



WINTER 2009

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

NAVAL HOSPITAL JACKSONVILLE STEPS UP TO PATIENT SAFETY

Universal TeamSTEPPS Training Enhances Patient Care and Safety

At an October 5th patient safety and care symposium hosted by Naval Hospital Jacksonville (NH JAX), Surgeon General of the Navy, Vice Adm. Adam M. Robinson, Jr. told attendees: “We have to lead from the front seat, not take the back seat, when it comes to patient care and safety”. The pace and success of TeamSTEPPS training at JAX is a testament to the facility’s out front leadership in delivering safe and effective patient care.

TeamSTEPPS was first introduced to staff from the Labor and Delivery (L&D) Department, Operating Room and Maternal-Infant Unit in February, 2009. Cheryl L. McDonald, CDR, NC, USN, Dept. Head, Staff Education and Training, explains that L&D embraced TeamSTEPPS with such enthusiasm that by the following week staff from all departments trained were motivated to utilize the TeamSTEPPS tools and share lessons learned. This fall, the Emergency Department adopted TeamSTEPPS, and it was introduced to out-patient clinics. CDR McDonald and her cadre of JAX trainers are currently taking TeamSTEPPS to outlying branch clinics.

CDR McDonald credits the facility-wide embrace of TeamSTEPPS to the perfect storm of leadership commitment, physician buy-in and providers who “want to do the right thing for patients and staff”. Capt. Bruce Gillingham, JAX commanding officer, saw the power of communication and collaboration first-hand during his 2005 deployment in Iraq, where the entire medical team worked together to solve a vexing patient care problem. When he assumed command at JAX, he brought with him his belief in the power of teamwork and an explicit charge to make it happen. His challenge resonated with physician champions who had experience with TeamSTEPPS from deployments and in state-side settings.

As staff in high-risk areas share success stories, TeamSTEPPS tools are gaining wide currency throughout the hospital. CDR McDonald affirms their lofty goal – to make TeamSTEPPS “the way we do business at Jacksonville”.

Contributing Author: Cheryl L. McDonald, CDR, NC, USN, Dept. Head, Staff Education and Training, Naval Hospital Jacksonville



Surgeon General of the Navy Vice Adm. Adam M. Robinson, Jr. at Patient Safety Symposium, Naval Hospital Jacksonville.



Navy Medicine East Rear Adm. William Kiser receives memento of Patient Safety Symposium from NH JAX Commanding Officer Capt. Bruce Gillingham.

ONE MISSION, ONE TEAM

Director's Corner

We all know that the Patient Safety Program (PSP) has a critical and meaningful mission: to create a safe patient environment. But how do we accomplish such an important, daunting task? We lean on each other's strengths. We get ideas from each other, pool our resources, and move forward, together, to make patient safety happen. We work as one team.

Often we look to the leaders to set the example for the rest of us. Our MHS leadership is no exception. Our Patient Safety Managers and Patient Safety Service Leads have paved the way towards a safer patient environment. They have shouldered the responsibility of bringing the patient safety issue to the forefront of their priorities, sharing new ideas with each other and their staff. They give feedback that helps us shape the direction of the Patient Safety Program.

I want to thank all of our leaders for your passionate and enthusiastic work.

How do we keep the momentum going? Teamwork. Collaboration. Creativity. It is now up to the rest of us to foster our culture of teamwork and learn more about the ways we can increase patient safety.

Here's where to start. Visit the Patient Safety Program Website (<http://www.dodpatientsafety.net/>) to get information on program relevant issues. Use the Patient Safety Learning Center (PSLC) (information located on the PSP Website) to share lessons learned, to communicate with your colleagues, and to see how and where you can help implement safety practices. The Patient Safety Program collaborates with our National and Federal partners. These agencies include the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), the Veterans Health Administration (VA) National Center for Patient Safety (NCPS), the National Patient Safety Foundation (NPSF), and the Joint Commission of Accreditation on Healthcare Organizations (JCAHO).

