

Patient Safety Program



PARTNERING FOR A NEW LEVEL OF CARE

FALL 2010

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

PSR FULL DEPLOYMENT



Official U.S. Navy Photo by Dan Barber, provided as a courtesy of NH Twentynine Palms

The Patient Safety Reporting System (PSR) is a Department of Defense (DoD) enterprise-wide Web-based tool that allows simple, efficient, and anonymous reporting of medication and non-medication patient safety events of any harm category. From unsafe conditions and near-misses to patient death, PSR replaces the nonstandardized electronic and paper-based incident reporting processes. It allows anyone with a Common Access Card (CAC) within Military Treatment Facilities (MTF) to easily report the “when, where, and what” of a patient safety event allowing for the Patient Safety Managers to then log in and begin the investigation process along with identified event investigators.

Authorization for PSR full deployment was granted in September 2010. PSR has begun to rollout across the Military Health System per an implementation plan agreed upon by the Services. Training will be conducted through instructor-led and virtual sessions

depending on PSR user type. Instructor-led training began in November with training schedules developed by Services.

Three MTFs from each Service comprising a total of nine initial test sites have used the PSR system since Spring 2010 to report their medication and non-medication events. At these sites, PSR currently is in wide use, replacing the previous paper-based and site specific electronic processes.

WHAT PSMs ARE SAYING

- During the first 6 months of PSR use, non-medication event reporting increased over the previous year's level.
- Since PSR was implemented, more clinics are reporting events.
- PSR has been well accepted as a viable event reporting tool for our MTF.

Continued on page 3

INNOVATING TEACHING METHODS

NH Sigonella Patient Safety Hosts ‘Room of Errors’

To encourage the spirit of teamwork and friendly competition among work areas, Naval Hospital (NH) Sigonella reprised what they fondly refer to as the “room of errors.” First presented during March 2010's National Patient Safety Week, it was enthusiastically resurrected in October for training, just in time for Halloween.

Lieutenant Lynn Skinner, NC, NH Sigonella's Command Patient Safety Officer, points out that with interactive training, “learning becomes three-dimensional, moving beyond the typical read-and-learn in-services or PowerPoint presentations.” She added “when you engage a person by active learning, the lesson sticks!” In the field of healthcare, repeated tasks often become rote, which may potentiate human error. The goal of patient safety training is to reduce error and promote understanding and compliance of National Patient Safety Guidelines. By using the above approach, it reinforces the information in a positive, interactive way and prepares clinical staff for Joint Commission and Medical Inspector General inspections.

The room of errors is set up as an actual working hospital room, complete with two “patients”—an adult and a baby mannequin.

Continued on page 2

TABLE OF CONTENTS

- 2 PSP Director's Corner
- 4 BPSM Course Updates
- 5 New PSAC Staff
- 6 PSP Updates

ONE MISSION, ONE TEAM

Director's Corner

I would like to take this opportunity to extend warm welcomes to Dr. Ronald Wyatt, who joins us as Director of the Patient Safety Analysis Center (PSAC) and Ms. Deborah Myers, R.Ph., as PSAC Deputy Director. They arrive with a wealth of knowledge and experience, as well as a shared vision and enthusiasm for patient safety.

Following initial piloting in nine Military Treatment Facilities (MTFs), three from each service, the Patient Safety Reporting System (PSR) has been in use since Spring 2010. PSR rollout is Service-wide and training sessions are in progress across the Military Health System (MHS). This easily-accessible web-based tool enhances the awareness and knowledge of users, better equipping them to continue to create safer environments for our patients.

The Basic Patient Safety Manager Course, reworked and piloted in Spring 2010, received overwhelmingly favorable feedback from participants, auditors, and reviewers. Course evaluations were outstanding, with on-the-job learning confidence rated 100%. Fiscal Year 2011 courses will be held in January, April, and September. Course

overviews are available at the Patient Safety Learning Center and patient safety managers interested in attending future courses should contact their Service representatives.

With the holidays approaching, I would like to remind us all to be thankful for our many blessings and express our gratitude to the dedicated patient care teams who work diligently every day to provide safe care within the MHS. To all, have a safe and happy holiday season.



