Defense Health Agency

PROCEDURAL INSTRUCTION

SUBJECT: Ready Reliable Care Safety Communication Bundle

References: See Enclosure 1

1. <u>PURPOSE</u>. This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (t), establishes the Defense Health Agency's (DHA) procedures to assign responsibilities and establishes procedures for implementing, measuring, and sustaining Ready Reliable Care (RRC) Safety Communication Bundle.

2. <u>APPLICABILITY</u>. This DHA-PI applies to:

   a. The DHA, DHA components (activities under the authority, direction, and control of DHA), the Military Departments (MILDEP), and all military medical treatment facilities (MTF).

   b. All personnel, to include: Assigned or attached Active Duty and Reserve Component members, federal civilians, members of the Commissioned Corps of the Public Health Service, contractors (when required by the terms of the applicable contract), and other personnel assigned temporary or permanent duties at DHA, to include DHA components.

3. <u>BACKGROUND</u>. DHA is committed to the delivery of safe, high-quality care to all beneficiaries. As the Military Health System (MHS) aims to become a high reliability organization (HRO), it is essential to learn from errors made in the past to create conditions for the delivery of the safest care in the future, and to implement processes to facilitate early recognition, communication, and mitigation of risk to move toward zero preventable harm.

   a. Reviews of DoD Reportable Event data show communication breakdown and the lack of leadership emphasis on the use of standardized patient safety policies and procedures as two significant patient safety vulnerabilities.

   b. In addition, respondents to recent MHS Patient Safety Culture Survey identified high rates of reported burnout across the MHS workforce. Survey analyses revealed higher burnout rates and higher reported workplace chaos were associated with lower teamwork within and across

units. Clinician burnout is nationally recognized as a threat to patient safety. Improving teamwork and communication are considered among the most effective strategies to target multiple burnout drivers.

c. Based on this information, leadership commitment to safe practices and a culture of safety through standardized procedures serving as the backbone of a safe, reliable, high-performing organization; DHA will implement the RRC Safety Communication Bundle as a strategy to focus on patient safety and ensure safe care and a safe environment for staff.

4. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (d) through (n), that the RRC Safety Communication Bundle policy will be implemented in all MTFs in the DHA. This policy:

a. Establishes Clinical Quality Management (CQM) procedures in the DHA to provide an integrated framework for implementation, measurement, and sustainment of the RRC Safety Communication Bundle.

b. Strengthens DHA CQM accountability, transparency, and standardization related to the RRC Safety Communication Bundle.

c. Affirms the DHA's unwavering commitment to quality health care for our beneficiaries, joint healthcare teams, and Combatant Commands across the globe, through CQM.

5. RESPONSIBILITIES: See Enclosure 2.

6. PROCEDURES. See Enclosure 3. A comprehensive Implementation Guide may be accessed through the Patient Safety Learning Center. The Implementation Guide contains more detailed descriptions of the implementation, measurement, and sustainment processes, related to the RRC Safety Communication Bundle.

7. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director (DAD), Medical Affairs (MA). When Markets and MTFs are unable to comply with this publication the activity may request a waiver that must include a justification, to include an analysis of the risk associated with not granting the waiver. The Director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if Director, DHA or their designee may grant the waiver.

8. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the Health.mil site at: https://health.mil/Reference-Center/Policies and is also available to authorized users from the DHA SharePoint site at: https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx.

9. <u>EFFECTIVE DATE</u>. This DHA-PI:

  a. Is effective upon signature.

  b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (c).

10. FORMS. The following DHA forms can be found on the internet at: https://info.health.mil/cos/admin/DHA_Forms_Management/Lists/DHA%20Forms%20Management/AllItems.aspx.

  a. DHA Form 206, Dental Universal Protocol Compliance Report

  b. DHA Form 228, Universal Protocol Checklist Operating Room Version

  c. DHA Form 229, Universal Protocol Checklist Procedural Version

  d. Optional Form (OF) 522, Medical Record–Request for Administration of Anesthesia and Performance of Operations and Other Procedures

/S/
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LTG, MC, USA
Director

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended

(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013

(c) DHA Procedural Instruction 5025.01, "Publication System," August 24, 2018

(d) Dai M., Willard-Grace R., Knox M., Larson S.A., Magill M.K., Grumbach K., et al. "Team Configurations, Efficiency, and Family Physician Burnout" Journal of the American Board of Family Medicine, 2020 Mau-June; 33(3): 368-377[1]

