

U.S. Department of Defense

Patient Safety Program

PARTNERING FOR A NEW LEVEL OF CARE



SPRING 2011

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

MHS CONFERENCE OVERVIEW



Photographs courtesy of the Military Health System

The 2011 Military Health System (MHS) Conference was held at the Gaylord National Hotel and Convention Center in National Harbor, MD from January 24-27, 2011. This year's theme was promoting the continued awareness and dedicated practice of the Quadruple Aim — achievement of readiness, population health, experience of care, and management of per capita costs.

There were over 4,000 military and civilian attendees and more than 200 exhibitors, displaying new products and services related to military health care. Components of the MHS, including the Patient Safety Program (PSP), also had exhibits and representatives at the conference, offering information and services to interested attendees.

Three patient safety-related breakout sessions were held before the award ceremony. "When You Can't Vote Them Off the Island — Promoting Professional Conduct Within Your Team: A World Café Dialogue" addressed the issue of functioning with challenging coworkers, while maintaining professional conduct and a positive work environment. Discussions among the service members were led by Heidi King, Deputy Director of the Patient Safety Program, and conflict resolution experts Debra Gerardi and Mary Salisbury.

"The Patient Safety Reporting (PSR) System" provided an overview of PSR, currently in deployment across the MHS. The use of a standardized tool enables more complete event capture, analysis, trending, and identification of areas in need of improvement. An additional advantage of PSR is that it captures and stores medication and non-medication events together, replacing the previously-used paper forms. One facility reported that they celebrated the initiation of PSR with a "pink and yellow party," where they served pink and yellow cupcakes and symbolically ended the separate paper form procedure by creating and then snipping pink and yellow daisy chains.

"The Healthcare Quality and Patient Safety Innovations: Lessons from the Field" session included an overview of the winning innovations, given by Leslie Atkins (USA Medical Department Activity (MEDDAC) Bavaria), Sandra Clark (U.S. Air Force Academy), LT Laura Jensen (U.S. Naval Hospital Pensacola), and LCDR Wendy Cook (U.S. Naval Hospital Bremerton). Award winners were chosen based on readiness, experience of care, population health, and responsible management of health care costs. Patient safety awards were given in the areas of teamwork training and skill building, and identification and mitigation of risks and hazards. The awards were presented on Wednesday, January 27. A video of the presentation may be viewed on the PSP Web site at <http://www.health.mil/dodpatientsafety/PatientsafetyAwards.aspx>.

Award submissions were reviewed and scored by a board of evaluators familiar with the DoD PSP and with expertise in education, data analysis, and quality improvement. Winners were selected based on an average score evaluating the abstract, design methods, results, conclusion, sustainability, and replication of the initiative to other MHS facilities.

It isn't too early to begin thinking about your DoD Patient Safety Award submission for 2011! See page 3 for more details.

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ONE MISSION, ONE TEAM

Director's Corner

I hope that all Patient Safety Awareness Week (PSAW) celebrations were productive and successful. During PSAW, facilities across the Military Health System (MHS) engaged in activities and events to educate in an entertaining and memorable way. They also equipped both providers and patients with the tools to help them partner together to maintain awareness of and commitment to improving the culture of safety to protect the health of the patients entrusted to our care.

We must continue to promote the focus of the MHS Conference: furthering the goals of the Quadruple Aim while advancing professionalism, enhancing partnerships, and sharing our knowledge and working strategies. The Patient Safety Reporting (PSR) System continues to go forward throughout the services, robustly improving event capture, analysis, and maintenance, while immediately identifying those areas that need improvement. Initially piloted in nine Military Treatment Facilities, PSR has now been in use for one year and training continues throughout the MHS.

The highly successful Basic Patient Safety Manager (BPSM) course is also in its second year and continues to receive overwhelmingly favorable feedback from both participants and reviewers. The BPSM will be offered twice more in 2011, in April and September. Interested patient safety managers should speak to their service representatives regarding attendance and may review the course summary in the Patient Safety Learning Center.

Thank you for your service, commitment, and continued enthusiastic pursuit of the greatness, efficiency, and safe care for which we are known.



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

THE 2011 MILITARY HEALTH SYSTEM CONFERENCE



Photographs courtesy of the Military Health System

BPSM COURSE

The Basic Patient Safety Manager (BPSM) course is a 5-day, face-to-face training session that provides new Patient Safety Managers (PSMs) in military treatment facilities with the knowledge and skills they need to begin their jobs.

