

U.S. Department of Defense

# Patient Safety Program

PARTNERING FOR A NEW LEVEL OF CARE



SUMMER 2010

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



Heidi King, Deputy Director, DoD Patient Safety Program and Director, PSP Patient Safety Solutions Center, addresses attendees at the TeamSTEPPS Collaborative DoD break-out session.

## TeamSTEPPS® COLLABORATIVE

### Sustaining the TeamSTEPPS Program

The Fourth Annual TeamSTEPPS Collaborative was held June 2-3, 2010 in Bethesda, Maryland.

The Collaborative is a joint venture between the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense (DoD). It is an opportunity for staff in the DoD Military Treatment Facilities (MTFs) to come together with staff in civilian organizations. The Collaborative provides a multidisciplinary perspective on selected topics related to improving communication and reducing medical errors by integrating teamwork principles into daily practice. Participants are able to connect, learn, and share success stories, lessons learned and emerging practices. Previous participants, AHRQ, and DoD concur that meetings such as the Collaborative are critical to sustain the TeamSTEPPS program by building a strong community of practice. This year's two-day TeamSTEPPS Collaborative,

attended by over three hundred health care providers and hosted by the University of Minnesota, one of five National Implementation of TeamSTEPPS project Team Resource Centers, was particularly powerful. It emphasized the post-training phase of TeamSTEPPS—more specifically aspects of John Kotter's model—"make it happen and make it stick". These include implementation, measurement and evaluation, aligning clinical skills with team skills and behaviors through simulation, and managing disruptive behaviors. Recognizing the difficulty of sustaining change, the Collaborative celebrated the spread, impact and sustainment of high-performing teams focused on team-driven care during stressful times in complex healthcare systems. RADM Hunter, Deputy Director, TRICARE Management Activity was the featured

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## BASIC PATIENT SAFETY MANAGER COURSE

Next course scheduled in November

Many of you attended the Basic Patient Safety Manager (BPSM) Course when you began your role as a Patient Safety Manager (PSM). Over the past several years, the PSMs and Service Headquarters shared ideas with the Patient Safety Program (PSP) on how to continue to evolve the BPSM course.

Responding to those ideas, the PSP conducted an assessment to determine the educational needs required for new PSMs and how to deliver those in an effective and efficient manner. The assessment involved:

- Review of the current BPSM course content
- Working group session with PSP Leadership
- Interviews with Patient Safety Service Representatives and designees
- Focus groups with PSMs
- Benchmarking the current BPSM curricula against Patient Safety education programs designed by other organizations and educational institutions

Synthesizing information across these sources, the PSP developed a plan to evolve the BPSM course to better address the needs of the field. In Spring 2010, new PSMs had the opportunity to attend a revamped pilot of the BPSM course.

The revamped course is designed for new Patient Safety Managers (PSMs) who have been in their role less than six months. The BPSM course provides

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# ONE MISSION, ONE TEAM

## Director's Corner — Summer Greetings to our patient safety community



Over the last few months, patient safety has continued to make strides across our system to make care safer for our patients. Many of our patient safety community members had the opportunity to attend the National Patient Safety Foundation's Annual Conference in May or the DoD TeamSTEPPS Collaborative in June. During these safety-focused gatherings, I spoke to several of you and developed a deeper understanding of the exciting endeavors you are undertaking as well as the associated challenges which you face. Throughout my conversations, one common challenge I heard was the need for greater leadership engagement.

From a Military Health System (MHS) stand-point, patient safety is a leadership priority. RADM Admiral Hunter spoke at the TeamSTEPPS National Collaborative on behalf of DoD and she discussed her thoughts on patient safety in the recent *Military Medicine* journal. Environmental factors, like the 2009 healthcare reform legislation which established patient safety as one of its core principles, will heighten patient safety awareness across the DoD. To that end, MHS leadership charged the Patient Safety Program (PSP) to develop a patient safety measure for the MHS scorecard, a mea-

surement tool which the Assistant Secretary of Defense reviews with the Services' Leadership.

I say all of this to convey that the PSP aims to answer your call for increasing leadership engagement and we believe the stars are aligned – political will, urgency, and critical mass – to continue maintaining patient safety as a priority across our system.

You may have heard of the Patient Safety Commanders' Forum which we launched earlier in the year. Encourage your MTF Commander/Deputy Commander to join that Forum to hear stories about how patient safety is making a positive impact in our Military Treatment Facilities (MTFs).