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(f) DHA-Procedures Manual 6025.13, "Clinical Quality Management in the Military Health System, Volume 2: Patient Safety," August 30, 2019

(g) Military Health System Leadership Engagement Toolkit, Department of Defense Patient Safety Program, December 2017[3]

(h) National Academies of Sciences, Engineering, and Medicine; "Taking Action against Clinician Burnout: A systems approach to professional well-being" *National Academies Press* (US), October 23, 2019[4]

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(j) Perlo J., Balik B., Swensen S., Kabcenell A., Landsman J., Feeley D. "IHI Framework for Improving Joy in Work" Institute for Healthcare Improvement White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017[6]

(k) DHA Ready Reliable Care website[7]

(l) DHA Ready Reliable Care Safety Communication Bundle Implementation Guide. DHA Patient Safety Program, September 25, 2021[8]

(m) Scoville R., Little K., Rakover J., Luther K., Mate K. "Sustaining Improvement" Institute for Healthcare Improvement White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016[9]

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[3] This reference can be found at: https://info.health.mil/hco/clinicsup/patientsafety/PSLCHome/SitePages/leadership.aspx#1
[4] This reference can be found at: doi: 10.17226/25521
[5] This reference can be found at: doi: 10.1097/JHQ.0000000000000016
[6] This reference can be found at: http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
[7] This reference can be found at: https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Ready-Reliable-Care
[8] This reference can be found at: https://info.health.mil/hco/clinicsup/patientsafety/PSLCHome/RRC/Documents/
[9] This reference can be found at: http://www.ihi.org/resources/Pages/IHIWhitePapers/Sustaining-Improvement.aspx

(n)   Smith, C. D., Balatbat C., Corbridge S., et al. "Implementing Optimal Team-Based Care to Reduce Clinician Burnout" *NAM Perspectives*. Discussion Paper, National Academy   of Medicine, Washington, D.C. September 17, 2018[10]

(o)   Agency for Healthcare Research and Quality, TeamSTEPPS® website[11]

(p)   TeamSTEPPS® DoD Public website[12]

(q)   TeamSTEPPS® DoD Secure website[13]

(r)   The Joint Commission Universal Protocol website[14]

(s)   United States Code, Title 10, Section 1102

(t)   DHA Procedural Instruction 6410.02, "Dental Universal Protocol," May 21, 2021

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ENCLOSURE 2

RESPONSIBILITIES

1. <u>DIRECTOR, DHA</u>. The Director, DHA, will:

a. Ensure Markets, Small Market and Stand-Alone Medical Treatment Facility Organization (SSO), and Defense Health Agency Regions (DHAR) assign responsibilities to implement RRC Safety Communication Bundle in all clinical and non-clinical areas, as outlined in this DHA-PI.

b. Support the Medical MILDEPs, Markets, SSOs, DHARs, and MTFs by identifying standard clinical, business, and administrative process changes or requirements, and assign resolution to the appropriate directorate within DHA.

c. Assign responsibility for tracking compliance with the standard processes and criteria as outlined in this DHA-PI to the DAD-MA.

2. <u>ASSISTANT DIRECTOR, HEALTHCARE ADMINISTRATION</u>. The Assistant Director, Healthcare Administration will establish direct implementation of, and ensure compliance with, standards and procedures in this DHA-PI.

3. <u>DAD-MA</u>. The DAD-MA will:

a. Ensure implementation of the requirements established by this DHA-PI within the MTFs.

b. Manage standardization of the data, measures, reporting, and analysis addressing compliance with the procedures in this DHA-PI.

4. <u>SECRETARIES OF THE MILDEPS</u>. The Secretaries of the MILDEPs will assist DHA in ensuring compliance with the guidance in this publication, where practicable in the operational setting.

5. <u>DIRECTORS, MARKETS, SSO, AND DHARS</u>. The Directors, Markets, SSO, and DHARs, will:

a. Review quarterly data collection related to safety practices adherence and provide a status update to DAD-MA.

b. Provide consultation, subject matter expertise, and coaching support for implementation of this DHA-PI.

   c. Disseminate this DHA-PI and updates to all MTF Directors.

