Department of Defense (DoD) Patient Safety Program (PSP)

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THE QUEST FOR SAFE HEALTH CARE

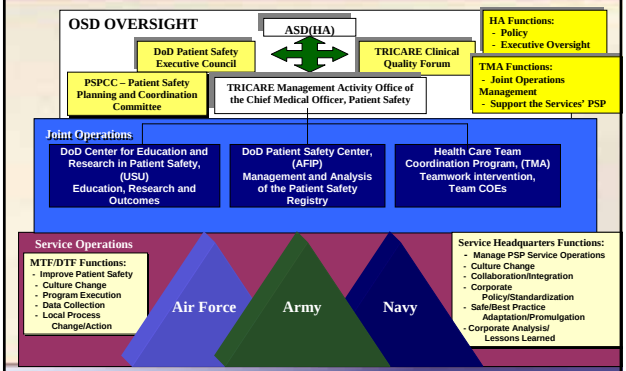
Department of Defense Legislation and Response

Date	Event
2001 Congress	**National Defense Authorization Act for FY 2001 (NDAA 2001):** established requirements for DoD PS program including a centralized error reporting system; PS program at each DoD hospital; Healthcare Team Coordination Program (HCTCP); Patient Safety Center at Armed Forces Institute of Pathology (AFIP)
Aug 2001 DoD	**DoD Inst 6025.17 "Military Health System Patient Safety Program":** defined DoD requirements for MHS Patient Safety program; addressed NDAA 2001 requirements; assigned responsibilities; defined structure; established patient safety managers; set requirement for compliance with JCAHO PS program
Dec 2003 ASD/HA	**Asst Sec Defense/ Health Affairs Policy 03-025 "Policy on Structure of the Dept of Defense Patient Safety Program":** described DoD Patient Safety program organizational structure and accountability
Jun and July 2004 DoD	**DoD 6025.13-R Military Health System Clinical Quality Assurance Program Regulation and DoD Dir 6025.13 Patient Safety Program:** updates DoD Inst 6025.17 Aug 2001

DoD PSP Vision

- **Lead the Military Health System (MHS) to a culture of safety and quality.**
- **Values:**
  - **Collaboration across the Services**
  - **Systems approach to change**
  - **Engaged leadership**
  - **Fostering trust and transparency**
  - **Improved teamwork, communication, and collaboration**

Organization Chart for the DoD Patient Safety Program



DoD Patient Safety Initiatives

Mandated by: National Defense Authorization Act 2001;
DoD Directive 6025.13 and DoD 6025.13R

Culture

- **Culture of Safety: "an integrated pattern of individual and organizational behavior, based on shared beliefs and values, that continuously seeks to minimize patient harm which may result from the processes of care delivery."**
  - » Ken Kizer, 1999. Large System Change and a Culture of Safety

…Transforming the MHS to a Culture of Safety requires more than Patient Safety Reporting…

Culture: Essential Components

- **Safety Culture is measured by the alignment of Values, Beliefs, and Behaviors.**
  - ***Values*** **are basic principles or tenets preserved by the policies, rules and methods specified by leaders to guide the organization.**
  - ***Beliefs*** **are what the members of the organization really think.***
  - ***Behaviors*** **are what the workers really do in practice. They are how people talk in meetings, the quality of questions asked, how people elevate or resolve issues, and the relationships that different organizations and individual people have when working with each other.**

Essential Component for Culture Transformation

Culture & Experience

- To change **behavior**, **attitude** must first be changed; **attitude** reflects the motivation to make a necessary change.
- To change **attitude**, it is first necessary to change **beliefs**; it is the **beliefs** that underpin and support **attitude**.
- To change **beliefs** it is usually necessary to change a person's **knowledge**.
- To change a person's **knowledge** requires their active participation; they must have a change in their **experience**.

Systems Approach Safety Culture: LEADERSHIP

- To establish a Culture of Safety the system must provide positive **experiences** and inspire confidence through adherence to the agreed upon and publicly known criteria and processes.
- *The key to establishing faith and trust in the culture of the system is to assure consistency and predictability.*
- Role of Leadership (by example) at all levels to provide, facilitate, or insure all of these components of a safe system.