Each person makes a difference. But as a team we are stronger. I look forward to working with you side-by-side as we strive to improve patient safety.

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



COMING SOON: THE PATIENT SAFETY REPORTING SYSTEM

Taking Patient Safety to the Next Level

In the Spring of 2010, nine sites (three from each Service) will pilot test the Patient Safety Reporting System (PSR), a web-based application that will standardize reporting across the MHS (Military Health System) enterprise by allowing the MHS to capture, track and trend healthcare events. Following this final test phase, PSR will be implemented across the MHS Direct Care system. Facility staff will use the PSR to report both medication and non-medication-related events with a single tool, allowing for a consolidated and streamlined event monitoring system.

The PSR is an important step in advancing patient safety: by reporting events with PSR, you will help identify areas for patient safety improvement in the MHS. Stay tuned for more information. In the meantime, facilities should submit events until PSR is available through Monthly Summary Reports and JAMRS.

2009 PATIENT SAFETY AWARD WINNERS

2010 Military Health System Conference

The Office of the Chief Medical Officer (OCMO) at TRICARE Management Activity (TMA), sponsor of the Department of Defense (DoD) Patient Safety Awards has just announced the 2009 award recipients:

- U.S. Naval Hospital Guam – Teamwork Training and Skill Building, Hospital Facility
- 15th Medical Group, Hickam Air Force Base – Teamwork Training and Skill Building, Ambulatory Facility
- Brooke Army Medical Center – Identification and Mitigation of Risks and Hazards, Hospital Facility
- Kenner Army Health Clinic – Identification and Mitigation of Risks and Hazards, Ambulatory Facility
- 99th Medical Group, Nellis Air Force Base – Culture Measurement, Feedback and Intervention

The awards will be presented at the **Military Health System Conference, January 25-28, 2010, Gaylord National Hotel and Convention Center, National Harbor, Maryland**. The DoD Patient Safety Program will host a number of breakout sessions at the MHS conference. The sessions will highlight initiatives underway and perspectives from the field on leadership engagement, creating a culture of safety, and medical simulation. In addition, the 2009 Patient Safety Awardees will share their award-winning initiatives, and will be honored at a formal awards presentation. Visit www.health.mil for the most current information on the MHS conference and agenda.

SHARE OUR KNOWLEDGE

Lessons Learned from the TapRoot® Summit

In September, five DoD MHS representatives attended Systems Improvement's Annual TapRoot® Summit. The 3-day Summit in Nashville, TN covered current trends and topics in the field of "Safety" from a variety of industries including nuclear, petroleum, aviation, and health care. Many issues and best practices regarding incident investigations and prospective analyses were universal across industries. Salient themes from the perspective of the DoD attendees have been compiled to "share knowledge" throughout the MHS.

Lead Change

- Provide responsive, nurturing, collaborative work environments - involve sharp end staff in manufacturing their own work processes to foster ownership of that process.
- "Put your face in the place" - Understand obstacles faced at the sharp end. Ask employees often what is not working and how it can be improved. Many changes are derived from listening to employees.
- Be the change you seek - Leaders should start with themselves in establishing a personal commitment to change. This translates into motivating and encouraging staff to be change agents.

Understand, Incentivize, Reward

- Incentivize hard fixes (engineering controls) as corrective actions – require that 50% of corrective actions in RCAs are fixes that are more effective and long-lasting based on a hierarchy of corrective actions; establish a reward system based on the fixes or controls implemented.
- Understand and change motivators/benefits for performing unsafe acts - Identify causes or motivators for performing shortcuts (i.e., takes less time, unable to follow policy as written); understand what the rationale/benefit is for performing a shortcut/work-around (i.e., see more patients); identify implicit rewards that incentivize shortcuts (e.g., facility may emphasize productivity and cost savings over safety/quality); change motivators and rewards (processes and culture) so that there is less incentive for performing shortcuts. Align expectations of staff with resources and culture that facilitate not defeat safe delivery of health care.

