initiatives and the **Quadruple Aim**—Readiness, Population Health, Experience of Care and Per Capita Cost—for a medically ready force.

## HOW TO ACCESS RESOURCES IN THIS GUIDE

We encourage you to take a few moments to read this Guide to gain awareness of the many resources available to you in support of your patient safety activities. Please see the footnote at the bottom of this Guide to access any of the highlighted resources.

## RECOGNIZING EXCELLENCE IN PATIENT SAFETY

The annual **Patient Safety Awards Program** recognizes facilities that have shown innovation and commitment to the development of systems and processes that meet the needs of the patient. Applications are accepted in the Fall and awards are presented at the annual MHS conference. The PSP strives to capture and disseminate these success stories and best practices to support patient safety across the MHS.



### THE QUADRUPLE AIM

- Enabling a medically ready force and resiliency of all MHS personnel.
- Improving quality and health outcomes. Advocating and incentivizing healthy behaviors.
- Managing the cost of providing care to the population. Eliminating waste and reducing unwarranted variation; reward outcomes, not outputs.
- Patient and family-centered care that is seamless and integrated. Providing patients with the care they need, exactly when and where they need it.





# Meeting the Goals of the Partnership for Patients

*MHS caregivers and personnel will drive system-wide improvements and contribute valuable knowledge in helping the nation achieve the aims of the Partnership for Patients.*

## THE ROLE OF THE MHS IN THE PARTNERSHIP FOR PATIENTS INITIATIVE

In April 2011, the White House Administration unveiled the **Partnership for Patients: Better Care, Lower Costs**, a public-private partnership that will help improve quality and safety of health care across the nation. This initiative is being led by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS). The DoD has signed a pledge on behalf of the MHS to work as a system, with the support and commitment of the Services, to make care for our war fighters and their families safer, more reliable and more efficient.

The Partnership for Patients supports **MHS Strategic Initiative #2—Implement Evidence-Based Practices Across the MHS to Improve Quality and Safety**—and serves as a stepping stone in developing a transformative enterprise approach to care in the MHS. The Partnership for Patients, with its existing, measurable aims that address specific aspects of improved patient health, will serve as a springboard to other comprehensive patient safety initiatives and organizational changes moving forward. As the MHS works to meet the aims of the Partnership, key personnel will be sharing leading practices and instituting an integrated operational plan for the Partnership’s two primary aims.

## GOALS OF THE PARTNERSHIP FOR PATIENTS INITIATIVE

### Goal 1:

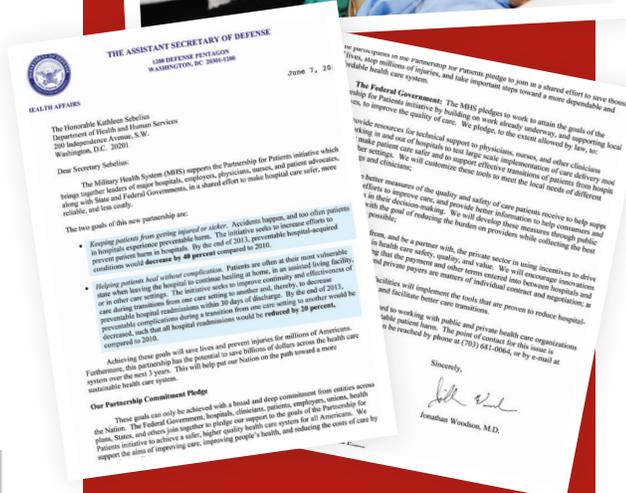
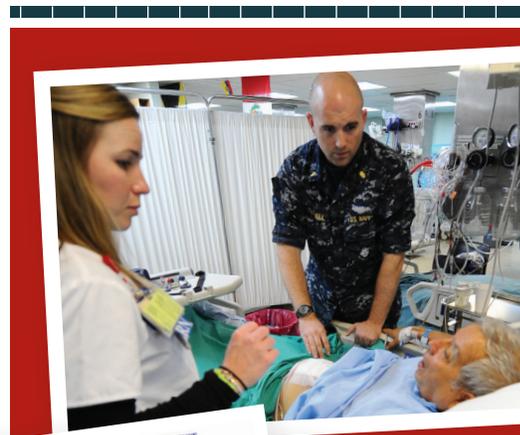
#### Keep patients from getting injured or sicker

**Summary:** This initiative will increase efforts to avoid and prevent harm in health care facilities. By the end of 2013, preventable hospital-acquired conditions would decrease by 40 percent compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved in three years.