PSP Strategies

Drive Organizational Change To Facilitate Quality and Safety:

- Leadership Engagement
- Data Analyses and Process Improvement
- Systems Approach
  - All levels--top down (blunt end) and bottom up (sharp end)
- Culture Survey (Assessment tool)
- Implement evidence-based "safe practices"
- Improvement Strategies for Teamwork and Communication
- Action Planning
  - Clinical Microsystems
  - Measurement
- Patient Involvement
- Training Medical Staff
  - Current & Future MHS Professionals & Combat Support Programs
  - Incorporating Simulation

…make it easy to do the right thing…

Engaged/Informed Leadership Proactive Responses

- Identify cost relationships to safety in organizational operations
  - Evaluate resource utilization
  - Site-specific history
  - Literature review: Identify patients and conditions associated with error and cost
- Utilize Proven Measures
  - Patient Safety and Quality Indicators
    - AHRQ, RAND, JCAHO, NPSF
- Educate Staff…including providers
  - Provide toolkits—patient falls, medication reconciliation, transitions in care
  - Relationship of clinical actions to resource utilization
  - Feedback
  - Open dialogue
  - Non-punitive environment

DoD Patient Safety Repository

- Hospitals and clinics report data (near-miss and adverse events) monthly to Patient Safety Center
- Collection, analysis, trending, and recommendations made at the aggregate level for DoD
- All Sentinel Events require a comprehensive Root Cause Analysis
  - Top contributing factor is inadequate communication
- Corrective Actions/Process Improvement—DoD system Alerts and Advisories
- Quarterly Reports for leadership

…In MHS, we strive to be a High Reliability Organization by having one hospital or clinic learn from incidents (or near misses) made by another facility in our system…

Patient Safety Reporting Tools

- Enterprise-wide reporting tools
  - TapRooT ®, root cause analysis to identify contributing factors to event
  - MEDMARX® medication error reporting system used by all sites --accumulating data for analysis for 3 years
- Healthcare Failure Mode and Effects Analysis (HFMEA)--ongoing, proactive program for identifying risks to safe care and reducing medical/health care errors is defined and implemented
- MHS moving to pilot a COTS Patient Safety Reporting (PSR) tool SafeCare™ 6.0, currently using a paper based monthly anonymous reporting process

Systems-Thinking in Healthcare

Perspective	Asks	Corrective Action(s)
Event	What **happened?** Who **did it?**	Reactive: **focus on individual and event**
Patterns	**Does event occur repetitively?**	Adaptive: **Adapt to the pattern, but don't change it.**
System Structure	How **did it happen?** Why **did it happen?**	Creative: **Design** new processes/systems **to** change **patterns and events**

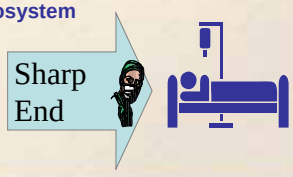
Source: Modified from Skillsoft. *What is Systems Thinking?* (NKO course STG40401)

Patient Safety Culture Survey

- Anonymous, web-based assessment tool focusing on patient safety culture sponsored and endorsed by AHRQ, AHA, JCAHO
- AHRQ maintains the benchmarking database with several hundred hospitals utilizing survey instrument
- 3 dimensions measured:
  - Leadership
  - Teamwork
  - Communications/Reporting of Errors

Engage Sharp End - Microsystems

- Individuals at the **sharp end** are in direct contact with the human-system interface.
- They administer care to patients.
- There is much they need to know!
- Their actions and decision may result in active failures.
- They work in a microsystem