Although training for new PSMs has been offered in the past, the new version of the BPSM course was piloted in April and May of 2010 and has been delivered on a regular basis since that time. Participant reaction to the course has been positive with comments including “informative,” “helpful,” and “excellent.”

The BPSM course focuses on four key areas:

- Evidence-based practice and standards.
- Leadership and change management.
- Quality management and process improvement.
- Risk identification and mitigation.

Throughout the course, new PSMs plan how they will put their knowledge into practice when they return to their facilities through the completion of roadmap activities. Course participants also have the chance to network with experienced healthcare professionals and meet with their service representatives. The course ends with training on the TapRoot® methodology and software, which PSMs use to conduct root cause analyses when they return to their facilities.

The BPSM course will be offered twice more in 2011: a Spring session scheduled for April 4 through 8 and a Fall session September

12 through 16. The registration for the April session closed on March 11. For additional information on the course, contact your service representative.



Basic Patient Safety Manager (BPSM) course training session

PATIENT SAFETY AWARDS

The DoD is committed to maintaining a culture of safety and quality care within the Military Health System. The DoD Patient Safety Awards are presented annually in the areas of Teamwork Training and Skill Building, Identification and Mitigation of Risks and Hazards, and Culture Measurement, Feedback, and Intervention. The awards recognize those who have shown innovation and commitment to the development of systems and processes that center around the needs of the patient.



It isn't too early to begin thinking about your award submission for 2011! The DoD PSP will begin accepting submissions starting in early September 2011 with an application deadline of early November 2011. Please monitor the PSP Web site for the latest information. The awards will be presented at the annual State of the Military Health System Conference, scheduled for January 30–February 2, 2012, at the Gaylord National Hotel and Convention Center in National Harbor, MD.

PATIENT SAFETY REPORTING SYSTEM

The Patient Safety Reporting (PSR) System is a new web-based system that replaces the paper-based reporting system. When fully deployed, it will enable the Military Health System to improve the safety of our medical beneficiaries worldwide. As a result, the Army, Navy, and Air Force will use a single, secure, system that allows each member of the DoD healthcare team to anonymously report patient safety events or potentially unsafe conditions via the Web. The application delivers standardized electronic reporting of patient safety events and can be used to track and trend medical adverse events. The PSR data will be used locally and at the DoD level to help determine why an event occurred and what steps can be taken to prevent its recurrence.

The DoD was successful in the limited deployment of PSR to selected military treatment facilities and moved to full deployment on November 1, 2010. Currently, 170 facilities have received PSR instruction, with 77 trained, 93 remaining to be trained, and 43% deployed.

PATIENT SAFETY AWARENESS WEEK

WHMC OBSERVES PSAW

Patient Safety Awareness Week (PSAW) was enthusiastically celebrated at Wilford Hall Medical Center (WHMC). The special events began on March 7, 2011, with a patient safety and team social in the hospital atrium. The goal was to educate and encourage patients, visitors, and staff to become more actively involved in their healthcare. Participating areas included Patient Safety, TeamSTEPPS®, Infection Control, Safety, the Wound Ostomy and Continence Clinic, Risk Management, and General Medicine Inpatient Flight. Discussions were held among hospital departments that support patient safety, education, training, and other programs designed to prevent medical errors from occurring. The exceptional team at WHMC made this event a success.

WHMC's first Good Catch Award from 59th Medical Wing Commander Maj. Gen. Byron Hepburn was presented to the General Medicine In-Patient Flight commander, Maj. Carolyn Pignataro. Her flight submitted the most anonymous patient safety reports for the last quarter.

A poster contest was also held. Posters were evaluated based on their creativity, content, organization, design, flow, and appeal. The judging panel was comprised of outstanding hospital leaders. The contest goal was to raise awareness of patient safety activities and inspire staff and patients to develop lasting partnerships among providers, patients, and communities. The winning posters were displayed throughout the hospital.

One of the staff's favorite activities was "What is wrong in the Room of Horrors?" For 4 days, the "Room of Horrors" was available 24-hours per day. All staff members were invited to view the room and identify the patient/risk/environmental/infection con-



Interactive information exhibit at WHMC during PSAW

trol-related safety errors. Prizes were awarded to the participants who recognized the most errors.