6. <u>DIRECTOR, MTF</u>. The Director, MTF, is responsible for the care and safe care practices provided at the MTF, and will:

   a. Submit a quarterly data collection report to the Director, Market, SSO, or DHAR within 45-calendar days of the end of the quarter.

   b. Hold leaders, healthcare providers, supervisors, and staff accountable for implementation, measurement, and sustainment of the safety practices as outlined in this DHA-PI.

   c. Disseminate this DHA-PI and all updates to all MTF healthcare providers and healthcare personnel.

7. <u>MTF LICENSED STAFF MEMBER</u>. MTF licensed staff members will comply with procedures detailed in this DHA-PI.

ENCLOSURE 3

PROCEDURES

1. READY RELIABLE CARE SAFETY COMMUNICATION BUNDLE: OVERVIEW

a. RRC is the DHA's approach to increasing high reliability across the MHS. It builds on the existing work and best practices of the Service medical departments and the DHA. RRC works across clinical and non-clinical settings to drive better outcomes for patients, staff, and the enterprise, with the aim of zero preventable harm. This approach is a critical part of how to get everything else right. MHS leaders and staff contribute to high reliability by embodying seven RRC Guiding Principles in their daily work. These Guiding Principles serve as the foundation for four Domains of Change, the organizational changes necessary to progress toward high reliability. The RRC Safety Communication Bundle operationalizes the Domains of Change and exemplifies the Guiding Principles. More information on DHA RRC may be found in Reference (k).

b. The RRC Safety Communication Bundle consists of six Practices: (1) Leader Daily Safety Brief, (2) Safety Leadership Rounds (SLR), (3) Unit-Based Huddles, (4) I-PASS (Illness Severity-Patient Summary-Action list-Situational awareness contingency Planning-Synthesis by receiver), (5) Surgical Brief/Debrief, and (6) Universal Protocol (UP). This is foundational to a supportive organizational culture, focusing on trust and respect to promote early identification and reporting of safety concerns which will create a healthy work atmosphere free of culture-related stressors contributing to staff burnout. Leaders at all levels must foster an atmosphere of mutual trust and respect that empowers all to speak up when safety concerns are identified and, when appropriate, take actions to mitigate risk and resolve preventable workplace stressors leading to workforce burnout. All leaders, healthcare providers, and staff must understand their roles in supporting a work environment that promotes team and individual well-being and resilience.

c. The Practices are designed to apply to clinical and non-clinical areas. Some departments and units may use all the Practices and some may not, depending upon the services provided in the facility, as follows:

(1) Daily Safety Brief: Command suite senior leaders, all MTF Department and Unit Leaders, and Patient Safety and Quality Officers participate.

(2) Senior Leadership Rounds: Command suite senior leaders facilitate; all clinical andb non-clinical units/departments participate.

(3) Unit-Based Huddle: All clinical and non-clinical units/departments conduct at least daily and more frequently as needed.

(4) I-PASS: Conducted in all clinical units for all transitions in care.

(5) Brief/Debrief: Brief conducted by Operating Room (OR) teams and Procedural Areas; debriefs using Operating Room Debrief Issue Tracker (ORDIT) are conducted by OR teams.

(6) UP: Conducted by OR teams and Procedural Areas.

    d. Though leaders are committed to and are involved in all the Practices, Practices 1 through 3 directly involve leaders daily. Practice 1, Leader Daily Safety Brief, is led by command suite senior leaders, but it is critical for leaders at all levels to identify and discuss issues that have occurred or are likely to occur. Practice 2, SLR, is led by the command suite senior leaders. Clinical and non-clinical units, departments, and work areas participate. Information from Practice 3, Unit-Based Huddles, may be a source of information for discussion during the Leader Daily Safety Brief. Information from Practices 1 and 3, Leader Daily Safety Brief and Unit-Based Huddles, may guide discussion during Practice 2: SLR. See Reference (l) for more information.

2. SUMMARY: RRC SAFETY COMMUNICTION BUNDLE PRACTICES

    a. PRACTICE 1: LEADER DAILY SAFETY BRIEF

        (1) Purpose: A brief meeting of the command suite senior leaders, all MTF Department and Unit Leaders, and Patient Safety and Quality Officers to provide updates on events from the past 24 hours and projections for the next 24 hours. The focus is on patient and staff safety and quality care for a shared situational awareness, promoting early identification and resolution of problems. Detailed guidelines for conducting the Leader Daily Safety Brief are in the Implementation Guide, accessed through Reference (l).