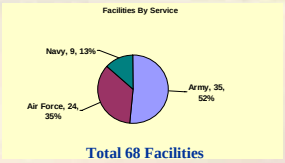


Health Care Team Coordination Program

- Collaborating with several federal agencies, regulatory agency (JCAHO) and civilian healthcare systems
- Publications (AHRQ, JCAHO and HF journals)
- Teamwork Outcomes Measures project underway (RAND)
- Longitudinal Labor and Delivery Quality Improvement Study
- Three Team Resource Centers established:
  - ❖ Army Trauma Training Center (ATTC) at Ryder Trauma Center in Miami
  - ❖ Air Force Centers for the Sustainment of Trauma and Readiness Skills (C-STARS) at Univ. of Maryland Shock Trauma Center
  - ❖ National Capital Area Medical Simulation Center at Uniform Services University of the Health Sciences

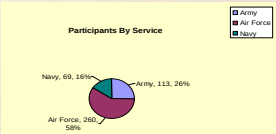
Health Care Team Coordination Program Initiatives

- Ongoing medical team training
  - ❖ "Train the Trainer"
  - ❖ In collaboration with AHRQ to make available to civilian hospitals
  - ❖ Focus on teamwork concepts, culture change, change management, implementation plans by MTF, trainer and coaching skill development, assessment and evaluation strategies and on-going consultative services
  - ❖ 5500 MHS staff trained in 2005



Total 68 Facilities

(28 Army MTF-PSM Awareness)



Total 442 Participants (new trainers)

TeamSTEPPS

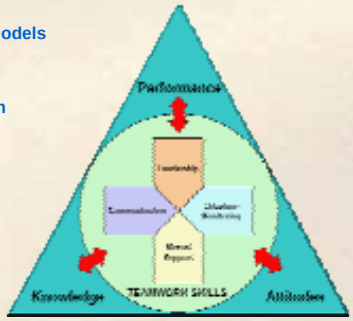
TEAM Strategies and Tools to Enhance Performance and Patient Safety

"Initiative based on evidence derived from team performance… leveraging more than 25 years of research in military, aviation, nuclear power, business and industry…to acquire team competencies"

TeamSTEPPS FRAMEWORK

OUTCOMES:

- Knowledge
  - Shared Mental Models
- Attitudes
  - Mutual Trust
  - Team Orientation
- Performance
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety

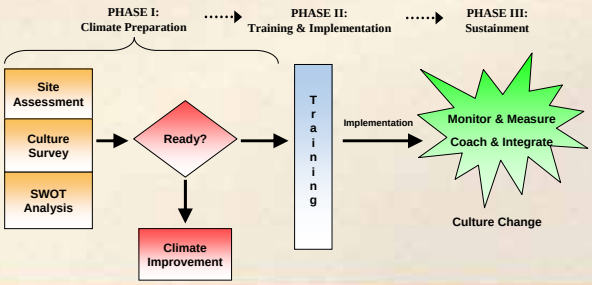


Not Just Training…It's A Teamwork System

- ✓ Lessons learned from behavioral sciences and aviation applied to medicine
- ✓ Comprehensive--teachable, learnable, and sustainable
- ✓ Focused on changing attitudes and behaviors
- ✓ Specific teamwork skills/behavioral tools
- ✓ Utilize lecture, discussion, vignettes, teamwork failures, demonstration, case studies
- ✓ Interactive learning and practice-based application (role play, simulation)
- ✓ Opportunity to practice thru feedback session
- ✓ Develop coaching and facilitation skills
- ✓ Include strategies for transition and sustainment
- ✓ Customize to unique needs of your institution

Shift Towards a Culture of Safety

Teamwork Initiative



Development of Outcome Measures for Effective Teamwork in Healthcare

Purpose:

To develop a set of measures that represent important patient safety or quality of care outcomes that can be expected to improve as a result of effective teamwork in delivering health care services

- 3 healthcare settings: Labor and Delivery, Surgical Services, and Cardiac Care in Emergency Department
- Clinical Advisory Panel (civilian and military)
- Selected measures based on potential relationship and feasibility of implementing

Next Steps:

- Comparative analysis of selected measures using DoD data to be done
- Panel will make recommendations
- Validations of candidate measures

