U.S. Department of Defense
Patient Safety Program
Newsletter
PARTNERING FOR A NEW LEVEL OF CARE

WINTER 2010 A QUARTERLY NEWSLETTER TO ASSIST THE MILITARY HEALTH SYSTEM IMPROVE PATIENT SAFETY

PATIENT SAFETY AWARDEES RECOGNIZED AT 2011 MHS CONFERENCE

The 2011 Military Health System (MHS) Conference theme is The Quadruple Aim: Working Together, Achieving Success. The focus is on sharing knowledge, celebrating innovation, and committing to new initiatives and policies created to improve the safety and quality of care across the MHS. Presented since 2004, the awards honor the achievements of medical facilities working to promote the culture of safety and maintain excellence in patient care. The 2010 DoD Patient Safety Award winners, to be recognized at the MHS Conference on January 24–27, 2011, are:

- **US Naval Hospital Pensacola**
- **US Naval Hospital Bremerton**
- **USA MEDDAC Bavaria**
- **US Air Force Academy**

TEAMWORK, TRAINING, & SKILL BUILDING

U.S. Naval Hospital Pensacola

In-Patient Facility

Title: Partnering with Patients

A key component in patient safety is including the patient as part of the healthcare team. US Naval Hospital Pensacola took the initiative to "Partner with Patients" by developing and implementing a plan in the obstetric (OB) inpatient unit of the hospital. Improving patients' levels of satisfaction and reducing call light usage were the objectives for the initiative.

The team practiced the AIDET acronym for introductions: **A**cknowledge the patient, **I**ntroduce yourself and your role in the team, **D**escribe the duration of the procedure, **E**xplain the plan of care, and **T**hank the patient for their confidence in the care that will be provided. Some behavior-modeling phrases practiced by staff members included, "Before I leave, are there any questions I can answer for you? I have time." "I am washing my hands to prevent the spread of infection. Please do not hesitate to remind us if we forget to wash our hands."

The "Partnering with Patients" initiative was highly successful in increasing patient satisfaction as compared with the previous year, and in decreasing use of the call lights. Patient satisfaction rates not only exceeded the previous' years for this

Continued on page 4

TABLE OF CONTENTS

2 PSP Director's Corner
3 Patient Safety Awareness Week
3 Additional Patient Safety Award Winners

USA MEDDAC Bavaria

Ambulatory Center Facility

Title: Improving the Quality of Patient Care Utilizing Tracer Methodology

A Joint Commission Tracer Team was developed to facilitate the delivery of quality, comprehensive, and safe healthcare to the organization's beneficiaries by evaluating compliance with national healthcare standards and promoting staff education and training at the point of care. Standardization of tools allowed for rotation of team members without loss of metric integrity.

In December 2008, the USA MEDDAC Bavaria Tracer Team was revised from a singular activity conducted by a group of five staff members located at medical command headquarters into a multidisciplinary team of command subject matter experts. Tracer tools were developed for each chapter in the Joint Commission Ambulatory Care Standard Manual. The tracer survey process was standardized for the organization. Tracers were conducted using a combination of direct observation, staff and patient interviews, and retroactive record audits.

The implementation of the Tracer Team had a positive impact on the organization, decentralizing knowledge and information from a few headquarters staff to every staff member within the organization. It also created more transparency between the US Army Health Clinic and its patients. The organization met the tracer objectives as evidenced by improvement in patient care and healthcare metrics measured. The Tracer methodology is adaptable to all care settings and is a practical way to involve all members of a healthcare team in maintaining and improving performance. The

Continued on page 4

ONE MISSION, ONE TEAM

Director's Corner

I wish all of you a safe and happy holiday season. I would like to extend my personal thanks for your service and commitment to patient safety in 2010. Your efforts to improve the quality and safety of patient care within the Military Healthcare System (MHS) are to be commended. We celebrated many successful initiatives in 2010 and look forward to another great year in 2011. Your work, day in and day out, helps us to create a culture of safety and enhance the quality of care provided to our world-wide beneficiary population.

I encourage your active participation in Patient Safety Awareness Week (PSAW) March 6–12, 2011. Please visit our Web site at http://www.health.mil/dodpatientsafety/PSAW.aspx for more information.