        (2) Who: Led by the Director, MTF or Senior Leader.

        (3) When: A 15 minute brief that occurs daily at the start of the day.

        (4) What: The topic order for each reporting participant:

        (a) Look Back at:

            1. Significant safety or quality concerns and issues in the past 24 hours.

            2. Any reported Joint Patient Safety Reporting events related to staffing, equipment, or patient safety in the past 24 hours.

            3. Any DHA Patient Safety Alerts/Advisories from defective medical products or devices that were already released (by Federal Drug Administration) for use in health care.

            4. DHA Patient Safety Healthcare Event Analysis Response Team messages with specific triggering events at MTFs.

<u>a</u>. Remedial actions taken.

<u>b</u>. Potential to occur in other areas.

<u>c</u>. Potential impact on other areas.

(b) Look Ahead at:

<u>1</u>. Anticipated safety or quality concerns and issues in the next 24 hours.

<u>2</u>. Mitigation efforts to prevent future occurrence.

<u>3</u>. Team preparation to prevent occurrence.

<u>4</u>. Error-prevention staff behaviors to prevent occurrence.

<u>5</u>. Patient and family involvement to prevent occurrence.

<u>6</u>. Communication plan for prevention of potential occurrence.

(c) Follow-Up:

<u>1</u>. Maintain record or database of concerns and issues discussed and mitigated, to include dates, department, or unit addressing the issue.

<u>2</u>. Provide status report on concerns and issues previously identified.

b. <u>PRACTICE 2: SLR</u>

(1) Purpose: A routine, planned event for MTF senior leaders to visit clinical and non-clinical areas and speak to staff about quality, safety, areas of potential risk, and policy compliance to improve the reliability of care and promote a culture of safety and workforce well-being. Detailed guidelines for conducting the SLR are in the Implementation Guide, found in Reference (l).

(2) Who: Led by the Director, MTF and other MTF command suite senior leaders.

(3) When: Weekly, for 15–20 minutes for each unit or department.

(4) What: The format for SLRs is as follows:

(a) Develop a set of planned questions to ask staff based on current safety concerns identified in Patient Safety reports, the Leadership Daily Safety Brief, or Culture Survey.

(b) Assign roles to members of the Leadership Team doing the rounds.

(c) Prepare opening and closing statements, potential topic questions.

<u>1</u>. Opening statement: Promotes transparent, blame-free conversation.

<u>2</u>. Open-ended topic questions: Centered on pre-specified areas of potential risk (operational processes, potential safety concerns, and actionable workplace stressors).

<u>3</u>. Closing statement: Promote understanding, sharing, and co-creating the method to ensure effective feedback.

(5) Post-rounds debrief provides the opportunity to synchronize and:

(a) Develop Action Plan from list of findings.

(b) Maintain record or database of SLR.

(c) Monitor progress of items identified, actions taken, or date resolved.

(d) Share findings and/or actions with facility leadership and unit within 30 days of discovery.

c. <u>PRACTICE 3: UNIT-BASED HUDDLE (UBH)</u>

(1) Purpose: The UBH establishes and maintains a shared mental model on the plan for the day, shift, or event of care. It is a method to communicate, collaborate, and coordinate with core team members, as defined by TeamSTEPPS®, on the medical or operational plan. The multi-disciplinary team provides the collective wisdom of all team members focused simultaneously on the needs of the patient.

(2) What: A planned event conducted by all MTF departments, units, and work centers.

(3) Who: Core team members; those essential to safely progressing medical plans of care and operations; includes physicians, dentists, nurses, technicians, social worker, pharmacy, etc. The huddle team may invite and engage the patient to participate in their care.

(4) When: Daily, at start of day, shift, or whole team change—up to 20 minutes. Should any team member lose situational awareness of the plan or operations, they must call a quick team huddle with Core Team members to restore their situational awareness related to planning, problem solving, and staying in safe forward action.

(5) Additionally:

(a) The UBH refers to a team planning session. In TeamSTEPPS®, it is called the team "Brief." A checklist for conducting the Unit-Based Huddle is in the Implementation Guide and may be accessed in Reference (l).

