



FREQUENTLY ASKED QUESTIONS

Why did the Department of Defense establish the Patient Safety Program?

Following the 1999 Institute of Medicine report, *To Err is Human*, the 2001 National Defense Authorization Act mandated the DOD PSP. The program resides at TRICARE Management Activity in the Office of the Chief Medical Officer. It is a comprehensive program with the goal of establishing a culture of patient safety and quality within the Military Health System.

The PSP is dedicated to several key functions:

- 1) Resources and Solutions
 - Led by the Patient Safety Solutions Center
 - Provides education, training, and best practices aimed at improving performance, advancing safety and quality in the experience of care, and eliminating preventable patient harm
 - Leverages findings from the DOD Patient Safety Analysis Center to address leading causes of patient harm and identify opportunities to improve safety of care
 - Maintains the Patient Safety Learning Center, a secure DKO-based community of interest that facilitates collaboration and the dissemination and sharing of knowledge and resources among DOD patient safety professionals
 - Establishes and supports Team Resource Centers
- 2) Data and Analysis
 - Managed by the Patient Safety Analysis Center
 - Analyzes and reports patterns identified through patient safety event reports, sentinel event notifications, root cause analyses and failure modes analyses
 - Shares information and collaborates with the VA to reduce patient safety-related errors
 - Develops actionable information from which solutions and mitigations are formulated
 - Provides mitigation consultative services
- 3) Education and Research
 - Includes the Patient Safety & Quality Academic Collaborative, a joint effort with the Uniformed Services University of the Health Sciences
 - Advances patient safety through medical education and original research
 - Fosters professional development of patient safety and quality leaders

The PSP is a comprehensive program supporting all DOD Medical Treatment Facilities by providing solutions to proactively ensure the safe delivery of high quality, streamlined health care and a positive patient experience to the 9.6 million beneficiaries across the MHS.

What is the vision and mission of the DOD PSP?

Vision: To 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.



Mission: 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.

Guiding principles of the DOD PSP to help achieve the mission and vision include:

- Encouraging an evidence-based systems approach to create a safer patient environment
- Engaging MHS leadership on the importance of patient safety and the establishment of a supportive organizational culture
- Fostering trust, transparency, teamwork, and communication

How does the DOD PSP support institutionalizing evidence-based safe practices?

Patient safety is a shared responsibility. The DOD PSP is promoting a culture of safety through engaging, educating and equipping patient-care teams across the MHS with the solutions and resources to support safe delivery of care.

To sustain positive change, the DOD PSP empowers all team members to make a difference for their patients through promoting innovation, leadership engagement, training, coaching, and skill-building for team-based care, and risk identification and mitigation.

The PSP works with champions of patient safety at MTFs worldwide. These champions bring patient safety issues to the forefront, sharing innovative ideas on how to address issues with each other and MTF staff, and implementing changes that will deliver positive results. The DOD provides solutions and resources to patient safety champions to help them lead change and build a just culture predicated on integrity, transparency, and openness.

What is patient safety and why should I care?

The Agency for Healthcare Research and Quality defines patient safety as the absence of the potential for or occurrence of healthcare-associated injury to patients created by avoiding medical errors as well as taking action to prevent errors from causing injury.

So what does this mean?

- Patient Safety is the identification and control of hazards that could cause harm to patients
- Patient Safety is the prevention of harm or injury to patients
- Patient Safety includes actions undertaken by patients and staff to protect patients from being harmed by the effects of health care services

Evolving a culture of patient safety is complex and takes time. The 1999 Institute of Medicine report, *To Err Is Human* stated that as many as 98,000 annual deaths occur as a result of medical errors with an associated cost of \$8-\$28 billion annually. Unfortunately, there is little evidence that suggests the number of people dying from preventable medical harm has dropped since this report first warned us over a decade ago. But we can start by addressing the culture of patient safety. This means involving patients and their families in decisions and taking the time to make the experience a positive and empowering one. We need to give warriors and their loved ones the care they deserve. Plotting the course towards a zero tolerance approach to preventable safety issues will allow us to properly serve those who serve us.

What role does teamwork play in improving patient safety?