Many of you are involved in the Patient Safety Reporting (PSR) System initial roll-out. Please continue your event reporting efforts so we are armed to inform leadership about patient safety within our facilities. We know reporting is not the solution, but a starting point. As well, we know that we must utilize the information from our reporting efforts, specifically the causal factors or root causes, to assure we institute actions which protect our patients. The Joint Commission recently released a 2009 Sentinel Event report

indicating that leadership engagement was the most frequently identified factor (68%) across all sentinel reports submitted. You told me that leadership engagement was a critical element to advancing patient safety in our facilities; indeed, it is.

I've mentioned PSP initiatives underway to further engage leadership; we really need your help. It is our collective duty to engage leadership in an effective manner. To do this, we must inform leadership of the current state of patient safety in our facilities and how we can continue to improve it - as opportunities to improve always exist. We must share specific recommendations with our leadership on how, in concrete terms, they can help. They are ready to engage and patient safety needs you - to help leadership understand how they can support patient safety most effectively within our facilities.

I thank you for working tirelessly. As I wish everyone a safe and enjoyable summer, please join me in thanking Lt Col Paul Hoerner for his service as the Deputy Director of the Patient Safety Analysis Center. We wish him the best as he begins his next tour at RAF Lakenheath.

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

## DEPUTY DIRECTOR PATIENT SAFETY ANALYSIS CENTER REASSIGNED

### Thanks and Farewell

Lt Col Paul Hoerner, Acting Director and Deputy Director, Patient Safety Analysis Center (PSAC), has been reassigned and will assume the position of Pharmacy Flight Commander at RAF Lakenheath in August 2010.

Lt Col Hoerner became the Deputy Director, PSAC, in September 2006 and has been an integral part of both the PSAC and Patient Safety Program's (PSP) dynamic growth and maturation. In addition to his duties as Deputy Director, Lt Col Hoerner served as the PSAC's subject expert in all matters concerning pharmacy and medication-related events. Under his leadership, the PSAC greatly enhanced its ability to assimilate, manage and report meaningful data on medication-related events and near misses. He played an instrumental role in the testing and selection of the DATIX data reporting system currently

scheduled to be fully deployed by September 2010.

Lt Col Hoerner has been a leader in establishing collaborative relationships with external organizations, most notably Veterans Affairs (VA), US Pharmacopeia (USP), Agency for Healthcare Research and Quality (AHRQ), and the Pharmacovigilance Center (PVC). He initiated and implemented a Data Use Agreement (DUA) with the Institution for Safe Medical Practices (ISMP) and championed changes in the ISMP pharmacist curriculum to include a rotation through the Patient Safety Analysis Center.

As Acting Director, PSAC since March 2010, Lt Col Hoerner has successfully and effectively steered the organization through a period of dynamic and challenging organizational change. He has been a

principal in the development, initiation and roll-out of the DATIX reporting system, the PSP CONOPS project, and has served as a strong advocate of reaching out to military Patient Safety Managers throughout the world.

From January through July 2009, Lt Col Hoerner was deployed to Afghanistan, where he managed the regional pharmacy at Bagram Air Base. While deployed, he maintained regular contact with the PSAC, and returned with a unique perspective on patient safety issues within the operational theater.

Lt Col Hoerner's exemplary performance and efforts are greatly appreciated by all who were fortunate to work with him at the PSAC and PSP. We wish him and his family the very best.

## TeamSTEPPS® COLLABORATIVE

### Sustaining the TeamSTEPPS Program

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speaker at the opening plenary.

Building on its successful break-out session last year, the DoD sponsored its second annual Collaborative break-out session for military participants on June 1st, just prior to the general conference. Approximately one hundred ten staff from thirty DoD MTFs and five Army Dental Regions attended this session, along with the Service Headquarters' Patient Safety Representatives. MTF participants selected to attend both the DoD session and the general Collaborative were TeamSTEPPS Champions (Patient Safety Managers and multidisciplinary change teams) and/or Instructors. Most are actively involved in the initiative in their facilities.

The full day DoD event included interactive collaboration sessions and strategy skill stations. Featured speakers were Dr. Jack Smith, Acting Deputy Assistant Secretary of Defense for Clinical and Program Policy and Acting Chief Medical Officer for TRICARE Management Activity and Heidi King, Deputy Director of the DoD Patient Safety Program and Director of the Patient Safety Solutions Center. The breakout session provided an opportunity for DoD teams to network and to discuss lessons learned and challenges to full implementation in the military environment.



