



# Patient Safety in the AMEDD



**1 MAR 2012**

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**National Patient Safety Awareness Week  
4-10 March 2012**

### *It Happened to Us*

By Cheryl Brown, DBA, RN  
MEDCOM PSP

Who is “us”?  
“Us” is the MEDCOM Patient Safety staff that has been personally touched or has had family members touched by medical and/or dental errors. The fervent passion for advocating safe patient care stems from not only our desire to do what’s good and right but also our own experiences from our pasts. Our staff would like to share our medical and dental stories....

“After 3 unsuccessful spinal anesthesia attempts during L&D, I sustained a 9 day spinal H/A and induced migraines. After such a bad experience and too scared to return for a blood patch, I’ve learned to manage the migraines for 13 years.”

“I received a dental implant with immediate, severe pain lasting 2+ months. After multiple dental visits and neurological medicines for jaw pain, they finally believed something was wrong, ordered a CT scan, diagnosed me with osteomyelitis, and sent me to surgery with a daily 6 week course of IV antibiotics.”

“My 2 ½ year old daughter, delayed in growth, was treated with antibiotics and eventually ear tubes for recurring otitis. She simultaneously experienced bladder reflux (unknowingly, a delayed diagnosis)



with urine backing up in her kidneys. One year later a urinalysis showed infection. She was treated and sent for an MRI that revealed bilateral kidney scarring, especially on the right. After 9 months of antibiotics, she received bilateral, bladder-ureter valve placements. She’s 10 now, catching up in growth, has recurring symptoms and had valves replaced.”

“I experienced continuous ‘migraine type’ headaches following an initial prescription and 2 refills of the wrong type of pain medicine. My PCM ordered a timed released dosage however, the pharmacy dispensed a different dosage.”

“My 83 year old mother fell, post procedure, in a hospital resulting in a CVA, MI, and death 2 weeks later.”

We pledge our devotion to safe patient care, to educating and getting the word out continuously to our military healthcare systems, communities, neighbors, friends and families because it happened to us.

## ***Retained Foreign Objects***

By LTC Cindy Renaker, MEDCOM PSP

According to MEDCOM Regulation 40-49 (Medical Services Surgical Counts) “accurately accounting for sponges (sharps, needles, instruments) should be a priority of the surgical team to minimize the risk of a retained object.” Despite the importance of performing accurate surgical counts, the Army Medical Department (AMEDD) continues to see Retained Foreign Objects (RFO) Sentinel Events. The two most common causal or contributing factors related to RFOs are: (1) communication failures and (2) lack of procedural/regulatory compliance.

Failure to communicate properly is a common contributing/causal factor among all sentinel events. After careful review of AMEDD’s 2010-2011 Sentinel Event data, there appears to be a pattern of failed communication in

the following examples:

1. Poor or lack of proper hand-off (surgeon, circulating nurse or scrub technician).
2. Lack of confirmation of surgical count (correct or incorrect) before closing incision.
3. Staff not speaking up when they knew the count was incorrect.
4. Equipment or instrument malfunctions that are not communicated (bent instruments, assembled instruments that are not intact once removed from patient).

MEDCOM Regulation 40-49 is the policy that provides “guidelines for accountability of items used during operative and other invasive procedures (inclusive of minimally invasive procedures) to ensure they are not retained in a patient undergoing an operative or invasive intervention.” Failure to follow written policy was evidenced by the following examples:

1. Failure to perform visual explo-

ration of the cavity (insertion of a device, sponge and/or packing material into an orifice) in order to verify removal of all items.

2. Failure to perform an x-ray of the surgical site (incorrect count, broken/damaged instruments) prior to skin closure and departure of patient from operating room.
3. Failure to confirm final correct count before skin closure initiated.
4. Failure to perform a count during a staff hand-off.
5. Failure to remove all instruments/wires or individual pieces of assembled instruments prior to surgical closure.

“Counts are fundamental to the surgical process and are the responsibility of the entire surgical/procedural team” (MEDCOM Regulation 40-59). It is the hope of MEDCOM Patient Safety that by sharing this information, it will aid in the prevention of retained foreign objects in the future.