Improving patient safety is a team activity – ineffective communication among frontline teams continues to be one of the leading causes of adverse events. Teamwork is at the heart of the coordination, cooperation, and synchronization of activities necessary to support patients' needs. It helps to align all of the care processes together across the continuum of care.

All staff members play a role in collectively caring for the patient and the patient's needs. This includes the core, ancillary, support, coordinating and administrative teams. Patients and family members are also a pivotal member of the care system. The DOD PSP offers solutions that help teams continuously learn and develop skills to communicate, mitigate risk and provide high quality care to patients.

What role does leadership play in improving patient safety?

Active and involved leadership is a key success factor to evolving a culture of patient safety. Strong leadership is crucial at all levels, from the senior executive leaders to the frontline leaders. This is true for all organizations. Leaders are the champions of change. They should be role models, set expectations and hold staff accountable for established patient safety goals.

The DOD PSP offers solutions to engage, educate and equip the entire patient-care team to be champions for patient safety and institutionalize evidenced-based safe practices. MHS leaders are dedicated to patient safety and to ensuring patient safety is a priority among all staff. The DOD PSP Patient Safety Managers and Service Representatives have paved the way towards a safer patient environment. They have shouldered the responsibility of bringing the patient safety issue to the forefront of their priorities, sharing new ideas with each other and their staff. They provide feedback that helps shape the direction of the DOD PSP. The DOD PSP offers leadership tools that help engage leaders and teach them how to communicate with staff and help staff engage their leadership. Some examples of these tools include the Basic Patient Safety Manager Course and the Commanders Forum.

How can training and education improve patient safety?

The DOD PSP offers individuals and teams, including frontline teams, opportunities for assessment, training, coaching and skill-building for team-based care. We have learned that 80 percent of training failures are associated with factors other than the training event. As a result, we are moving beyond pure training models to address those organizational factors that will lead to success. We understand that many MTFs see training as the foundation for the beginning of a patient safety initiative. As such, the DOD PSP offers a catalogue of opportunities and resources that encourage learning. This includes course curriculum, toolkits, Learning Action Networks/webinars, and podcasts.

Team Strategies and Tools to Enhance Performance and Patient Safety, or **TeamSTEPPS®**, is a great example. **TeamSTEPPS** is an evidence-based teamwork system for improving patient safety through a comprehensive suite of ready-to-use materials, tools, and training materials. The curriculum works to produce health care teams that optimize process and patient outcomes through highly effective communication, coordination and other essential teamwork competencies – creating a better experience for all providers and patients. Through leadership support, diligent practice, ongoing training and coaching the teamwork system becomes an integral part of the caregiving culture. We use medical simulation in most TeamSTEPPS Train the Trainer classes.



Simulation allows practice of the strategies and tools as a means to change strongly ingrained patterns of behavior in a low-threat environment.

The DOD PSP has designated five regional Team Resource Centers/Centers of Excellence. The purpose of the TRC/COE is to conduct training, fundamental research and special projects on teamwork and patient safety. TRCs/COEs develop and validate team metrics and tools to include simulation, demonstration projects and applied research with a specific focus on translating research findings and theory into safer team processes and patient outcomes.

PSP sponsors the Basic Patient Safety Manager's course. This is a 5-day course that focuses on preparing the MTF Patient Safety Manager to effectively assume that role. Course content looks at the Patient Safety Manager's Role 1) As the Patient Safety Expert 2) As a Leader 3) In Quality Management and Process Improvement and 4) In Identifying and Mitigating Risk.

Is patient safety a particular problem within the MHS?

Patient safety is a universal issue and has become a focus in the MHS. The DOD PSP collaborates with several key Federal Agencies including the Agency for Health care Research & Quality, the Centers for Medicare & Medicaid Services, Department of Veterans Affairs, and the U.S. Food & Drug Administration, as well as non-governmental organizations to transform the military and national health care systems toward a culture of safety.

What are some strategies for preventing medical errors?