DoD attendees gather at a skills station and network over lunch at the TeamSTEPPS Collaborative DoD break-out session

## BASIC PATIENT SAFETY MANAGER COURSE

### Curriculum Redesigned and Expanded

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an overview of patient safety standards, practices, and resources; human factors; systems approach; safety culture; quality management; performance improvement; data collection, analysis and feedback; risk identification and mitigation; and many other topics. In addition to the classroom portion of the course, participants are expected to take part in virtual (online) continuing professional development and feedback sessions for twelve months following the course. The follow-up activities intend to address the need, expressed by PSMs, for ongoing skill building. As well, the classroom based course followed by reinforcing virtual activities reflects the structure of other nationally recognized patient safety education programs.

For more information on the BPSM course, including the course agenda and how to register for the course, please visit the BPSM section within the Patient Safety Learning Center.



Attendees at the revamped BPSM course.

# 2010 NATIONAL PATIENT SAFETY FOUNDATION ANNUAL CONGRESS

## DoD PSP Plays Active Role in Conference

The 2010 National Patient Safety Foundation (NPSF) Annual Congress took place in Orlando, FL from May 18-19 at the Gaylord Palms Hotel & Convention Center. This year's event was carefully crafted by leaders in the field to provide real-world tools, resources, and evidence-based solutions to patient safety issues and featured the first-ever Learning & Simulation Center.

Widely recognized as the preeminent patient safety forum, the NPSF Congress also presented thirty-five individual sessions under seven core tracks, a Measurement Boot Camp, a Leadership Day designed to address accountability within an organization, strategies for patient and family engagement at the grassroots level, the Lucian Leape Institute plenary, and much more.

Over fifty Patient Safety Managers from across the Air Force, Navy, Army Medical Department, and Army Dental Command attended the Congress where the traditional exhibit hall format was transformed to create an environment capturing the essence of practical learning that is core to the NPSF Patient Safety Congress. The Learning & Simulation Center, an innovative educational setting offering interactive demonstrations, was facilitated by leaders in simulation learning techniques. The DoD Patient Safety Program was responsible for setting up, creating scenarios, and staffing and providing training at the Handoffs and Critical Communication simulation station.

Save the date for next year's event. The 2011 NPSF Annual Congress will be held on May 25-27, 2011 at the Gaylord National Resort Hotel and Convention Center in National Harbor, MD. Please visit <http://www.npsf.org/> for further information.



LTC Donald Robinson, Director DoD Patient Safety Program, facilitates the Handoffs and Critical Communication simulation station at the 2010 NPSF Congress.



The NPSF Congress (pictured left) was an important collaborative venue for the PSP. Above, attendees at a demonstration of the new Patient Safety Reporting (PSR) system.

# PATIENT SAFETY PROGRAM UPDATES AND INFORMATION

## Bookmark the New Patient Safety Program Web Site!

The Patient Safety Program Web site is now part of health.mil, the official Web site of the Military Health System (MHS) and a leading site for health and military information worldwide. With the goal of establishing a culture of patient safety and quality within the MHS, this site streamlines program communications and serves as an information destination for all stakeholders

within the MHS and the civilian community. The primary objectives for this new site are to create a more interactive experience for visitors, reinforce the value of teamwork and engage the health.mil web traffic to expand awareness of the program.

The new site features information about the Patient

Safety Program mission and history, a calendar of events, details about patient safety solutions the program provides such as TeamSTEPPS® or the Learning Action Network Webinars, program news and awards, and contact information for the program. Please take the time to visit the new site at:

<http://www.health.mil/dodpatientsafety>.

## Patient Safety Learning Center Enhancements and Redesign

The DoD Patient Safety Learning Center (PSLC) is a resource for medical and dental professionals to come together and partner for a new level of care. Members create connections across facilities and professions dedicated to advancing patient safety knowledge. The DoD PSLC is currently being redesigned with a more enhanced, user-friendly navigation. The main content in the DoD PSLC will be organized into four topics, which align to the first four National Quality Forum

Safe Practices.