Staff members also volunteered to participate in the Patient Safety Cart Walk. They visited all patient waiting rooms and nurses stations and shared educational information and items regarding patient safety awareness. They focused on the electronic patient safety reporting system, TeamSTEPPS, and process improvement. The estimated number of patients, staff members, and visitors reached during PSAW was more than 1,000 individuals. WHMC would like to extend an exuberant "Thank you!" to everyone who supported PSAW.

PSAW ACTIVITY AT MACH

Moncrief Army Community Hospital's (MACH) celebration of Patient Safety Awareness Week (PSAW) emphasized the National Patient Safety Foundation's 2011 theme of "Are You In? Commit to Safe Health Care." MACH Commander's philosophy is that the patient is at the center of everything we do and every decision we make. The central question asked by staff is "what is in the best interests of the soldier or family member?" They respond accordingly, based on the reply. This process succeeds best when, as the theme for this year describes, everyone is involved, informed, and invested in the process.

Throughout the week, a patient safety information table was set up at the main entrance to the hospital. Its purpose was to engage patients in discussions on the importance of their involvement in the care process and to remind them that patient-centered care is the model of care at MACH.

Additional challenges for the staff included a "Room of Horrors," where staff was asked to identify all patient safety hazards in a mock hospital room, a patient safety quiz, and a patient safety word search. Another activity that was very popular with the staff was the "roving" hand hygiene experiment. Participants placed their hands on agar plates before and after performing hand hygiene. People from 25 departments within the hospital participated in the challenge. The staff members that competed and won received prizes, including a week's parking in a command parking space, dining facility meal tickets, and several other items.



PSAW participants enjoy the "roving" hand hygiene experiment at MACH

MACH's year-round activities focus on keeping patient safety at the forefront, with active encouragement of identifying at-risk behaviors and system issues, reporting of patient safety events, and presenting a monthly Good Catch Award, which is selected from that month's near miss reports.

Naval Medical Center Portsmouth (NMCP) Patient Safety Awareness Week (PSAW) 2011

Naval Medical Center Portsmouth (NMCP) observed Patient Safety Awareness Week (PSAW) by incorporating several creative strategies to emphasize this year's theme, "Are You In? Commit to Safe Health Care." This theme highlighted the need for the entire healthcare community—from patient to provider—to be fully involved, informed, and invested in making healthcare safe.

The focus was on empowering patients and strengthening patient-to-provider communications to promote patient safety and reduce the incidence of error. The educational materials and messages were developed with an awareness of the impact of cultural diversity in the healthcare setting.

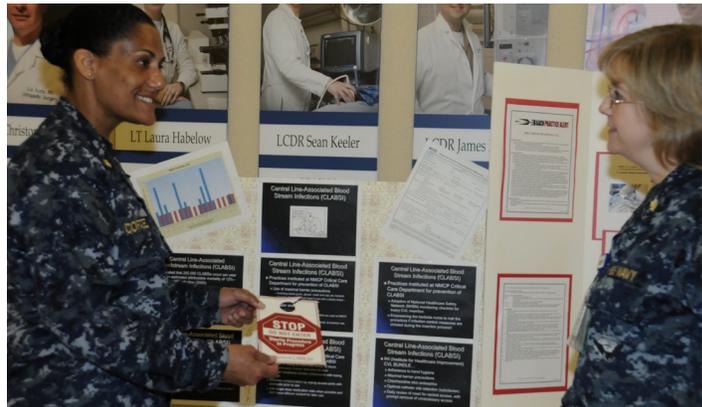
NMCP used various media tools to advertise, inform, and engage all healthcare constituents in providing patient safety, such as posters, flyers, and plasma screen messages. This information was distributed in the clinics and inpatient areas to encourage patients to ask specific questions about their healthcare. It began two weeks before PSAW and was followed up with daily patient safety messages throughout the week.

A patient safety fair was held on Wednesday, March 9, 2011. Interactive exhibits were designed to educate patients and staff and included games, prizes, and teddy bears for children. Healthcare providers were asked to join the campaign by wearing "Are You In? Commit to Safe Health Care" buttons on their lapels to encourage constructive dialogue between patients and healthcare providers.