Team Intervention in Labor and Delivery Environment Study

To determine whether MedTeams™ training in L&D Departments can improve:
- Maternal and neonatal outcomes
- Process measures - proxy for efficiency of care
- Staff and patient satisfaction

- Cluster-based randomized controlled trial (15 hospitals)
- Data base: Total 45,622; 28,356 deliveries pre & post intervention
- Results were inconclusive

Longitudinal Labor and Delivery Quality Improvement Study

Purpose:
- An evaluation of quality improvement (QI) initiatives currently being undertaken by hospital labor and delivery (L&D) units in five hospitals; two military and three civilian hospitals.
- To conduct a process evaluation of the implementation process, as well as assessment of the impact of the teamwork improvement on selected L&D outcomes.
  - Using TEAMSTEPPS curriculum and DoD training intervention model with ongoing coaching and consultation
  - Activity tracking, staff perception, and teamwork behavior observations
  - Labor and delivery patient outcomes tracked by National Perinatal Information Center

Team Resource Center: Air Force Expeditionary Medical Skills Institute

Centers for the Sustainment of Trauma and Readiness Skills (C-STARS)

- Delivering TEAMSTEPPS in trauma environment and provide objective data on course effectiveness on 2 integrated projects:
  - Evaluation of Distance Learning
  - The Evaluation of the Readiness Skills Verification Program (include simulation based evaluations and video analysis of actual trauma evaluations)

Teamwork Resource Center: Army Trauma Training Center (ATTC)

- Extensive training Forward Surgical Teams and Combat Support Hospital units prior to deployment
- Three-phase training program
  - Phase I – Completion of a pre-rotation team assessment
  - Phase II – Physical 17-day rotation through the ATTC
  - Phase III – On-line team sustainment training conducted through the ATTC website
- Focus:
  - Conducting program validation and sustainment
  - Simulation critical to training; teamwork is key to assessment in MASCAL exercise
  - Reinforce interdependency of team skills/tools at every interaction
  - Game planning for low work-load times
  - Incorporating lessons learned from units once 'down range'

Partner With Patients

1. Ask questions if you have doubts or concerns.
2. Keep and bring a list of ALL the medicines you take.
3. Get the results of any test of procedure.
4. Talk to your doctor about which hospital is best for your health needs.
5. Make sure you understand what will happen if you need surgery.
   - **Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation. Ask your doctor, "Who will manage my care when I am in the hospital?" Ask your surgeon:**
     - **Exactly what will you be doing?**
     - **About how long will it take?**
     - **What will happen after the surgery?**
     - **How can I expect to feel during recovery?**
     - **Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.**

JCAHO GOALS AND GME COMPETENCIES Accreditation meets Education

- **Goal 1: Improve the accuracy of patient/resident/client identification**
- **Goal 2: Improve the effectiveness of communication among caregivers. ("handoff" transitions of care)**
- Goal 4: Eliminate wrong-site, wrong-patient, wrong-procedure surgery.
- Goal 7: Reduce the risk of health care-associated infections
- **Goal 8: Accurately and completely reconcile medications across the continuum of care.**
- **Goal 12: Implementation of applicable National Patient Safety Goals and associated requirements by components and practitioner sites.**
- **Goal 13: Encourage the active involvement of patients and their families in the patient's own care as a patient safety strategy.**

- **Patient Care**
  - **Interviewing**
  - **Counsel & educate pt's and families**
  - **Develop & carry out pt. Management Plans**
  - **Work within a team**
- **Practice-Based Learning & Improvement**
  - **Analyze own practice for needed improvements**
  - **Use of information technology**
- **Interpersonal & Communication Skills**
  - **Creation of therapeutic relationships with patients**
  - **Listening skills**
- **Systems-Based Practice**
  - **Understand interaction of their practices with the larger system**
  - **Knowledge of practice and delivery systems**
  - **Practice cost effective care**
  - **Advocate for patients within the health care system**