Donald W. Robinson, LTC, MC
Director, DoD Patient Safety

Innovating Teaching Methods

Continued from page 1



NH Sigonella Patient Safety Room of Errors Team

They are positioned in the bed, wearing ID bracelets, oxygen masks and bandages—just like real, live patients. The training itinerary allows 10-15 minutes for each staff member to inspect the room and identify the errors. Some of the errors include allergy bands that are incorrect for the noted allergy on chart; a sharps container on the floor that is not secured; an adult holding a baby in a bed that is not locked and with the side rails down; an oxygen mask of the wrong size and oxygen not hooked to the wall; an unread note in an accident victim's hand suggesting the patient is at risk for self-harm; a corpsman's note to a nurse containing critical information being passed incorrectly; and a large blood spill (innovatively created with red construction

paper) posing a biohazard on the floor. In addition to recognizing the errors, the staff is required to provide the corrective action for each or demonstrate that they can to the patient safety officer or representative.

In addition to the room of errors, LT Skinner has hosted trainings that involved a question-and-answer format similar to the game show Jeopardy—complete with buzzers and prizes such as stress balls and notepads for correct responses. However, her favorite project was the song the patient safety team created to remind everyone to follow the steps involving time outs and universal precautions that was sung to a memorable tune from the 80s. Plans are to resolve the base theater to present trainings involving skits, game show for-



Overview of the Room of Errors

mats, like Wheel of Fortune, and maybe even “pin the tail on the patient safety officer.” LT Skinner believes that innovative teaching methods are effective and instrumental in “outside the box” thinking. “The military community is a transient community and it is my hope that the staff takes these teachable moments with them,” said LT Skinner.

She has been able to share these ideas with NH Rota and NH Naples, who are also looking at utilizing the above methods and ideas. She welcomes the collaboration as we are all on the same team and have the same mission to ensure safety of our patients and staff. If it can be done in an energetic and fun way, she says, “well, that is icing on the cake!”

PSR Full Deployment

Continued from page 1

What will PSR do for You?

Protecting patients is the principal goal of the easy-to-use, readily-accessible Web-based PSR, which has many benefits beyond the scope of the local electronic or paper-based incident reporting systems. Including:

- **Standardization:** The automated PSR system's intuitive design will help you report events more easily and thoroughly in a systematic/standardized manner. There will be an increase in the consistency in which information is inputted and that can then be trended, tracked, and acted upon within your facility, Service, or enterprise-wide.

- **Data Granularity:** PSR captures event-level data, providing a greater level of depth and detail. This higher data granularity allows for a more effective understanding of how and why an event occurred. This is a departure from the more aggregate Monthly Summary Report "tic mark" approach.

- **Increased Awareness and Proactive Learning:** Not only is PSR a medium to report and track events, it is an instant educational tool. The user can understand and better identify the types of information necessary for reporting events, as well as the mechanisms that increase the risk of a patient safety event occurring. This knowledge can be applied to enhance situational awareness of the patient care environment and proactively improve processes within an MTF, as well as Service or Enterprise-wide.

- **Real-Time Assessment/Analysis:** PSR's real-time reporting allows for real-time analysis, facilitating instant awareness and understanding of system vulnerabilities and hazards across MTF, Service, and Department of Defense Patient Safety Program levels in which risk-mitigating strategies can be implemented.

Special Features

- Easy-to-use standard and ad hoc reporting features within the program eliminate the need for external graphic software support.

- Consolidated tool for reporting medication and non-medication data greatly reduces analytical challenges that occur when using disparate systems.

- Maintains confidentiality and enables all individuals with a CAC to anonymously report patient safety events. Security is maintained through ROLE-based settings enabling only those users with authorization to access PSR



PSR training at Naval Hospital Twentynine Palms

data.

- Includes a causal factor/root cause where circumstances or factors that influenced the occurrence or risk of a patient safety event can be identified and direct/effective corrective actions can be implemented to enhance patient care processes and protect future patients.

- Aligns with the Agency for Healthcare Research and Quality (AHRQ) Harm Scale allowing one to measure the patient safety event's impact on a patient's functional ability, including quality of life, 24 hours after the event.

PSR will facilitate your continued efforts to identify threats, develop risk mitigating strategies, improve patient safety, and ultimately give the opportunity to provide the safest care possible. Together, we can systematize event data, heighten our situational awareness, and

enhance analysis to provide increased protection for our patients.

Information about PSR benefits, features, FAQs, and more can be accessed through the Patient Safety Learning Center (PSLC) under the "Reporting and Information" link at <https://us.army.mil./suite/portal/index.jsp>.

Please note, the PSLC is restricted to members with an Army Knowledge Online (AKO) account, and who are authorized users of the community page.