The DoD PSLC enables Members to access and contribute lessons learned, best practices, community events, and more. Members can contribute to the latest discussion topic designed for patient safety professionals to share their insights and experiences or check out the details for the upcoming Learning Action Network Webinar and add it to their personal Microsoft

Outlook calendar. The DoD PSLC contains great tools and resources, like the most current patient safety news and alerts, the new Professional Conduct Toolkit, and the Patient Safety Manager network.

To become a Member of the DoD PSLC, email the PSLC Support Team at [PSP\\_PSLC@bah.com](mailto:PSP_PSLC@bah.com) or visit the DoD PSLC Web site at:

<http://www.health.mil/dodpatientsafety>.

## Patient Safety Reporting System (PSR)

We are excited to announce the initial (limited) deployment of PSR, the DoD enterprise-wide, online patient safety event reporting system. PSR features an anonymous reporting feature as well as a feature to report confidentially and receive feedback about the event. The initial deployment serves as a testing period for users to assess PSR's operational capabilities and its ability to meet critical mission requirements. System Acceptance Test (SAT) began 21 June and will conclude on 23 July at the nine MTF sites along with

Army, Navy, Air Force Headquarters, the Patient Safety Analysis Center and the Patient Safety Program Office. The testing teams include representatives from Developmental Test and Evaluation, Operational Test and Evaluation, and Joint Interoperability Test Command who will conduct one-on-one interviews with survey participants from each system user role. Feedback from these sites plays a critical role in the decision to go to full world-wide deployment. SAT is the final step before the formal Full Deployment Decision slated

for September of 2010. PSR aims to enhance patient safety event reporting efforts by making the reporting process less burdensome while improving the quality of data and reports available to the MTFs. Preliminary results from the initial deployment sites confirm those aims are being realized through the number and type of reports received to date. We thank the initial deployment sites for their participation and look forward to their feedback.

## Call for Patient Safety Awards



The TRICARE Management Activity and DoD Patient Safety Program will begin accepting submissions for the 2010 Patient Safety Awards beginning in late August with the deadline for submission in early November 2010.

The DoD and the Patient Safety Program (PSP) are committed to creating a culture of safety and quality care within the Military Healthcare System. The DoD Patient Safety Award recognizes efforts designed to improve the care delivered within the Military Healthcare System. The award identifies those who

have shown innovation and commitment to the development of systems and processes that are tightly organized around the needs of the patient. DoD seeks to recognize efforts that create an environment where safe, quality care is provided and is the responsibility of all members of the team.

# GOOD CATCHES AT 30TH MEDICAL GROUP

## MTF Strengthens Culture of Safety

The 30th Medical Group at Vandenberg AFB has established a robust Good Catch initiative. The program was instituted to encourage a proactive thought process and culture of safety among leadership, staff and patients, ultimately leading to process improvements. Since the start of the revitalized effort ten months ago, nearly 2,100 good catches have been submitted.

Persistence, consistency and leadership support have been critical to the initiative's success. The non-punitive approach that leadership established has generated an enormous amount of good will in each department.

There has been a strong, positive response to the Good Catch Program in the area of problem identification, and the staff has taken the initiative to the next level by embracing those identified problems as opportunities to take an active role in both the development and implementation of process improvements. The program has challenged the staff to maintain a higher attention to detail, take ownership of processes, and enhance the facility's commitment to improve patient safety. It has encouraged staff to look for patient safety opportunities beyond their normal activities and outside their own workspace. The result has been a constant flow of good catches to the Patient Safety Manager. These reports have averted several potential clinically-related errors. We are especially pleased with the good-natured attitude associated with this vigilance.

An individual good catch winner is recognized at Commander's Call each month. Additionally the flight that submits the highest number of good catches is



Winners with Good Catch Trophy at 30th MDG, Vandenberg AFB

recognized with a certificate and a "traveling trophy" in the shape of a catcher's mitt. The department purchases a baseball for the mitt and everyone who submitted a good catch for that month signs the baseball. This has become a healthy competition among the departments and a morale booster.

Visible proof of this program's sustainability lies not merely in the enhanced reporting and the process/procedure improvements the good catch program has generated. The most impressive and gratifying evidence of the impact of our successful Good Catch initiative is the phenomenal drive of the staff to identify opportunities for improvement and make them a reality.



30th MDG, Vandenberg AFB, Good Catch Trophy

## PATIENT SAFETY PROGRAM NEWSLETTER

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