### Goal 2:

#### Help patients heal without complication

**Summary:** Members of the Partnership will work to improve continuity and effectiveness of care during transitions from one care setting to another, thereby decreasing preventable hospital readmissions within 30 days of discharge. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased, such that all hospital readmissions would be reduced by 20 percent compared to 2010.



### AIMS

- 40% reduction in hospital-acquired conditions by the end of 2013.
- 20% reduction in hospital readmissions by the end of 2013.





# Advancing a Culture of Safety

*An organization with a strong safety culture demonstrates professionalism and the ability to learn from failure. Staff, leaders, patients and families take an active role. Staff exemplify the attitudes, beliefs, perceptions and values that demonstrate a relentless pursuit to provide safe, quality care for their patients.*



## FOR STAFF: MEASURING THE SAFETY CULTURE

Every three years, the DoD distributes the **Tri-Service Survey on Patient Safety (Culture Survey)** to all MTFs in the MHS. This survey captures staff attitudes and beliefs about patient safety, medical errors and event reporting. The anonymous survey encourages all staff to communicate their perceptions so that leaders can identify strengths and opportunities for improvement in areas essential to a culture of safety, including communication, empowerment of frontline staff and collaboration among staff and units.

## FOR LEADERS: PARTICIPATING IN THE COMMANDER'S PATIENT SAFETY FORUM

The **Commander's Patient Safety Forum** provides a venue for MTF Commanders to meet and lead a culture of safety in medical facilities by sharing patient successes and challenges, celebrating the impact of safe practices on patient care, engaging the wisdom of the Forum, connecting available solutions and sharing hard-fought lessons learned.

## FOR PATIENTS: GROWING THE WILLINGNESS, CONFIDENCE AND KNOWLEDGE TO PARTICIPATE IN HEALTH CARE

An activated patient possesses the willingness, confidence and knowledge to take an assertive, decision-making role in managing his or her own health and health care. Because activated patients are less likely to encounter an adverse patient safety event and more likely to engage in preventive behaviors, understanding a patient's level of activation can help the health care team customize a plan of care that encourages the highest-level of involvement the patient is comfortable with and one that has the greatest chance for improved clinical outcomes. The PSP's 2012 **Patient Activation Reference Guide** provides resources for patients, families, health care teams and MTFs to assist in moving patients forward on the patient-activation continuum. Your MTF can also participate in the **AskMe3 patient education program**, which is designed to promote communication between health care providers and patients to improve health outcomes. And, you can use the **TEAM UP** brochure to provide guidance on how patients can actively participate in their care.





# Excelling as a Patient Safety Manager (PSM)

*While the Basic Patient Safety Manager (BPSM) course is one of the courses specifically geared towards PSMs, there are many other resources available through the PSP for both PSMs and champions of patient safety, to include data analysis, webinars, reporting and measurement tools, training and coaching.*

## BPSM COURSE

The **BPSM Course** is a five-day, interactive, face-to-face training that provides new DoD PSMs in MTFs with the knowledge, skills and learning resources they need. After the conclusion of classroom training, participants are offered follow-up coaching to support the adoption and sustainment of skills and outcomes. The BPSM course is geared towards first-year PSMs and focuses on four key areas:

- Evidence-based practice and standards
- Leadership and change management
- Quality management and process improvement
- Identifying and mitigating risk.

Throughout the course, new PSMs plan how they will put their knowledge into practice when they return to their MTFs through the completion of roadmap activities. Course participants network with experienced health care professionals and meet with their Service representatives. The course incorporates training on **Root Cause Analysis (RCA)** methodology and **TapRoot®** software, which PSMs use to conduct RCAs at their MTFs. If you are a DoD PSM, you have the unique opportunity to engage with experts and other PSMs in this award-winning BPSM course.



## “ BPSM FEEDBACK FROM STUDENTS

*Overall excellent program and enthusiastic, well-engaged staff.*  
—Navy Participant

*Networking and exchanging information with participants was terrific.*  
—Air Force Participant

*I thought this was an excellent seminar.*  
—Army Participant

## HOW CAN I ENROLL?

The BPSM course is offered quarterly and is regularly updated to reflect the latest developments in patient safety. Participants must be referred by their Service representatives. Contact your Service representative for upcoming class dates and registration information.