For more information, please contact your Service POC:

Army: jorge.carrillo@amedd.army.mil

Navy: carmen.birk@med.navy.mil

Air Force: beverly.thornberg@lackland.af.mil

Or

Visit the DoD Patient Safety Learning Center

BASIC PATIENT SAFETY MANAGER COURSE – UPDATES

Pilot Courses Conducted in Spring 2010

As reported in our last quarterly newsletter, the Basic Patient Safety Manager (BPSM) Course was revamped and piloted in the Spring (April and May) of 2010. The revised course design and content was based on a front-end analysis of the educational needs of new patient safety managers (PSMs), feedback from Service Headquarters, and input from PSMs who had previously attended the course. The two pilot courses were attended by a total of 36 participants and five auditors. They were taught by multidisciplinary subject matter experts (SMEs) including medical doctors, nurses, pharmacists, and experts in human factors, quality improvement, patient engagement, and health administration.

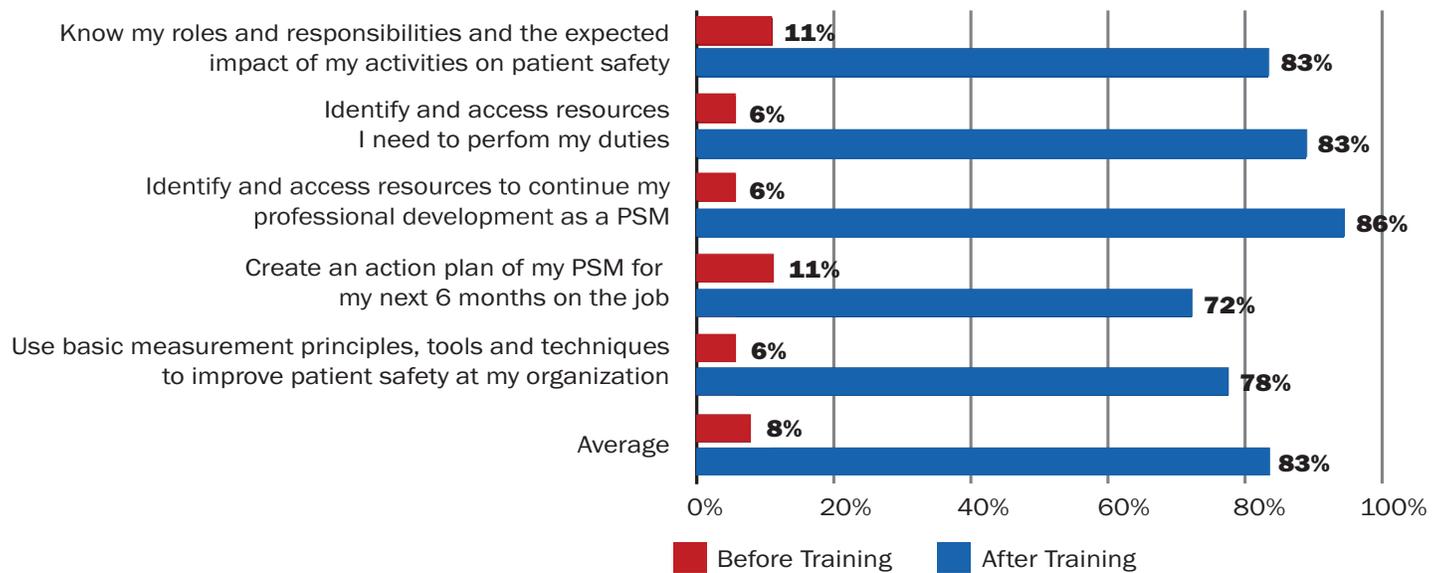
Reactions to Training

Both pilot courses had an overwhelmingly positive response from multiple stakeholders, including course participants, auditors, and

reviewers of course materials. Participants completed evaluations on overall impact of the course, its content, materials, and instructional techniques. Each element was rated highly by all participants. Analyses were conducted separately on the target audience, who were PSMs who had been in their positions for less than a year. Of the respondents, 100% said that the training was well-organized and they were confident using the knowledge they learned on the job. The graph below depicts their responses on several training impacts.

Participants also demonstrated a significant increase in knowledge and skills immediately after training as shown in the following graph. Pre-training baseline levels of the targeted knowledge and skills were very low for each objective with only 6% to 11% of participants reporting confidence in their abilities. After training was conducted, ratings soared into the 72% to 94% range.

