

U.S. Department of Defense

Patient Safety Program

PARTNERING FOR A NEW LEVEL OF CARE



FALL 2011

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

2011 PATIENT SAFETY RISK MANAGEMENT CONFERENCE

Nearly 300 U.S. Army Medical Department (AMEDD) participants from around the world met for the U.S. Army Medical Command (MEDCOM) Patient Safety Risk Management Conference in San Antonio, Texas, August 2–5, 2011. This year's conference theme, "Are You In?" encompassed a daily focus of "Involved, Informed, Invested, and Integrated," suggesting genuine engagement in Patient Safety and Risk Management at all levels throughout the AMEDD Military Treatment Facilities (MTFs) and U.S. Army Dental Activities (DENTACs). In an effort for continuing leadership engagement on patient safety issues, this year's conference planners extended invitations to members of MTF and DENTAC command



LTC Jorge Carrillo, Army Patient Safety Program Managers closes the 2011 Patient Safety Risk Management Conference

groups. Participants from DoD, Navy, Air Force, and civilian counterparts were also in attendance.

The conference was kicked off by a welcome from COL Doreen Lounsbery, Chief, Army QM, followed by Patient Safety, Risk Management and DoD program updates by LTC Jorge Carrillo, LTC Jennie Irizarry, and LTC Donald Robinson respectively. Mr.

Herbert Coley, MEDCOM Chief of Staff, discussed patient safety in the AMEDD. National speaker Fred Lee and author of *If Disney Ran Your Hospital* lectured on "Going from Good to Great: Learning from Disney."

Incorporating the Just Culture (JC) concepts across the AMEDD, a dynamic and national speaker David Marx, Outcomes Engineering and author of *Whack-A-Mole*, plus Ms. Judy Smetzer, Institute of Safe Medication Practices, lectured and trained on the JC methodology. Among the 20 speakers, Ms. Barbara Moidel from the National Naval Medical Center spoke on Healthcare Resolutions, while Mr. John Casciotti, DoD Office of General Counsel and Ms. Rosalind Gagliano, MEDCOM Judge Advocate General's Corps discussed congressional mandates and legal issues.

Three civilian speakers from New York City Health & Hospitals, Mr. David DeJesus, Ms. Mei Kong, and Dr. Abdul Mondul, spoke on Patient Safety and Risk Management Collaboration plus on the integration of JC and TeamSTEPPS. In addition, a four-person panel with representatives from Patient Safety and Risk Management discussed and answered questions regarding potential compensatory events. A touching and memorable personal story by MAJ Kendall Mower was presented, which reminds us of our deep commitment to patient safety and risk management.

Various policy and operational elements of Patient Safety and Risk Management were presented in addition to TeamSTEPPS initiatives; Culture of Trust, integration, techniques for transparency in healthcare delivery disclosure, potentially compensable



Participants at the 2011 Patient Safety Risk Management Conference in San Antonio, Texas

event data analysis, creative thinking, and problem solving. Evening events consisted of an icebreaker and dinners in which a social atmosphere on the city's famous River Walk contributed to networking opportunities.

The final day of breakout sessions consisted of 14 mini-lectures covering the Patient Safety Reporting System, Root Cause Analysis, Balanced Score Card, Patient Safety Dashboard, Leadership Best Practices, APEX IP8, RM Strategy and Plans, Suicide Update, Universal Protocol, Falls, and Unintended Retention of Foreign Objects. We look forward to seeing you again at next year's conference.

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ONE MISSION, ONE TEAM

Director's Corner

I am pleased to announce that [The DoD Military Health System \(MHS\) has signed on](#) to be a participant in the Partnership for Patients: Better Care, Lower Costs program. The goal is to help improve the quality, safety, and affordability of healthcare for all Americans. The Partnership for Patients brings together the leaders of major hospitals, employers, physicians, nurses, and patient advocates, along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. Accomplishing these objectives will save lives and prevent injuries to millions of Americans, helping to put the nation on the path toward a more sustainable healthcare system. I would like to commend all of those involved with the U.S. Army Medical Command Patient Safety Risk Management Conference held August 5–8 in San Antonio, Texas. The conference featured several dynamic speakers, workshops, breakout sessions, and even casual evening social activities, providing numerous networking opportunities. Some topics of discussion included TeamSTEPPS initiatives, culture of trust integration, creative thinking, problem solving, and techniques for transparency in healthcare delivery disclo-

sure. “Involved, Informed, Invested, and Integrated” was the focus of this year’s theme, “Are You In?”