# Equipping Teams for Performance in Safety and Quality

*In the dynamic environment that we operate in each day, patient safety depends on the coordinated interactions of individuals and teams committed to creating a safe patient experience.*



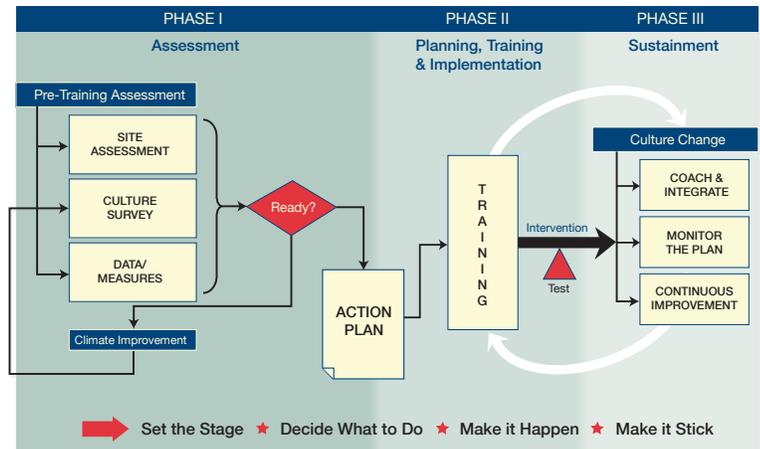
*One of my non-negotiable priorities is to uphold the quality of care in the Military Health System, guided by priorities and initiatives that are based on a sound foundation of evidence. TeamSTEPPS is supported with over two decades of research and lessons learned. It remains the Military Health System's flagship initiative to improve teamwork, communication and the delivery of safe care to our beneficiaries worldwide.*

—Jonathan Woodson, M.D.,  
Assistant Secretary of Defense for Health Affairs

## TeamSTEPPS®

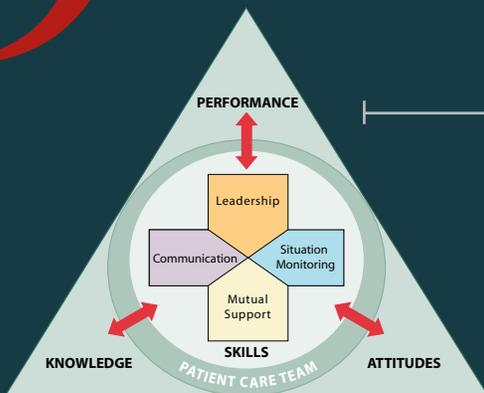
**TeamSTEPPS** (Team Strategies and Tools to Enhance Performance and Patient Safety) is an evidence-based **teamwork system** designed to improve the quality, safety and efficiency of health care. TeamSTEPPS consists of a collection of instructions, materials and tools to help drive a successful teamwork initiative from the initial planning to implementation through to sustainment. The system is designed to improve patient safety using a three-phase approach:

- **Phase I Assessment:** Facility determines organizational readiness.
- **Phase II Planning, Training & Implementation:** Facility “decides what to do” and “makes it happen.”
- **Phase III Sustainment:** Facility spreads the improvements in teamwork performance, clinical processes and outcomes resulting from the TeamSTEPPS initiative.



## COACHING AND CONSULTATION, TRAINING AND MORE

The PSP can help you assess your readiness, create an action plan, support training and provide coaching to sustain continuous improvement in team behavior. Contact us at 703-681-0064 or





# Measuring Patient Safety to Improve Patient Outcomes

# 10

*Given the challenge to reduce medical and dental errors and eliminate preventable harm, health care facilities must report and measure how many—and how often—errors occur. They also must measure their performance to show improvement over time. Reporting contributes to a just culture, knowing that you have the opportunity and the freedom to report what you are seeing without retribution. With accurate reporting, you can target actions to mitigate future risk to ultimately build resilience to improve patient outcomes.*



## CONFIDENTIAL REPORTING OF EVENTS IN THE PATIENT SAFETY REPORTING SYSTEM (PSR)

PSR is a Web-based, standardized reporting tool that enables anyone in the MHS with a Common Access Card (CAC) to anonymously report a patient safety event or near miss. After an event is reported, the PSM reviews it and initiates an investigation to identify the factors that contributed to the incident and develops corrective actions that address those factors. Service headquarters and the PSP analyze the reports to identify trends throughout the Services or the MHS. It is important to understand that if you witness a situation, you should report it. What you report through PSR can lead to needed change and enhance safety in your workplace. To learn more about PSR, download the job aids and complete the training courses, visit the Patient Safety Learning Center (PSLC), which is accessible from the **PSP website**. See page 12 to learn how to become a PSLC member.

## WHAT EVENTS SHOULD BE REPORTED IN PSR?

All levels of the **DoD Harm Scale** should be reported. Whether a near miss or sentinel event, it is imperative that all events are captured and reported for analysis. Near misses, in particular, can identify organizational or systemic weaknesses before a patient is harmed.