Before/After BPSM Course: PSM Knowledge & Skills



Evaluation and Coaching Follow-up

Participants identified at least three commitments to action that they would complete in the 3 months following the BPSM course. At the end of 3 months, evaluation and coaching calls were conducted with participants to follow up on their progress with these commitments to action and to provide support and assistance in resolving any barriers they encountered in the completion of these actions. Participants most frequently identified that ongoing training, coaching, and mentoring were the most important enablers to performance. They also indicated that they were applying course content on the job and finding course materials very useful.

Next Steps with BPSM Course

On the basis of evaluation results of the pilot course, four lessons were redesigned to meet PSM needs. This redesigned course was

presented in November at the National Capital Area Medical Simulation Center in Silver Spring, MD, and was well attended by all services. Future dates for the course in FY 2011 are:

- January 10-14, 2011
- April 4-8, 2011
- September 12-16, 2011

New PSMs who are interested in registering for upcoming courses are requested to contact their Service Representatives for obtaining approval to attend. Information about course registration will be sent out by the Service Representatives prior to each course. An overview of the BPSM course is available on the Patient Safety Learning Center (PSLC).

WELCOME DR. RONALD WYATT

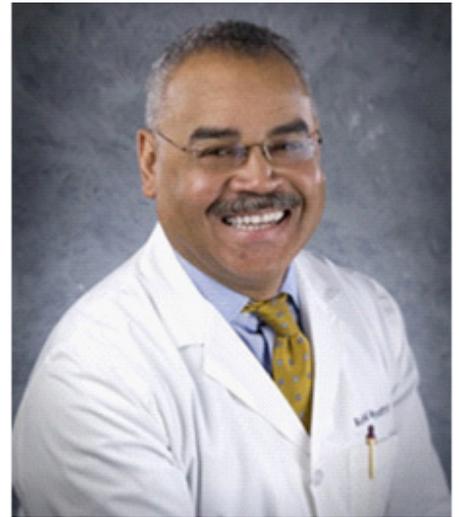
The Department of Defense (DoD) and the Patient Safety Program welcome Ronald Wyatt, M.D., M.H.S., as the new Director of the Patient Safety Analysis Center (PSAC) in Silver Spring, MD. He is a 2009–2010 George W. Merck Fellow at the Institute for Healthcare Improvement (IHI). Dr. Wyatt believes that the year he spent as a fellow at the IHI has been the most beneficial experience of his professional career, and will be most valuable to his role as patient safety director.

In addition to completing all major IHI programs, he led a research and development project, worked with a Triple Aim site, and served as improvement advisor to a large academic medical center. His clinical experiences in academic and private practice, Veterans Administration Medical Center (VAMC) practice, and active military duty in Desert Storm have shaped the real-world perspective he brings to his new position.

Born in Selma, AL, Dr. Wyatt credits his life experiences as a primary influence on his commitment to improving health care. He earned his medical degree from the University of Alabama – Birmingham and completed his

internship and residency at St. Louis University Hospitals, serving as the first African-American Chief Resident in Internal Medicine.

He completed the Clinical Effectiveness Program at Harvard Medical School/Harvard School of Public Health in 2009 and also served as improvement advisor to the Tufts New England Medical Center Readmission Team under the Commonwealth State Action on Avoidable Rehospitalizations (STAAR) Initiative. He and other IHI Fellows completed a training program on Unprofessionalism and Disruptive Behavior, which included a WIHI talk show program that drew the largest attendance of any program in its history. Dr. Wyatt looks forward to the challenge of improving patient safety and achieving new sustained DoD levels that can be spread system-wide. “It is exciting to see, hear, and feel the energy around the implementation of the Quadruple Aim, as well as be involved with a culture of safety that will focus on process improvement, system design, and the building of an improvement system that desires to be a highly reliable system of care. Working with an organization that is displaying the aims



and the will to make improvements that are patient-focus and patient-centered is very exciting,” said Dr. Wyatt. Dr. Wyatt and his wife Pamela have four children, three sons and one daughter, and he is an avid jazz fan.

WELCOME DEBORAH MYERS

The Department of Defense welcomes Ms. Deborah Myers as the new Deputy Director at the Patient Safety Analysis Center (PSAC). As a self-described lifelong ‘buckeye’ this is her first position outside of a pharmacy and her first inhabitation in a state other than Ohio.

Ms. Myers earned concurrent Bachelor’s Degrees in Biology and Pharmacy from the Colleges of Arts & Sciences and Pharmacy at Ohio Northern University and holds an MBA from Ohio State University. She has worked as a registered pharmacist in a Level 1 trauma hospital, lectured in Contemporary Pharmacy Practice at her alma mater, was a preceptor for numerous pharmacy students, and was involved with the Thai Red Cross in Thailand following the tsunami of 2005.