The Patient Safety Reporting (PSR) System implementation across the military health system continues, replacing the paper-based and site-specific electronic processes, and the Fiscal Year 2011 Basic Patient Safety Manager Courses are being offered in January, April, and September.

Please join me in congratulating the DoD Patient Safety Award Winners: in the Teamwork, Training, and Skill Building category, Naval Hospital Pensacola and their "Partnering with Patients" project, and USA MEDDAC Bavaria with "Improving the Quality of Patient Care Utilizing Tracer Methodology." Winners in the Identification and Mitigation of Risks and Hazards category are Naval Hospital Bremerton's "Improving the High Level Disinfection Process of Vaginal Ultrasound Probes" project and the US Air Force Academy's "Labeling Patient Specimens." They will be recognized at a presentation on January 26, 2011, during the upcoming MHS Conference. All participants in these process improvements are to be congratulated for their dedication and commitment to constantly maintaining and improving safe patient care.

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

We encourage you to attend the following Patient Safety-related sessions being highlighted at the MHS Conference!

Monday, January 24, 2011
1:00 - 2:30 PM

When You Can't Vote Them Off the Island — Promoting Professional Conduct Within Your Team: A World Cafe Dialogue

Great teamwork requires mutual support, including the ability to address lapses in professional conduct to ensure a safe patient experience. This highly interactive session will integrate components of the TeamSTEPPS Professional Conduct Toolkit with dialogue and a live demonstration of the Connect & Correct technique.

Monday, January 24, 2011
3:00 - 3:45 PM

The Patient Safety Reporting System (PSRS)

The session provides an overview of PSR, currently in deployment across the MHS. PSR captures both medication and non-medication patient safety events including near misses using a standard taxonomy. The use of a standardized tool across the enterprise enables more complete event capture, analysis, trending and identification of areas for improvement.

Tuesday, January 25, 2011
1:00 - 2:30 PM

Healthcare Quality and Patient Safety Innovations: Lessons from the Field

Winners of healthcare innovation awards based on readiness, experience of care, population health and responsible management of health care costs will present their innovations. Patient safety awards are given in the areas of Teamwork Training and Skill Building, and Identification and Mitigation of Risks and Hazards.

PATIENT SAFETY AWARENESS WEEK

The National Patient Safety Foundation (NPSF) invites hospitals and healthcare organizations nationwide to participate in Patient Safety Awareness Week (PSAW), March 6–12, 2011.

Patient Safety Awareness Week (PSAW) is an annual, NPSF-led education and awareness campaign for healthcare safety. Each year, healthcare organizations internationally take part in the event by prominently displaying the NPSF campaign logo and promotional materials within their organizations and deploying NPSF educational resources to hospital staff. NPSF is the founding sponsor of PSAW and has led the event since 2002, annually producing a visible campaign theme and toolkits specific to the most pressing patient safety issues.

PSAW toolkits are one of the exciting benefits of a membership in NPSF's Stand Up for Patient Safety and Ambulatory Stand Up for Patient Safety Program. To celebrate PSAW, all DoD facilities receive a FREE TOOLKIT and access to supplemental materials and resources in honor of Patient Safety Awareness Week.

Military Treatment Facilities (MTFs) across the Military Health System (MHS) have enthusiastically embraced PSAW; past activities have included games such as Patient Safety Jeopardy and Poker, poster contests, school visits, radio shows, and patient-centered displays and hand-outs. MTFs are again invited to observe and celebrate PSAW.

We look forward to your active participation in PSAW 2011! For more information regarding PSAW, please visit the Patient Safety Program Web site at http://www.health.mil/dodpatientsafety.

IDENTIFICATION AND MITIGATION OF RISKS & HAZARDS

US Naval Hospital Bremerton

In-Patient Facility

Title: Improving the High Level Disinfection Process of Vaginal Ultrasound Probes

Recognizing the need for consistency, the US Naval Hospital Bremerton's Infection Control Preventionist (ICP) recommended practice changes to ensure compliance with the latest standards. The objectives were to improve quality of care and patient safety by ensuring a consistent and correct process for the high level disinfection (HLD) of vaginal ultrasound probes.

The HLD process has a potentially high degree of risk for patients when performed incorrectly. The hospital leaders wanted to proactively explore and improve current capabilities.