The Patient Safety Reporting System (PSR) is now deployed worldwide and Version 1.2 will incorporate many of the user-requested features, such as floating and drop-down menus, allowing the selection of more than one medication in the medication event section, and others. A dashboard module has been added so that patient safety managers, Headquarters, and the Patient Safety Analysis Center (PSAC) can log in and view updated snapshot reports. For sustainment training, the program office’s vendor is updating the web-based training. The Patient Safety Program (PSP) is developing intermediate scenario-based training in areas where difficulty was noted during the worldwide training. This training will focus more on the conceptual matters of how the software should be used rather than the “point and click here” issues. The PSP will continue to maintain a block of PSR training in the Basic Patient Safety Manager’s course, and PSAC will provide webinars as needed.



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

PSR UPDATE

With the completion of the worldwide implementation of the Patient Safety Reporting System (PSR) Version 1.0, work has begun on PSR Version 1.2, which will incorporate Datix Version 11.2. PSR Version 1.2 integrates many of the features users have requested and will be available in the fourth quarter of Fiscal Year 2012. Some of the enhancements include a more modern look than the current version. Floating menus on the left side of the page will include Save, Cancel, and Menu, eliminating the need to scroll up and down. Selecting “Menu” will display the Datex Input Form (DIF) 2 form sections menu, which allows the user to jump to those sections. In the medication section, drop-down menus are available for either generic or trade names with the therapeutic class being automatically populated. The medication section will also allow the selection of more than one medication. Causal factors will be upgraded to a two-tiered model that will work very much like the event classification section. When the initial group of the eight categories of causal factors is chosen, only applicable selections for the secondary causal factors list will display. Not only will this make selections easier, it will significantly reduce the length of the DIF 2 form.

One of the major enhancements is the inclusion of HOTSPOTS. HOTSPOTS will enable Patient Safety Managers (PSMs), Headquarters (HQ), and the Patient Safety Analysis Center (PSAC) to set criteria, which will then notify them if the criteria are exceeded. This should considerably increase success in monitoring

trends. The reporting engine has been significantly improved by adding new menu selections. A dashboard module will be available so that PSMs, HQ, and PSAC can log in and see their updated snapshot reports. The plan is for the decoupling of reports administration from system administration in a future release; however, for PSR Version 1.2 reports will still have to be defined by Tier III. PSMs will have a “copy event reports” capability. This will also allow PSMs to submit events while logged on. By using this function, the copied reports in total numbers will be included.

Finally, for sustainment training, the program office’s vendor is updating the web-based training. The Patient Safety Program (PSP) is developing intermediate scenario-based training in areas where difficulty was noted during the worldwide training. This training will focus more on the conceptual matters of how the software should be used rather than the “point and click here” issues. The PSP will continue to maintain a block of PSR training in the Basic Patient Safety Manager’s course, and PSAC will provide webinars as needed.

PARTNERSHIP FOR PATIENTS

The DoD Military Health System (MHS) has signed on to be a participant in the Partnership for Patients: Better Care, Lower Costs program. This partnership is aimed at helping to improve the quality, safety, and affordability of healthcare for all Americans. The Partnership for Patients brings together the leaders of major hospitals, employers, physicians, nurses, and patient advocates, along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly.

The two goals of this new partnership are:

- Keep patients from getting injured or becoming sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40%, as compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients, with more than 60,000 lives saved over 3 years.
- Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20%, in comparison to 2010. Achieving this goal would result in more than 1.6 million patients recovering from illness without suffering a preventable complication necessitating rehospitalization within 30 days of discharge.

Accomplishing these objectives will save lives and prevent injuries to millions of Americans, helping to put the nation on the path toward a more sustainable healthcare system.

The MHS pledges to pursue the goals of the Partnership for Patients initiative by building on work that is already underway and supporting local initiatives to improve the quality of care. The MHS looks forward to working with public and private healthcare organizations committed to reducing preventable patient harm. Furthermore, the federal government pledges to:

- Provide resources for technical support to physicians, nurses, and other clinicians working in and out of hospitals to test large-scale implementation of care delivery models that make patient care safer and to support effective transitions of patients from hospitals to other settings. These tools will be customized to meet the local needs of different settings and clinicians.
- Develop better measures of the quality and safety of care patients receive to help support hospital efforts to improve care, and provide better information to help inform consumers and employers in their decision-making. By developing these measures through public processes, the goal of reducing burden on providers, while collecting the best information possible, can be reached.
- Seek to learn from, and be a partner with, the private sector in using incentives to drive improvements in health care safety, quality, and value. Innovations will be encouraged, while recognizing that the payment and other terms entered into among hospitals and other providers and private payers are matters of individual contract and negotiation.
- Assure that where the federal government is a direct provider of care, Partnership for Patients will implement the tools that are proven to reduce hospital-acquired conditions and facilitate better care transitions.



ARMY MEDICATION SAFETY EFFORTS SHOWCASED AT NATIONAL MEETING

Five Army pharmacists and two patient safety managers presented lectures at the 2011 American Society of Health System Pharmacists (ASHP) summer meeting, which was held June 12 to 15, 2011, in Denver, Colorado.