Ms. Myers brings experience from the civilian sector having worked for a privately-held, family-owned pharmaceutical company and involvement in Drug Information and Safety, as an Analyst and Clinical Safety Officer responsible to the U.S. Food and Drug Administration (FDA) reporting Adverse Events for more than 100 new drug application/abbreviated new drug application (NDA/ANDA) products. She led and completed a successful audit in less than 2 days receiving zero FDA-483 warning letters. Ms. Myers is passionate about patient safety and calls herself “one of those geeky, overachiever pharmacists.” The opportunity to work in a closed medical system excites Ms. Myers, because of the abundance of collected information that is relayed back to prescribers and patients, thus aiding in preventing future occurrences and assisting in making more informed decisions. She views the development of the patient safety program at TRICARE Management Activity (TMA) as being a leader and exemplary of future healthcare programs.



According to Ms. Myers, her position with PSAC is her professional dream come true. “I could not have dreamed of a more perfect opportunity. I am sincerely looking forward to working with the team to help provide the safest possible healthcare for our military and their families. They have made such deep sacrifice and certainly deserve this.”

Ms. Myers has a daughter, Juliana, who is a freshman at Vanderbilt University and a history enthusiast for whom this is also an exciting opportunity. In addition to enjoying time with her daughter and pets, Ms. Myers is an enthusiastic baker and reader.

PATIENT SAFETY PROGRAM UPDATES

Patient Safety Awareness Week March 6-12, 2011



Patient Safety Awareness Week (PSAW) is an annual, National Patient Safety Foundation (NPSF)-led education and awareness campaign for healthcare safety. Each year, healthcare organizations internationally take part in the event. Department of Defense (DoD) facilities are no exception. Army, Navy, and Air Force medical treatment facilities around the world proudly participate and conduct numerous activities to engage and educate staff members and patients in various patient safety initiatives.

As members of the Stand Up for Patient Safety Program, DoD facilities will begin receiving their toolkits in January 2011. The theme for the 2011 PSAW is "are you In? commit to safe health care."

Commanders' Patient Safety Forum

The DoD Patient Safety Program (PSP) launched a Commanders' Patient Safety Forum in the spring of Fiscal Year 2010. This collaborative session, conducted every other month, brings together military treatment facility commanders and deputy commanders from all Services to share stories and discuss leading practices around patient safety. The primary objective for these sessions is to provide resources to leaders for engaging, educating and equipping the entire patient-care team to institutionalize evidence-based safe practices.

To date, the PSP has held five forums. The next session is scheduled for December 02, 1200-1230 ET. Commanders and Deputy Commanders interested in learning more about the forum and signing up should contact Lieutenant Colonel Donald W. Robinson, MD, Director, DoD Patient Safety Program at Donald.Robinson@tma.osd.mil.

Patient Safety Learning Center

The Department of Defense (DoD) Patient Safety Learning Center (PSLC) is rapidly growing in content and membership. We have recently added PSP frequently-asked questions, impact stories, help with renewing accounts, and materials from patient safety events, such as conferences, collaboratives, brown bag lunch meetings, and more. The community has grown to more than 430 members and 12 specialized groups.

For assistance with facilitating your adoption and use of the DoD PSLC, please contact the PSLC Support Team at PSP_PSLC@bah.com for live support, to schedule a coaching session, provide feedback, and more. We have also established a PSLC Support Line, an open phone line with live support, available every Tuesday from 1000-1200 ET. We encourage you to reach out for real-time answers and support related to the DoD PSLC. Call 866-657-9756 and enter 723389 (SAFETY) when prompted for an access code.

Patient Safety Program Monthly eBulletin

The DoD PSP is pleased to announce the launch of a monthly eBulletin. We've heard from you, our stakeholders, who make up patient-care teams. Patient safety managers, military treatment facility leaders, quality managers, and other MHS healthcare staff told us you want to receive patient safety information, but that you want it streamlined, monthly, and via email.

Our new PSP eBulletin is our answer for you. With this email, you receive information on PSP program updates, news, tips you can use, success stories and upcoming educational activities. For more information and to sign up to receive the eBulletin, please visit <http://www.health.mil/dodpatientsafety> and click on "Sign Up To Receive Our Monthly eBulletin."

PATIENT SAFETY PROGRAM NEWSLETTER

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