## OTHER TOOLS FOR MEASURING OVERALL HARM

Research indicates that self-reported events represent only a small percentage of all adverse events within an organization. DoD is studying the use of “triggers,” or clues, to identify adverse events used in determining the overall level of harm in our system. By tracking adverse events over time, we can detect if changes being made are improving the safety of the care processes.

“

*The reporting of every harm event represents an opportunity to improve patient safety, enhance the patient experience, ensure readiness and cultivate population health, meeting the goals of the Quadruple Aim and creating a safer care environment for every patient.* —Ronald Wyatt, M.D., M.H.A.,  
Director, Patient Safety Analysis Center

”





# Using Data to Guide and Drive Change

You can be the catalyst that drives change. Events occur. Learn from reported adverse events and near misses by identifying causal factors and establishing measures to prevent reoccurrence. Using retrospective and prospective analyses, it is possible to mitigate preventable harm.

## Data Interpretation and Consultation Services

We encourage you to request assistance with your specific data interpretation needs. The PSP provides consultation in the areas of process improvement, environmental risk assessment, task analysis and human factors. We can help you use PRA to drive the change you need, isolate data to identify trends and generate ad hoc reports from PSR to answer Leadership questions, RCA-based queries and more.

## Success Story

An MTF identified a trend in near misses that led up to an actual event—misreading an EKG machine. Because they identified it early, they prevented harm from reaching the patient. The facility identified why the malfunction in the equipment occurred and a temporary fix was implemented until the manufacturer changed the way the equipment was labeled.

## PROACTIVE RISK ASSESSMENT (PRA) ANALYSIS

PRA is a process that helps identify and mitigate risks and hazards. It includes Failure Modes and Effects Analysis (FMEA), a technique that involves identifying potential problems (failures), ranking the severity of the failures and identifying ways to prevent them. TapRoot® methodology and software can be used by PSMs to conduct PRAs.

## ROOT CAUSE ANALYSIS (RCA)

RCA is a structured method used in the DoD to understand the causes of sentinel events occurring in MTFs. Service headquarters may recommend an RCA on an event that presents a significant risk to the patient population. RCAs are based on the premise that medical errors result not from individual error, but from systemic process and structural failures. The RCA process helps identify those factors that contribute to errors. RCA teams answer specific questions to determine the strongest corrective actions possible. PSMs also use TapRoot to conduct RCAs and develop a corrective action plan to mitigate future risk.

## FOCUSED REVIEWS

Focused Reviews present patient safety case scenarios and topics, findings, root causes and recommendations for strong corrective actions. These actions are most likely to reduce the probability that the mistake will reoccur.

The collage contains several key documents:

- Understanding and Measuring Patient Safety:** A report discussing the challenges of reducing medical errors and the importance of patient safety culture.
- Meaningful Patient Activation:** A document detailing how patient activation levels impact health outcomes and the role of healthcare providers.
- Figure 2: PRA (Proactive Risk Assessment) Matrix:** A grid showing the relationship between patient activation levels and the risk of adverse events.
- Figure 3: Patient Activation Measure (PAM):** A scale used to assess a patient's knowledge, skills, and confidence in managing their health.
- Table 2: Example Triggers:** A list of specific events or conditions that can trigger a focused review.
- Figure 4: Patient Activation Levels (2012):** A diagram showing four levels of patient activation, from Level 1 (Limited Health Knowledge) to Level 4 (Active Health Management).
- Conclusion:** A summary of findings and recommendations for improving patient safety through patient activation.



# Getting On-Demand Access: Just-in-Time Resources

The PSP is always “on call,” ready to equip you with the tools you need.

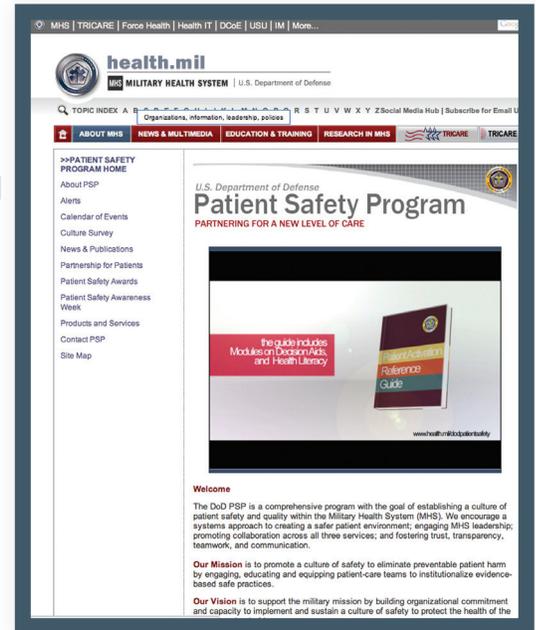
**Visit the PSP Website** The **PSP website** aims to educate and equip patient care teams, reinforce the value of teamwork, expand awareness of the PSP, advance a culture of patient safety and foster communication between the PSP and the field. Visit the website at [www.health.mil/dodpatientsafety](http://www.health.mil/dodpatientsafety) to access the resources highlighted in this Guide.

