MTF Responsibilities

- Execute AMEDD Patient Safety Program
- Increase staff awareness of patient safety issues
- Create a culture of non-attribution for reporting medical errors and near misses
- Report near misses and medical errors
- Implement and monitor effectiveness of system and process improvement recommendations resulting from systems analyses (Prospective and Root Cause Analysis)
- Implement safe and best practices identified by MEDCOM

What’s Ahead in the AMEDD?

- Corporate PS Climate Survey Analysis
- MTF Patient Safety Training
- Standardized Incident Reporting Tool and Database
- MTF Patient Safety Tool Kit
- MEDCOM Patient Safety Support Team
- Dissemination of Innovations and Improvement Successes
- PS “Distance Learning” Program

Patient Safety Related Websites

- MEDCOM PS
  www.es.amedd.army.mil/qmo/ptsafety/pts.htm
- AMEDD Knowledge Exchange
  https://ke.army.mil
- AFIP
  www.afip.org/psc/index.html
- JCAHO
  www.jcaho.org
- IHI
  www.ihi.org
- VA
  www.va.gov/ncps/

For more information, questions and/or program suggestions contact:

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Why the focus on Patient Safety?

It saves lives! It saves money! Each year many patients are harmed or die in U.S. hospitals due to preventable medical errors. The total cost to the health care industry is over $29B annually. The statistics are so alarming that in 1999 all federal healthcare agencies were directed to implement error reduction strategies focusing on preventing errors, making errors visible and mitigating the effects of errors.

Deadly Secret?

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
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<tbody>
<tr>
<td>Fire</td>
<td>1,700</td>
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<tr>
<td>Drowning</td>
<td>4,100</td>
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<tr>
<td>Poisoning</td>
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<td>Falls</td>
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<td>MVA</td>
<td>41,200</td>
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<td>Med Errors</td>
<td>28,000</td>
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National Safety Council: Philadelphia Enquirer; L. Lepee, MD

Culture of Safety

We must create a culture of safety throughout our healthcare facilities. We will focus our efforts on system and process improvements NOT on placing individual blame. One change that has been reported to be effective is developing a blameless but accountable reporting system designed to encourage staff to report accidents, near misses, adverse drug events and risks. Leaders must facilitate a proactive approach to patient safety emphasizing communication, learning and implementation of effective strategies to reduce preventable harm as a top organizational priority.

MHS Patient Safety Program

The goal of MHS Patient Safety Program is to avoid medical harm and improve patient safety by focusing on prevention, not punishment. The key is to find ways of improving medical systems and processes to prevent human error or diminish the consequences of an error.

MHS Patient Safety Working Group

The MHS Patient Safety Working Group (PSWG) includes physicians, nurses, risk manager, and pharmacists, educators and safety experts. After reviewing the MHS patient safety issues, the PSWG published their first document titled “Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors & their Impact”. The PSWG also authored the DoD Instruction 6025.17 entitled “Military Health System Patient Safety Program (MHSPS). A MTF Patient Safety “Train-the-Trainer” Program to educate MTF’s on their roles and responsibilities for patient safety is being implemented in all DoD facilities. The training program introduces tools to analyze actual or potential patient safety-related events including: Safety Assessment Code (score reflects level of review required); a standardized process for Root Cause Analysis (RCA)/Aggregate Reviews, and introduction to other systematic methodologies to facilitate completion of a thorough, credible and timely systems analysis.

MEDCOM Patient Safety


MEDCOM Patient Safety Center (Rev. Mar 02)