Patient Safety Issues: Complexity and Coupling

- System interactively complex thus independent failure events can interact in non-predictable ways resulting in system failure.
- Systems working at limit capacity: increasing complexity
  - Pushed by technology
  - Pushed by innovation
  - Pushed by productivity/efficiency goals
- Tight coupling: activities/conditions in one part of the system have significant effect of activities in another part of the system.
  - May be distant
  - Unintended consequences
    - Consequence of greater efficiencies in one area not necessarily matched with those in another
    - System - System interface that ultimately effect sharp-end providers
      - ER/ICU to floor
      - OR to PACU
      - Floor to home

Medicine Meets Virtual Reality

…to provide safest, high quality health care for our patients throughout the Military Health System….validated in simulation labs, transferable to virtual environment as close to medical units…

Aim is to practice, coach, and learn…transfer to daily practice…ultimately improving patient outcomes

How?

- Create situational learning environment for new and practicing professionals…through integration of simulation and technologies➔ build trust
- Develop sound, effective evaluation tools for debriefing and process improvement
- Team-based, motivating and adaptable to microsystem
- Improve decision-making capabilities by practicing error reduction and recovery strategies
- Build proficiencies by incorporate patient safety principles, teamwork concepts, and improved communication, communication, communication

New Legislation

The Patient Safety & Quality Improvement Act of 2005 Public Law : 109-41

- Amends Title IX of the Public Health Service Act to provide for the improvement of patient safety and to reduce the incidence of events that adversely effect patient safety.
- Impact: Establishes a "secure" and "protected" healthcare reporting system
  - Patient Safety Organizations to collect, analyze, and provide feedback on medical error data for purposes of improving safety
  - "PRIVILEGE.—Notwithstanding any other provision of Federal, State, or local law, and subject to subsection (c), patient safety work product shall be privileged"
  - "CONFIDENTIALITY OF PATIENT SAFETY WORK PRODUCT. Notwithstanding any other provision of Federal, State, or local law, and subject to subsection (c), patient safety work product shall be confidential and shall not be disclosed."
- History
  - Passed and signed by the President 7/28/05
  - DoD response under consideration: currently exempt

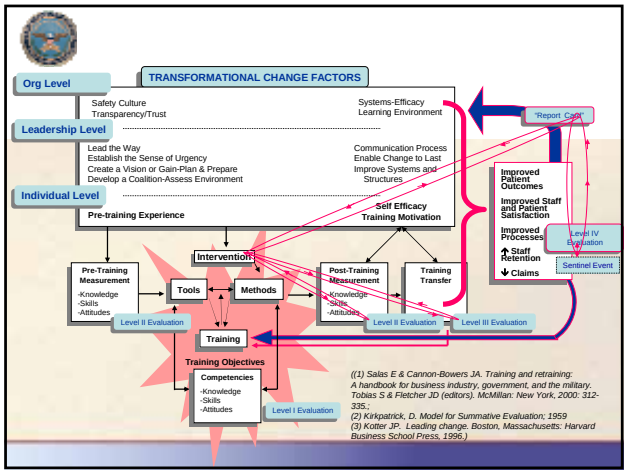
The Future of Patient Safety

"Dramatic advances likely within the next 5 years in…."

- Implementation of electronic health records
- Wide diffusion of proven safe practices
- Training on teamwork and safety
- Full disclosure to patients following injury

Leape. Five years after *To Err is Human:* What have we learned? *JAMA*. May 2005.

What is the best way to optimize and advance simulation over the next 5 years?



Sources of Information

https://patientsafety.satx.disa.mil/
DoD updates, links, & news items from PSP, PSC, and CERPS

www.psnet.ahrq.gov: Patient Safety Network - updating subscribers on latest insights from patient safety research from the US Agency for Healthcare Research and Quality

www.qualityhealthcare.org: Joint product of the Institute for Healthcare Improvement and the British Medical Journal which provides tools and virtual workgroups

www.patientsafety.gov: VA website with tools and an excellent safety glossary (the "magic words")

Quality and Safety In Health Care

DoD & AHRQ Sponsored QSHC Supplement: Resource For Simulation and Team Training

Point of Contact

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