**Interact and Stay Informed with the Patient Safety Learning Center (PSLC)** The **PSLC** is a member-based online community wiki that enables patient safety personnel across the MHS to access and share best practices, tools, news articles, learning activities and more. Anyone engaged in patient safety activities from the Services can request access to the PSLC and become an active collaborator in a secure environment. Submit a request for access via the PSP website.

**Download Patient Safety Toolkits** **Toolkits** developed by the PSP offer just-in-time information, action steps, facilitator and participant guides and slides for specific patient safety concerns. Visit the PSP website and the PSLC to access toolkits on topics including professional conduct; Situation, Background, Assessment, Recommendation (SBAR); briefs and huddles; debriefs and more.

**Post Questions on PSLC Discussion Forums** **PSLC Discussion Forums** are online conversations accessible only to members of the patient safety community. The forums provide space for requesting insights from professionals engaged in patient safety and continuing knowledge transfer long after learning activities take place.

**Follow the Alerts, Advisories and Medication Safety Notices** Use the PSP website and the PSLC to stay abreast of the latest **alerts, advisories and medication safety notices** from the Patient Safety Analysis Center (PSAC), Institute for Safe Medication Practices (ISMP), Joint Commission, Air Force Notices to Airmen (NOTAMs), Food and Drug Administration (FDA), Aeromedical Evacuation, Clinical Operations Patient Safety Acts (COPSAs) and more.



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# Staying Current with the PSP: Regularly Scheduled Resources

# 13

*Engaging in the patient safety community by sharing news and participating in activities helps sustain momentum. Access these learning opportunities to continue your patient safety education. These resources are available through the PSP website and the PSLC, described on the previous page.*

U.S. Department of Defense  
Patient Safety Program  
**PATIENT SAFETY  
MONTHLY eBULLETIN**

December 2011 Edition

The Department of Defense Patient Safety Program works to eliminate preventable patient harm by empowering patients and engaging, educating and equipping patient-care teams, including the patient, to institutionalize evidence-based safe practices. Our eBulletin disseminates PSP program updates, news, useful tips, success stories and upcoming educational activities that will help us achieve this goal. In this issue, you'll learn about the Patient Activation Reference Guide, Focused Reviews, and what's new online. Enjoy!

**Contents**

**Announcements**  
[PSP Set to Release Patient Activation Reference Guide](#)  
[New PSP Focused Review and Report Available](#)  
[Naval Hospital Bremerton Hosts National Healthcare Quality Week](#)  
[Upcoming Events](#)  
[What's Happening Online?](#)  
[In the Patient Safety Headlines](#)

**Announcements**  
**2011 DoD Patient Safety Awards:** The submission period for the 2011 Patient Safety Awards has ended. The DoD PSP would like to thank all who took the time to participate and submit nominations. The program received 27 online submissions, which will be evaluated by a team of nine reviewers with expertise in education, data analysis, quality improvement and information management. Winners will be announced in December, and will be selected based on a point scale by evaluating the abstract, design methods, results, conclusion, sustainability and potential for replicating the initiative in other Military Health System facilities.



U.S. Department of Defense  
Patient Safety Program  
**LEARNING UPDATE**

December 2011 Edition

A Monthly Summary of Patient Safety Learning Activities

**About the Learning Update**  
 Welcome to the DoD Patient Safety Program Learning Update. This update is distributed monthly and provides information around patient safety learning activities. While the update will mostly highlight activities coming up in the next month, we will sometimes add important reminders for other high priority learning and networking opportunities. We encourage you to share this update with your colleagues.

**PATIENT SAFETY WORKSHOPS**  
 Instructor-led or self-paced online learning sessions focused on a specific product  
 No activities in December

**PATIENT SAFETY CONNECTION**  
 In-person networking and leading practice discussions  
 December 4-7, All Day  
 Institute for Healthcare Improvement: 23rd Annual National Forum on Quality Improvement in Health Care  
 More information.

**PATIENT SAFETY HELPLINES**  
 One-on-one sessions available to stakeholders  
 No activities in December

**PATIENT SAFETY LEARNING CIRCLES**  
 In-person or web-based forums focused on a specific topic  
 December 8, 1400-1500  
 Second Victim Part I: Disclosure After an Event\*  
 Click here to register.