Data was collected by the ICP and Lean Six Sigma using the HLD Audit Tool during unannounced inspections of utility rooms in which HLD was performed. Baseline data was collected in October 2009 and follow-ups occurred monthly to evaluate progress. Final post-improvement data was collected for all clinical areas in March 2010, with random, unannounced inspections of two clinical areas per month in September 2010.

The benefits of the project included improved compliance with

Continued on page 4

US Air Force Academy

Ambulatory Center Facility

Title: Labeling Patient Specimens

The US Air Force Academy Military Treatment Facility identified a high-risk process regarding the ordering and labeling of patient specimens. This revealed a need for improvement to ensure enhanced communication amongst clinic staff and delivery of the best possible care to their patients.

The specimen-labeling improvement target was to have 100% of the specimens labeled or ordered correctly the first time they were received by lab staff. A standardized specimen labeling process was developed, which included posted visual reminders; verification of patient identification information; standardized labels to include name, date, and source of specimen; intranet training slides; and the implementation of revised clinical orientation checklists to include specimen labeling and ordering procedures. Additionally, compliance tracking was monitored through bimonthly Tracers.

Initial results were outstanding: within 3 months of training and implementation of the new process, incidents of mislabeling drastically decreased. The initial goal of establishing a

Continued on page 4

TEAMWORK, TRAINING, & SKILL BUILDING

Partnering with Patients

Continued from page 1

facility, but also surpassed the satisfaction rates achieved in OB units at four other similar facilities. This supports continuation of the initiative, as well as implementation in other medical settings such as pediatrics, medical-surgical, and other inpatient units.

IDENTIFICATION AND MITIGATION OF RISKS & HAZARDS

Improving the High Level Disinfection Process of Vaginal Ultrasound Probes

Continued from page 3

disinfectant and equipment manufacturer guidelines, as well as the Centers for Disease Control and Prevention recommendations. Also, process variation was reduced by implementing a consistent method among the clinical areas. Improvements supported the hospital's commitment to providing and maintaining a safe patient care environment.

The HLD audit tool was invaluable in achieving successful completion of the project; department heads were able to evaluate their department's compliance quantitatively and the executive board was regularly briefed. By elevating the process of HLD to a recognized priority, the teams experienced active participant support from all levels and positive changes were accomplished with resulting improvements to the process.

This initiative has also been successfully replicated in other areas of the hospital performing HLD on other types of medical instruments and these projects have also been shared beyond the hospital. This realistic and practical approach is easily utilized within other healthcare settings such as clinics.

TEAMWORK, TRAINING, & SKILL BUILDING

Improving the Quality of Patient Care Utilizing Tracer Methodology

Continued from page 1

positive gains from utilizing this method suggest that this is the most practical method to facilitate improvement in the delivery of safe patient care. Additionally, it promotes teamwork because it is a multidisciplinary activity that requires all levels of staff to participate in order to achieve a comprehensive and complete assessment of an organization's compliance.

IDENTIFICATION AND MITIGATION OF RISKS & HAZARDS

Labeling Patient Specimens

Continued from page 3

standard work process across all clinics was met. This process ensures the accuracy of labeling as specimens move from patients to the clinical and pathology laboratories. It can be easily implemented in any ambulatory setting. Teamwork is key: active patient and staff involvement, timely staff training, and an attitude of interdisciplinary cooperation results in a process that is followed before a patient even leaves the clinic. Other clinics in the Military Health System are encouraged to study and use this process as a benchmark.

PATIENT SAFETY PROGRAM NEWSLETTER

DoD Patient Safety Program
Office of the Assistant Secretary of Defense (Health Affairs)
TRICARE Management Activity

5111 Leesburg Pike, Suite 810
Falls Church, Virginia 22041
703-681-0064

Division Director, Patient Safety Program
Donald W. Robinson, LTC, MC

Director, Patient Safety Data Analysis Center
Ronald Wyatt, MD

Director, Patient Safety Solutions Center
Ms. Heidi King, MS, FACHE

Interim Director, Patient Safety and Quality Academic Collaborative
Ron Gimbel, Ph.D.

Forward comments and suggestions to:
patientsafety@tma.osd.mil

http://www.health.mil/dodpatientsafety