The educational materials were prepared with an appreciation for the impact of diversity in healthcare settings where cultural health beliefs, education, and other factors can affect how patients understand their health and its care.



NMCP demonstrates safe handwashing at a patient safety fair during PSAW



NMCP patient safety fair during PSAW

MARCH SAFETY MADNESS

Malcolm Grow Medical Center celebrated Patient Safety Awareness Week with "March Safety Madness," an array of activities promoting patient safety. The festivities included the "Room of Horrors," a mock hospital room organized with a variety of unsafe scenes such as unlabeled syringes, sharps containers on tables, patients lacking identification bracelets, incorrect amounts of medications in intravenous bags, and more. Participants were challenged to identify and correct as many discrepancies as possible in the required timeframe. They also had a "Minute to Win It" question-and-answer table set up each day during lunch and prizes were awarded to those who correctly answered the most patient safety questions.

The first annual "Sharps Vendor Fair" was coordinated by Lori Malady in Infection Control, which incorporated patient safety awareness with the fulfillment of the Occupational Safety and Health Administration's safety device trail requirement. Vendors from as far away as California were in attendance, exhibiting sharps safety devices for all areas of military treatment facilities.

UPCOMING EVENTS

April 2011

- **4th–8th:** Basic Patient Safety Manager's Course.
- **10th:** National Patient Safety Foundation (NPSF) Professional Learning Series Webcast: "Shared Decision Making: The Safety & Quality Imperative for Patient Engagement in Care Delivery."
- **13th:** DoD Patient Safety Program Webinar: "TapRoot® Version 5 Webinars for DoD: Functional Webinar."

May 2011

- **5th:** World Health Organization (WHO): SAVE LIVES: Clean Your Hands: WHO's global annual campaign.
- **25th–27th:** National Patient Safety Foundation Patient Safety Congress: "Sharing Accountability and Responsibility in Pursuit of Patient Safety."
- **25th:** Agency for Healthcare Research & Quality TeamSTEPS® Webinar 20: "Sharing the Successes of TeamSTEPS - Part II". 12:00 pm–1:30 pm EST.

June 2011

- **5th:** National Patient Safety Foundation (NPSF) Professional Learning Series Webcast: "Medical Simulation 101 - Fundamental Strategies for Advancing Your Patient Safety Agenda."
- **16th:** Department of Defense Patient Safety Program Commander's Forum.

CULTURE OF PATIENT SAFETY SYMPOSIUM

Empowering people in the organization to speak up

By Patricia Deal

Carl R. Darnall Army Medical Center Public Affairs

At the Culture of Patient Safety Symposium held January 14, 2011, at Howze Theater at the Fort Hood, Carl R. Darnall Army Medical Center (CRDAMC), staff and employees learned first-hand how all members of the healthcare team positively affect patient safety.

This year's theme was "Good Catch! Don't Drop the Ball on Patient Safety." Staff and employees were educated on how to change the patient safety culture for maximum effectiveness and how leadership is essential in guiding the culture of patient safety.

"By supporting the symposiums, leadership here shows the value it puts on patient safety. Anything we can do to be proactive when it comes to patient safety is win-win for everyone."

Some of the topics presented at the symposium included Leadership Engagement in Patient Safety, Medication Safety, Risk Management for Dummies, and Seminal Reports and Sentinel Events. Various healthcare professionals from throughout the Medical Command in the United States and Europe made presentations.

Colonel (Dr.) Kimberly Kesling, CRDAMC Deputy Commander for Clinical Services, has presented at all past symposiums (three) and affirmed that the intent is to create a constant vigilance for patient safety, staying mindful of the things that go beyond the standard operating procedures and practices.

"Patient safety goes to the core of what we do as a healthcare organization. We are not specifically trying to provide a 'safe environment' for our patients, as we already have a safe environment," she said. "Most errors in any facility are due to common practices not being followed or updated to reflect new realities. We must empower all people in the organization to speak up and point out the variances. These symposiums are one way to draw attention to that responsibility and to allow individuals to be part of the solution."

CRDAMC is the only Army hospital to hold annual symposiums dedicated to patient safety, according to Chantel Robling, Patient Safety manager.

"By supporting the symposiums, leadership here shows the value it puts on patient safety," she said. "Anything we can do to be proactive when it comes to patient safety is win-win for everyone."



PATIENT SAFETY PROGRAM NEWSLETTER

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