December 14, 1400-1500  
 Switching Chans: When the Health Professional Becomes the Patient  
 Click here to register.

December 15, 1400-1500  
 Second Victim Part II: Building a Culture of Support\*  
 Click here to register.

\*denotes that the activity is CEU-eligible

Don't wait to register for other PSP activities!  
 Click here to view the 2011 PSP Calendar:  
<http://health.mil/dodpatientsafety/Calendar.aspx>

Do you have a learning activity or networking opportunity that should be included?  
 Email us here: [patientsafety@tma.osd.mil](mailto:patientsafety@tma.osd.mil)

To subscribe to have the Learning Update delivered to your inbox each month, go to:  
<http://psps.gti.org/ce>

**Attend Patient Safety Learning Circles and Workshops**  
 PSP hosts many online and in-person **webinars and workshops**, many of which are approved for Continuing Education (CE) credits. Facilitated by subject matter experts, these activities share the latest research, emerging practices and lessons learned about patient safety. Topics include safety culture, leadership engagement, medical error prevention and more. Register for events through the PSP website. If you miss the live presentation, check out the archives online, available on the PSP website and the PSLC.

**Opt-in to the PSP e-Bulletin via GovDelivery**  
 The **PSP e-Bulletin** is a monthly **electronic newsletter** that provides patient safety updates, news, tips, success stories and upcoming events. Subscribe through the PSP website.

**Opt-in to the PSP Learning Update via GovDelivery**  
 The **PSP Learning Update** is a monthly publication that provides a summary of **patient safety learning activities** through email. Subscribe through the PSP website.

**Read Annual and Midyear Summaries**  
**Annual and Midyear Summaries** provide an analysis of patient safety events (medication and non-medication), RCAs, PRAs and other reports that were submitted by the Services. They identify trends, lessons learned and other observations impacting the safety of patient care in the MHS.

**Study the Focused Reviews**  
**Focused Reviews** present patient safety case scenarios and topics, findings, root causes and recommendations for strong corrective actions. Recent issues have included such topics as "Understanding and Measuring Patient Safety," "Dental Patient Safety" and "Patient Safety in Aeromedical Evacuation."





# Simulating Real-World Events to Enable Feedback and Assessment

*Simulation-based training with formal feedback mechanisms helps you assess, train and sustain high-performing teams.*

## SIMULATION-BASED TRAINING

The PSP collaborates with MTFs and simulation centers to provide simulation as an adjunct to training or to enhance skills and knowledge. There are a wide-range of options, including opportunities for teams to use low-fidelity simulations and role-play activities to strengthen teamwork skills, mannequin-based patient simulators, the **Mobile Obstetric Emergencies Simulator (MOES)** and simulation scenarios and environments for a spectrum of medical emergencies and wartime and battlefield scenarios.

The **National Capital Area Medical Simulation Center (NCAMSC)** is one of the simulation centers that provides the Services with a wide array of training tools—from simulated clinical exams using live patients, to task trainers designed to improve skills, to the Wide Area Virtual Environment (WAVE) for training combat medical and surgical teams.

The PSP participates in the **Federal Medical Simulation Training Consortium (FMSTC)**. The FMSTC is focused on enhancing the medical education and training practices through joint collaborative sharing in research and development, knowledge management, curriculum, validation and strategic partnership.

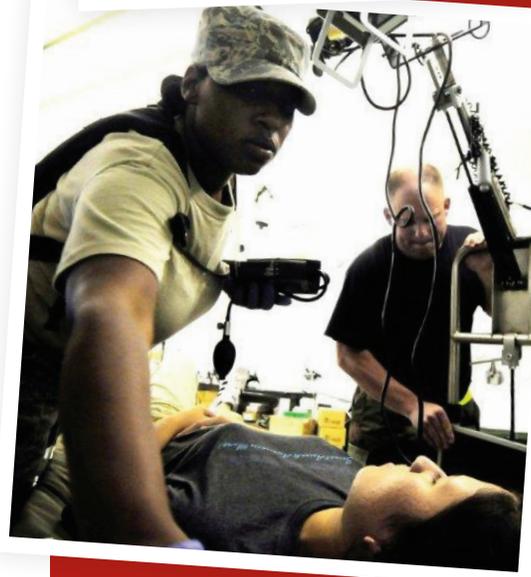
## OBSERVATION AND ASSESSMENT TOOLS

### Medical Team Performance Assessment Tool (MTPAT)

Practice alone is not enough to ensure learning from experience. Learners must receive accurate, timely and improvement-focused feedback. **MTPAT**, a tablet-based software application, enables the capture of team performance in live and scenario-based medical environments to provide behavior-based qualitative and quantitative feedback and **track performance improvements**. This tool was developed by Naval Air Systems Command (NAVAIR) with the support of the PSP.