(b) The multi-disciplinary UBH is not the same as the patient handoff of care across the continuum. That is Practice 4; I-PASS is the tool for handing over the patient and their information from one care team member to another.

d. <u>PRACTICE 4: I-PASS UTILIZATION FOR TRANSITIONS OF CARE</u>

(1) Purpose: I-PASS is a verbal mnemonic to communicate information during a transition in care; for example, during change of shift from one nurse or provider to another, or during an inter-unit or inter-facility transfer of care. I-PASS is an evidence-based bundle of interventions shown to significantly decrease communication errors during patient care handoffs. It is centered around a verbal mnemonic: I = Illness Severity (e.g., Stable, "Watcher", Unstable); P = Patient Summary (e.g., summary statement, events leading up to admission, hospital course, ongoing assessment/plan); A = Action List (to do list, timeline, and ownership); S = Situational Awareness and Contingency Planning (know what's going on; plan for what might happen, e.g., "if this happens, do this…"); S = Synthesis by Receiver (receiver summarizes what was heard; asks questions; restates key action/to do items). A written, printed, or electronic handoff document that is organized in I-PASS format should also accompany the verbal handoff but should not serve as a substitute for verbal communication. A detailed example of an I-PASS verbal handoff and an I-PASS printable version is in the Implementation Guide and may be accessed through Reference (l).

(2) Who: All Clinical Services; all team members involved in a patient's care—both currently and after the transition.

(3) When: Required during a transition in care.

NOTE: I-PASS and Situation-Background-Assessment-Recommendation/Request (SBAR) are not interchangeable. If a patient's condition has changed but there is not a transition in care, the tool of choice remains SBAR. SBAR ensures communication of critical information requiring immediate attention and action concerning a patient's condition.

e. <u>PRACTICE 5: SURGICAL BRIEF/DEBRIEF</u>

(1) Purpose: The Surgical Brief is a short team planning session prior to the start of an invasive procedure to discuss the plan and team formation, assign roles and responsibilities, establish expectations and climate, and anticipate outcomes and likely contingencies. The goal is to ensure all surgical and procedural team members are informed about key components of upcoming surgery/procedure, empower all team members to speak up for safety concerns, and utilize lessons learned to continually improve patient safety. The Surgical Debrief is a peer review and information exchange session, protected pursuant to Reference (s), required after all procedures conducted in the OR with the surgical team. It is designed to improve team performance and effectiveness through identifying and analyzing Lessons Learned, followed by recognizing and reinforcing positive behavior. It also directs the collection of information through the DHA ORDIT).

(2) Who: Entire surgical team to include staff surgeon, resident, intern, staff anesthesia, circulating nurse, surgical technician, students, etc.

(3) When:

(a) The Surgical Brief occurs prior to the start of an invasive procedure (in the OR and other procedural areas), prior to opening instruments, and prior to the patient arriving.

(b) The Surgical Debrief occurs at the end of a case in the OR after final counts are confirmed and before any team member leaves the room; recommended timing is during skin closure.

(4) How: Surgical Brief and Debrief checklists are available in the Implementation Guide (see Reference (l)).

f. <u>PRACTICE 6: DHA UNIVERSAL PROTOCOL</u>

(1) Purpose: Practice 6 provides a standardized procedure for conducting the three components of the UP: pre-operative/pre-procedure verification, marking the operative/procedural site, and a time-out immediately before starting the procedure. The UP applies to all surgical and other invasive procedures, regardless of location. It is a team activity based on the principle that wrong-patient, wrong-procedure, and wrong-site/wrong-side surgery can and must be prevented.

(2) How: The team will document the process using the appropriate DHA UP checklist:

(a) DHA Form 228, "Universal Protocol Checklist Operating Room Version"

(b) DHA Form 229, "Universal Protocol Checklist Procedure Version"

(c) DHA Form 206, "Dental Universal Protocol Compliance Report"

(3) What:

(a) <u>Pre-procedure verification process</u>: The pre-procedure verification is an interdisciplinary collaborative process to ensure the correct patient receives the intended procedure at the intended site with all necessary equipment or supplies available. It is purposefully designed with multiple redundancies in place to decrease the risk of zero preventable harm events. Every member of the surgical team is expected to actively engage in this process. Minimum requirements are:

<u>1</u>. For surgical procedures, the elements of the pre-procedure verification will be completed by a licensed staff member. For procedures outside the OR, it is recommended that the elements of the pre-procedure verification be completed by a licensed staff member if one is available.