Emphasize Proactive Not Reactive

- Shift emphasis of managing safety towards prospective process evaluation – dedicate resources towards identifying weaknesses in processes that could manifest in a safety event. All employees should take personal accountability (as opposed to blame) for what they do and how they perform.

Share Best Practices/Useful Approaches

- Close calls – rate severity of close calls based on potential for harm and conduct RCA process accordingly. This is useful to facilities with low-risk profiles that infrequently experience sentinel events.
- Establish checklist for completing RCAs and FMEAs – help ensures that all parts of the process are completed and understood by people not directly involved.
- Provide just-in-time refresher training – reorient facilities to RCA process and software every 6 months to avoid becoming unfamiliar
- Utilize TapRoot® to fullest potential – TapRoot® can be used for other safety evaluations in MTFs such as safety drills and as a resource for facilities engineers and safety staff at MHS MTFs
- Other software – Modeling software can depict the movement/actions/interactions of people and equipment involved in an accident. In a health care context, it could be used to produce three dimensional examples of effective ways to perform a task (e.g., a timeout, or outpatient medication reconciliation). Other software can be used to evaluate and predict intervention effectiveness, and optimizing resource hours committed to safety activities.

For further information, contact Erin Lawler (lawlerl@afip.osd.mil or 301-295-8125).

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PATIENT SAFETY IN ACTION

Experience and Suggestions From Across the MHS

YOKOTA INTRODUCES TeamSTEPPS SIMULATOR LAB Scenarios Reinforce Communication Skills

At Yokota Air Base, Japan, Patient Safety Program Manager Scott Chittenden, BSN, HRM, MBA has collaborated with Maj Stephen Sapiera, Group Education and Training Chief to design a TeamSTEPPS Simulator Lab for incoming staff. The Lab provides a “hands-on” approach to learning the fundamentals of TeamSTEPPS. Students participate in a variety of scenarios where they practice and enhance communication skills.

Yokota is no stranger to simulation training and the benefits it provides. Last year the hospital introduced the Mobile Obstetric Emergency Simulator (MOES), which recreated common obstetric emergency situations. Specific TeamSTEPPS skills relating to these emergencies were incorporated into the MOES drills, with the stated goal of improving both technical proficiency and team performance in the obstetrics arena.

With the introduction of the TeamSTEPPS Simulator Lab, Yokota has expanded its focus on teamwork and communication. Newly arriving staff experience a diverse set of scenes – conflict resolution, incorrect verbal medication order, code blue, cross-monitoring. Each vignette is designed to elicit and promote a TeamSTEPPS skill – use of a DESC (describe, explain, state, consequence) script, two-challenge rule, team huddle, check-back, debrief, hand-off, task assistance and timely feedback. As in the MOES training, the TeamSTEPPS simulation utilizes a high-fi-

delity mannequin, as well as actors, and students are observed and coached by instructors throughout their training.

Eventually Yokota plans to use the TeamSTEPPS Simulation Lab to support refresher training to sustain communication skills among all trained staff. For now, incoming staff are assured an introduction to TeamSTEPPS and a chance to become proficient with the TeamSTEPPS tools.

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TeamSTEPPS Simulation Training, Yokota Air Base, Japan. Pictured left to right: Capt Mikel Merritt, Psychologist; SrA Sheena Smith, Dental Asst.; Mr. Scott Chittenden, Instructor; TSgt Erik Baker, WRM NCOIC; A1C Omar Hue, Med Tech, Family Care.

PATIENT SAFETY PROGRAM NEWSLETTER

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PATIENT SAFETY AWARENESS WEEK

March 7-13, 2010

LISTEN UP! PLAN NOW FOR PATIENT SAFETY AWARENESS WEEK

This photo from the Naval Medical Center, Portsmouth 2009 Patient Safety Awareness Week (PSAW) celebration shows just how creative patient safety awareness activities can be. Begin planning now for your PSAW observations. As members of Stand Up for Patient Safety, DoD in-patient and ambulatory facilities can receive a FREE PSAW toolkit. Access the National Patient Safety Foundation website: www.npsf.org/hp/psaw for ideas, materials and order forms.