As a member of ASHP's Medication Safety Section Advisory Group, LTC Jorge Carrillo, Manager, Army Patient Safety Program, developed 4.5 hours of pharmacy continuing education by demonstrating medication safety practices in the Army Medical Department. Ms. Phyllis Toor, Army Medical Command Patient Safety Nurse Consultant, and Ms. Julia Gannon, Chief Pharmacist at the Heidelberg Army Health Center, spoke on the implementation of TeamSTEPPS in a pharmacy environment; Dr. Donna Kido, Medication Safety Pharmacist at Tripler Army Medical Center (AMC), and Ms. Jaclyn Whelen, Patient Safety Manager at Tripler AMC, lectured on the collaboration between patient safety and medication safety; Dr. Aki Singam, Medication Safety Pharmacist at Walter Reed AMC, and Mr. Timothy Ekola, Medication Safety Pharmacist at Landstuhl RMC, spoke on conducting clinic and ward inspections and tracers to improve medication safety; and LTC Carrillo discussed pharmacy leadership in support of the medication use process.

These lectures were part of the Medication Safety Education Program that was attended by more than 250 pharmacy professionals from hospitals across the United States.



FROM THE FIELD: NAVAL HOSPITAL (NH) JACKSONVILLE TeamSTEPPS SUCCESS STORY

Since implementing TeamSTEPPS in 2008, NH Jacksonville has experienced extraordinary success achieving patient safety goals. Under the direction of Dr. Robert Jackson, CDR, MC, U.S. Navy, the new initiatives were first implemented in the high-risk areas of operating rooms, labor and delivery, and the mother/infant center. By September, the entire hospital and all branch clinics were on board with the new program.

TeamSTEPPS was developed by DoD and the Agency for Health Care Research and Quality (AHRQ), and has been adopted by civilian institutions, who have also experienced outstanding results. These institutions are recognized as Team Resource Centers (TRCs) and include Duke University, the University of North Carolina, the University of Washington, Carillon University, and Creighton University.

CDR Jackson shared some of their success stories, one involving a wounded warrior, a young marine who had sustained a devastating ankle injury. Despite multiple surgeries, the patient continued to suffer severe pain and had not retained normal use of the ankle. Upon his arrival, he and his wife met with the entire care team: the surgeon, anesthesiologist, surgical technician, and nurses. All aspects of and options for the surgery and aftercare were presented and the patient had a choice in each matter – the surgical procedure, pain management, etc. The team met the day of the surgery to be certain that everything was in place as the patient had chosen, and huddled before, during, and after the procedure. The surgery was a success, the patient recovered quickly

and painlessly, and he made it a point to return to the hospital to thank them for the excellent care that was provided. He indicated that he had endured multiple surgeries but that this had been “the best surgical experience of his life.”

Another positive experience was that of a Navy pilot with an extreme needle phobia who experienced five failed procedures at other clinics. He needed extensive dental work and a care plan was in place to anesthetize him before any needles would be introduced into the scenario. Just before the surgery, a change in the plan made it impossible to anesthetize the patient. The team huddled with the patient and asked him “What can we do to make this as comfortable and as least stressful as possible for you?” After some thought, the patient replied that if he could lie down with a warm towel on his forehead, have someone hold his hand, and have the “best IV starter you’ve got” do the insertion, he thought it would be manageable for him. The conditions were all met and the patient received his dental care with no complications whatsoever. He was so pleased with the experience that he wrote a letter to the commanding officer, saying in part, “This was awesome! This was all I needed, someone to listen to me.”

The family is included in every step in the procedure, from start to finish. They team up for a preview of everything and there are multiple opportunities to agree, decide, or make changes to the plan. This empowers patients, knowing that they have choices and are actively involved in their own healthcare. It fosters cooperation and trust within the healthcare

UPCOMING EVENTS

September 2011

- **22nd:** Patient Safety Learning Circle on the Patient Safety Reporting System: Harm Event Classification
- **28th:** Partnership for Patients – National Quality Forum National Priorities Partnership Patient Safety Webinar Series, Webinar 7: “Obstetrical Adverse Events”

October 2011

- **5th:** Partnership for Patients – National Quality Forum National Priorities Partnership Patient Safety Webinar Series, Webinar 8: “Venous Thromboembolism (VTE)”
- **16th:** Society for Healthcare Risk Management (ASHRM) 2011 Conference

November 2011

- **6th:** Association of Military Surgeons of the United States (AMSUS) 117th Annual Meeting “Transformational Pathways to Global Healthcare”

December 2011

- **4th:** Institute for Health Care Improvement (IHI): 23rd Annual National Forum on Quality Improvement in Health Care

team, as all members at all ranks can speak up and challenge when necessary. The biggest benefit, of course, is that it provides the patient with the best possible care in the best case scenario.

PATIENT SAFETY PROGRAM NEWSLETTER

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