2. Whenever possible, pre-procedure verification should occur with the patient (or guardian) involved, awake and aware, and be performed prior to the administration of medications that may result in an altered level of consciousness or orientation (e.g., sedation).

3. The process confirms the patient's identification (full name and date of birth) verbally with the patient or guardian and, for procedures conducted in the OR, visually using the patient's armband. It also confirms the patient's identification is consistent with signed consent(s) and other relevant documents.

4. The applicable team members will verify the patient's planned procedure and site and match relevant documented procedural plans (e.g., procedure consent).

5. When the patient is in the pre-procedure area and immediately prior to moving the patient to the procedural area, the procedure team members verify the following items are available and accurately matched to the patient (any discrepancy will be immediately reported to the provider performing the surgery or procedure):

a. Relevant documentation (e.g., history and physical/progress notes, pre-anesthesia assessment).

b. Accurate and complete OF 522, Medical Record–Request for Administration of Anesthesia and Performance of Operations and Other Procedures, signed by both the provider and patient, completed within the last 30 days.

c. Correct and properly labeled diagnostic laboratory and radiology test results.

d. Any required blood products, implants, devices, and/or special equipment for the procedure.

(b) Marking of the operative/procedural site: Site marking is done to prevent errors of wrong site surgery. Minimum requirements are:

1. Site markings or the alternative marking method is required for all operative and invasive procedures unless noted as exceptions. Markings should be legible and unambiguous.

2. The operating provider who is privileged to perform the procedure will mark the site using, at a minimum, the first and last initials of the marking provider. This individual must be directly involved in the procedure and must be present at the time the procedure is performed. Residents in Graduate Medical Education programs may mark the site as permitted by the MTF, if present and actively involved in the procedure.

3. When possible, the patient/guardian should participate by verifying the procedure and site to be marked.

    <u>4</u>. The site will be marked prior to moving the patient to the procedural area. If the procedure is performed in an area other than a surgical suite, such as a clinic office, the site will be marked prior to the time-out.

    <u>5</u>. The mark must be made with an indelible marker that remains visible after site prepping and draping are completed. If the mark is removed during prepping, the operating provider must mark the surgical site again prior to the time-out.

    <u>6</u>. The alternate marking method is used in cases when it is not possible for the provider to mark the site with their initials. The primary alternate marking method is to mark the patient's procedure identification band. For information on marking dental sites, see Reference (t).

    (c) <u>Time-out</u>: A time-out is a pause immediately before the start of a surgical or other invasive procedure during which the team verbally agrees the correct patient, site, and procedure are identified. In some cases, a procedure may require multiple time-outs (e.g., surgical procedures done under spinal anesthesia require two time-outs: one for anesthesia and the second for the actual surgical procedure). If two or more procedures are conducted on the same person, a separate time-out must be conducted for each.

    <u>1</u>. The time-out is led by the operating provider and involves participation of the entire procedural team, to include the patient in some settings. All procedural team members must actively listen and remain engaged during the time-out.

    <u>2</u>. The time-out confirms:

    <u>a</u>. The correct patient is present by confirming the patient identification band against the consent.

    <u>b</u>. The correct OF 522 is present and team members agree on the planned procedure.

    <u>c</u>. The correct site is identified and marked with the provider's initials, or an alternate marking method is used.

    <u>d</u>. The patient's position is appropriate for the planned procedure.

    <u>e</u>. Relevant images and test results are properly labeled and appropriately displayed.

    <u>f</u>. The required items are available (e.g., equipment, implants, blood products).

    <u>g</u>. The need to administer antibiotics and/or fluids for irrigation purposes has been addressed.

h. Safety precautions based on patient's history or medication use have been identified.

i. The Fire Risk Assessment is complete and need for identified mitigation strategies addressed before the start of the procedure.

3. Each team member is accountable for speaking up and working toward reconciling any discrepancy with the information exchanged during the time-out. If a discrepancy cannot be reconciled, the team will stop the procedure immediately and complete the appropriate patient safety documentation.