### Team Effectiveness Accelerator (TEA)

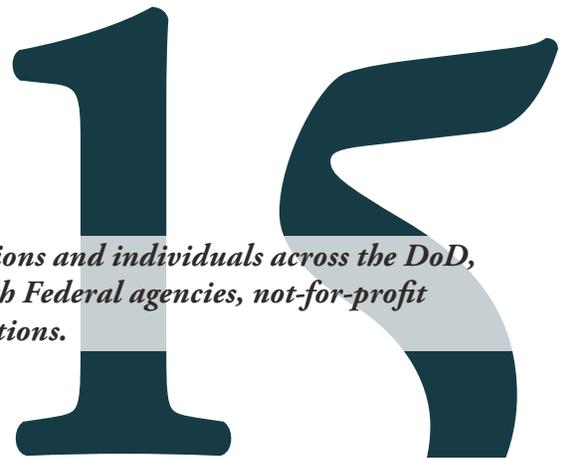
**TEA**, a Web-based assessment tool, enhances teamwork skills by capturing information and feedback from team members after completion of a simulation exercise or work experience. The tool produces a customized guide that a facilitator uses to lead a debrief or an after-action review. This tool was developed in partnership with the Group for Organizational Effectiveness, Inc. (gOE) and Naval Air Warfare Center, Training Systems Division with support from the PSP.





# Partnering with External Organizations

*Achieving safety for our patients requires the commitment of organizations and individuals across the DoD, Services, industry and academia. For this reason, the PSP partners with Federal agencies, not-for-profit organizations, educational institutes and civilian health care organizations.*



## FEDERAL AGENCIES

The PSP interacts and engages with Federal agencies, including the Veterans Health Administration's National Center for Patient Safety (NCPS), the Agency for Healthcare Research and Quality (AHRQ) and the CMS, as well as other leading organizations in the patient safety field. These partnerships enable cross-sharing and collaboration.

## NOT-FOR-PROFIT ORGANIZATIONS

The PSP also partners with not-for-profit organizations, such as the National Quality Forum (NQF), the Joint Commission and the National Patient Safety Foundation (NPSF). The PSP is a member of both the NPSF's Stand Up for Patient Safety and Ambulatory Stand Up for Patient Safety programs, through which DoD facilities have access to data comparisons, resource guides, online information and webcasts. NPSF also sponsors the annual Patient Safety Awareness Week campaign.

## EDUCATIONAL AND HEALTH CARE ORGANIZATIONS

The Institute for Healthcare Improvement (IHI) and the Institute for Safe Medication Practices (ISMP) are examples of organizations that we leverage for their outstanding subject matter expertise. Through the PSP relationship with ISMP, the Services gain access to the electronic medication safety newsletters for health care professionals and consumers, including the ISMP Medication Safety Alert: "Acute Care," "Community Ambulatory Care" and "Safe Medicine" editions. The newsletters are accessible through the PSLC.

## TEAM RESOURCE CENTERS (TRCs)

TRCs conduct fundamental applied research on teamwork and they develop, pilot and validate tools to improve patient safety. The TRCs also conduct training and disseminate their research findings. TRC sites include the Army Trauma Training Center, FL; Andersen Simulation Center at Madigan Army Medical Center, WA; Naval Medical Center Portsmouth, VA and David Grant Medical Center at Travis Air Force Base, CA.





## Obtaining Continuing Education (CE) Credit

*The completion of CE has long been used to demonstrate professional growth. Courses that are eligible for CE credits are designed to help individuals improve and enhance their knowledge, skills and talents. CE credits are not just a requirement for professionals to renew or maintain their license, but they also enable you to learn about new and developing areas in the medical and dental fields.*