The DOD PSP directly supports the Quadruple Aim— advancing the quality of care for military patients and their families, ultimately supporting overall military readiness. The DoD is also serving as a vanguard partner for the Partnership for Patients initiative. The Partnership for Patients has two goals: 1) Decrease hospital readmission rates by 20 percent by the end of 2013 and 2) Decrease the rate of hospital-acquired conditions by 40 percent by the end of 2013. Additionally, the PSP is aligned with the National Quality Forum's Safe Practices (specifically Practices 1-4). These focus on: 1) Leadership Structures and Systems 2) Culture Measurement, Feedback, and Intervention 3) Teamwork Training and Skill Building and 4) Identification and Mitigation of Risks and Hazards.

One of the most effective ways to prevent medical errors is to focus on overall system improvement. This may start with defining the patient safety vision and goals and then designing, implementing and evaluating programs to determine impact and sustainment. Some strategies and/or tools that may instill a culture of safety and continuous improvement are standardization of policies and procedures, checklists, and technology.

Reporting events helps identify trends and areas needing improvement. By taking a non-punitive and proactive approach, health care providers can cultivate an environment of trust and communication which will lead the way to safer patient care. The DOD PSP is helping MHS health care teams by supporting the implementation of the web-based Patient Safety Reporting System, which will allow individuals to anonymously report events more easily and accurately. Additionally, programs like **TeamSTEPPS**, the BPSM and other safety training curriculum and materials help instill a culture of enhanced communication by improving team skills and behaviors.



Does the DOD PSP implement any risk identification and mitigation programs?

Changes and improvements in patient safety will occur at the local level. Developing tools and resources to assist MTFs in improvement is the primary strength of the PSP. The program works with the Service Representatives and MTF patient safety champions to determine needs and then develops resources and tools that assist MTFs in mitigating harm.

In March 2010, nine sites (three Army facilities, three Navy facilities, three Air Force facilities) began pilot testing the Patient Safety Reporting System, a web-based application that standardizes event reporting across the MHS by allowing the MHS to capture, track and trend health care events. Facility staff will use the PSR to report both medication and non-medication related events with a single tool, allowing for a consolidated and streamlined event monitoring system. Full deployment is expected to be completed in FY11.

In addition to providing local support and the PSR, the DOD PSP provides alerts, advisories and summaries with time-sensitive information related to patient safety issues to senior leadership, providers and staff. These publications provide background, general information and recommendations for addressing patient safety issues. The DOD PSP also supplies focused reviews to inform health care providers of trends, reasons why and useful lessons learned from events reported in facilities. These reviews include the latest patient safety innovations and recommended solutions from medical journals and military treatment facilities.

Does the DOD PSP work with other patient safety programs?

Yes, patient safety is a universal issue. The DOD PSP directly supports the MHS Quadruple Aim, the Partnership for Patients and the National Quality Forum's Safe Practices. The DOD PSP also collaborates with several key federal agencies including the Agency for Health care Research & Quality, the Centers for Medicare & Medicaid Services, Department of Veterans Affairs, and the U.S. Food & Drug Administration, as well as non-governmental organizations to transform the military and national health care systems toward a culture of safety.

How does the DOD PSP promote patient safety awareness in the MHS and beyond?

The DOD PSP uses several mechanisms to promote patient safety awareness throughout the MHS. The DOD PSP website is a public-facing site and offers information on PSP partners, upcoming events, and PSP products and services. You can access the website at <http://health.mil/dodpatientsafety>. The Patient Safety Learning Center, another resource available to patient safety champions in the MHS, is designed to foster communication and awareness of lessons learned, best practices, tools and resources, news articles, and community events. The DOD PSP also sponsors learning activities to include instruction such as the Basic Patient Safety Manager's course, **TeamSTEPPS** and Patient Safety Reporting. Additionally, there are monthly interactive Learning Action Network/webinars. These are open to all MTFs and feature experts who share the latest evidence, lessons learned, leading practices, and success stories from the DOD as well as the civilian community. DOD PSP also publishes and disseminates a quarterly newsletter and sends a monthly eBulletin that share topics of interest and PSP updates.

Where can I learn more about the DOD PSP?

DOD PSP Frequently Asked Questions



For more information about the DOD PSP, please visit <http://health.mil/dodpatientsafety> or e-mail us at patientsafety@tma.osd.mil.