ENCLOSURE 4

INFORMATION COLLECTION

1. <u>MEASUREMENT AND REPORTING OVERVIEW</u>

a. RRC means consistent excellence in quality and safety across all services maintained over long periods of time. As the MHS advances in maturity (from beginning, to developing, to advancing, to approaching) toward high reliability, leadership commits to achieve zero preventable harm, instills a culture of safety, and marries it to a continuous process improvement system. The result is a learning organization that learns and improves from its successes and failures and celebrates transparency and contributions from every individual regardless of their position.

b. Toward this end, measuring and reporting of the RRC Safety Communication Bundle Practices will be required for all MTFs on a quarterly basis, through the appropriate Market Leads. Targeted Performance Improvement Measures will focus on implementing and sustaining the Practices.

c. When implementing and evaluating the impact of the RRC Safety Communication Bundle Practices, individual facilities may track changes in staff burnout levels and/or fulfillment. These assessments are currently optional and for local use; reporting of results is not required by this policy.

2. <u>MEASUREMENT AND REPORTING PROCESS</u>

a. When:

(1) MTFs will report quarterly, within 45-calendar days of the end of each quarter, through the appropriate Market.

(2) MTF measurement data will be aggregated to the Market level for reporting, on a quarterly basis.

b. Who:

(1) The Director, MTF is responsible for ensuring reporting requirements are maintained.

(2) MTFs may identify staff members to support in data collection and reporting.

(3) Market Patient Safety Managers will support the collection and reporting of the data for their facilities.

(4) Final quarterly reports will be signed and owned by one individual at the MTF, a Patient Safety Professional or equivalent.

c. How: RRC Safety Communication Bundle data will be reported through several channels:

(1) ORDIT: Records debrief of OR cases.

(2) Tracers with Accreditation Manager Plus®: A software tool to help evaluate how safety practices are conducted across the enterprise, as well as a tool to collect data on safety practices.

(3) DHA Data Collection Site: Provides a template for MTFs to use as they collect data necessary to measure the performance of the RRC Safety Communication Bundle Practices; automatically totals the data for ease of reporting in SharePoint at the end of the quarter.

d. What: A list of Targeted Performance Improvement Measures with detailed descriptions is in the Implementation Guide and may be accessed through Reference (l).

<u>GLOSSARY</u>

<u>PART I. ABBREVIATIONS AND ACRONYMS</u>

CQM	Clinical Quality Management
DAD-MA	Deputy Assistant Director, Medical Affairs
DHA	Defense Health Agency
DHA-PI	Defense Health Agency Procedural Instruction
DHAR	Defense Health Agency Regions
HRO	High Reliability Organization
I-PASS	Illness Severity-Patient Summary-Action List-Situational Awareness and Contingency Planning-Synthesis by Receiver
MILDEP	Military Departments
MHS	Military Health System
MTF	Military Medical Treatment Facility
OF	Optional Form
OR	Operating Room
ORDIT	Operating Room Debrief Issue Tracker
RRC	Ready Reliable Care
SBAR	Situation-Background-Assessment-Recommendation/Request
SLR	Safety Leadership Rounds
SSO	Stand-Alone Medical Treatment Facility Organization
TeamSTEPPS®	Team Strategies and Tools to Enhance Performance and Patient Safety
UBH	Unit-Based Huddles
UP	Universal Protocol

<u>PART II. DEFINITIONS</u>

<u>Compliance</u>. The ongoing process of meeting the legal, ethical, and professional standards applicable to a particular healthcare organization or provider; conformity in fulfilling official requirements.

<u>MTF</u>. Established for the purpose of furnishing medical care, dental care, or both to eligible individuals in the MHS.

Procedural Area. An OR, cardiac catheterization or interventional suite, radiation or nuclear medicine area, treatment or procedure room, patient room, emergency room, clinic room, or any other location where surgical or invasive procedures occur.

Process. A goal-directed, interrelated series of actions, events, mechanisms, or steps. Processes should always be designed with flexibility in mind and the ability to periodically introduce controlled, measurable changes.

Ready Reliable Care. The DHA approach to increasing high reliability across the MHS.

Ready Reliable Care Safety Communication Bundle. Addresses patient safety; a set of six Practices designed to improve leadership engagement, teamwork with a goal of zero patient harm.