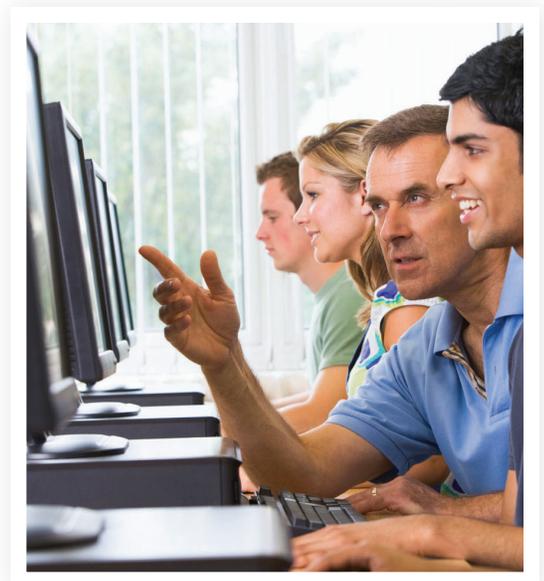
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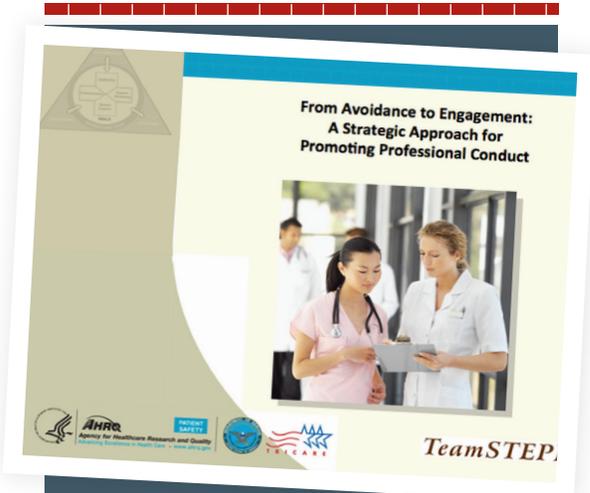
### WHY EARN CE CREDITS THROUGH THE PSP?

Health care is constantly changing, as are the dynamics within the realm of patient safety. Consider the PSP your go-to resource for educational opportunities that address current and emerging issues within the world of patient safety. Participation in the CE-credited PSP learning activities reinforces your commitment to remain current with the evolving issues and technologies related to patient safety.

### WHICH EDUCATIONAL ACTIVITIES QUALIFY FOR CE CREDIT?

**Webinars.** Because the PSP believes in the value of the topics discussed and knowledge exchanged during our webinars, we have invested in receiving accreditation through organizations that issue CE credits for health care professionals. The PSP delivers more than 35 webinars per year.





**Self-Paced Focused Reviews.** Understanding the value that Focused Reviews bring to the MTFs, the PSP has also invested in offering CE credits for your participation in self-paced study of the Focused Review.

**Instructor-Led Training.** PSP places much emphasis on the value of instructor-led training, and provides continuing education units for your participation in both TeamSTEPPS courses and the BPSM course.

### WHO CAN RECEIVE CE CREDIT?

If you register for and complete a CE-credited course, then complete the associated course evaluation, you are eligible to receive CE credits. For every hour of credited CE completed, the CE provider, Duke Medicine, offers the following types of credits: Continuing Medical Education (CME) for Physicians, American Nurses Credentialing Center (ANCC) Nursing Contact Hours, American College of Healthcare Executives (ACHE) for Healthcare Executives, American College of Physician Executives (ACPE) for Pharmacists and International Association for Continuing Education & Training (IACET) Continuing Education Units (all other professions).

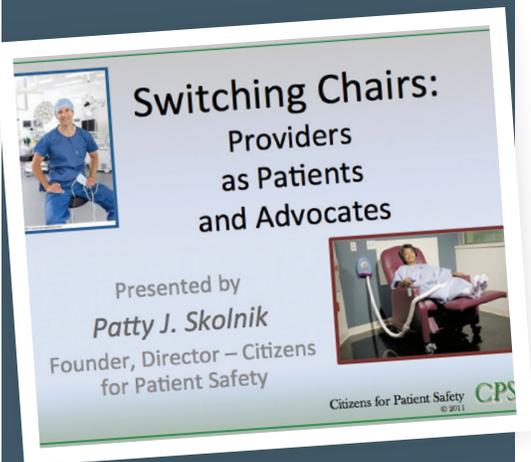
### HOW DO I RECEIVE CE CREDIT?

It's simple! Register for the course or learning opportunity through the Online Registration Center. Specific registration links for each learning opportunity can be found within the PSP Learning Update and/or the PSP e-Bulletin. After you have registered, completed the course, and completed the associated course evaluation, your CE certificate will be issued to you directly via email approximately four weeks post-course.



#### Criteria for Successful Completion of Authorized Educational Activities

- ✓ 100% attendance
- ✓ Full participation
- ✓ Satisfactory completion of all related activities
- ✓ Completion and return of evaluation at conclusion of educational activity



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**We hope the products, services and solutions highlighted in this Guide will help you to ensure the safe delivery of care in the MHS.**

*We encourage your participation in using the resources highlighted in this Guide.*

*Please contact us if you have any recommendations for future versions of this Guide.*

*We value your feedback.*







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