## ***TeamSTEPPS®***

By Phyllis Toor, TeamSTEPPS® Coordinator, MEDCOM PSP

Tripler Army Medical Center’s (TAMC) TeamSTEPPS® Change Team began their full facility implementation plan March 2011. They are successfully working to hardwire the TeamSTEPPS culture in all departments.

MAJ Taylor Sawyer, TeamSTEPPS® provider lead, was interested in looking at teamwork training and its effect on clinical environment performance. Below is a summary of the project conducted by MAJ Sawyer and the Tripler Team.

During April-May 2011, 10 physicians, 29 nurses and 3 respiratory therapists from TAMC’s

Neonatal Intensive Care Unit participated in a TeamSTEPPS® training course. The course included simulation-based training. Three measures were obtained (teamwork attitudes, knowledge and skills) before and after the TeamSTEPPS® course. A prospective, pre-test and post-test design was implemented. The simulation involved a neonatal resuscitation scenario using an event-based approach to training. Physicians were directed to request an incorrect dose of epinephrine and nurses were directed to provide slow and ineffective compressions. Challenges to the incorrect medication dose and correction of ineffective chest compressions were recorded.

TeamSTEPPS® trainers at

TAMC demonstrated significant improvements in the 3 measures. The odds increased for a nurse speaking up and challenging an Attending’s incorrect order. This is the first report of improvements in teamwork skills during neonatal resuscitation after TeamSTEPPS® training. TeamSTEPPS® trainers at TAMC feel these short term learning outcomes are important, and they hope the TeamSTEPPS® training will be associated with improvements in clinical care and patient safety throughout their institution.

***“Working Today for a Safer Tomorrow”***

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## ***Dental Patient Safety Notes***

By LTC(P) Todd Kimura



Pacific Regional Dental Command (PRDC) Commander COL Randy Ball and TeamSTEPPS®

MEDCOM leads LTC Cindy Renaker and Ms. Phyllis Toor conducted their first Defense Connect Online (DCO) Regional Patient Safety (PS)/TeamSTEPPS® quarterly meeting. Past meetings, conducted by VTC were lengthy and difficult to attend by 18 geographically separated units. DCO provided participation and camaraderie by all geographic locations, leadership and instructors. PRDC is able to

## ***Comprehensive Unit-based Safety Program***

By Jaclyn Whelen, PSM, PRMC

The Comprehensive Unit-based Safety Program (CUSP) provides Tripler Army Medical Center's ICU with a structured, flexible strategic framework for safety improvement. Staff is encouraged to contribute ideas re: fixing hazards perceived as risk. CUSP, developed by Johns Hopkins University Quality & Safety Research Group, integrates communication, teamwork, and leadership to support a "harm-free" patient care culture. CUSP's 5 steps, using continuous processes, are designed to incorporate ongoing, evidence-based patient safety (PS) infrastructure for existing units. Steps build on previous work, equip frontline providers with tools, metrics, and tackle quality improvement challenges.

not only sustain monthly training events, but the interactive PS/TeamSTEPPS® Program through clinic level daily briefs, huddles, and debriefs.

Through an extremely proactive and comprehensive screening process, new teammates are identified and trained in concepts of TeamSTEPPS®. Concepts, which consist of a 2-hour basic course, are taught by one highly qualified PS teammate.

Efforts continue across the command to improve the Patient Safety Reporting System (PSRS) process. This requires collaboration and feedback among clinicians, administrators and the profession of dentistry as a whole. Through the efforts of LTC(P) Todd Kimura, PRDC Patient Safety Officer and

CUSP's steps: (1) Educate staff on safety training science. Learning objectives include an understanding that: (a) safety is a system property; (b) basic principles of safe design include: standardized work, key processes with independent checks, learn from mistakes and applied team work; and (c) teams make wise decisions with diverse, independent input; (2) Use written surveys identifying defects using unit reports, liability claims, and sentinel events. All ICU staff, ward clerks and housekeepers are asked to complete a 2-question survey to identify defects, how patients might be harmed, and prevention ideas; (3) Assign a senior hospital executive to partner with the unit improving communications and educating leadership. The Chief Medical Officer partners with ICU staff, opens lines of communication, improves frontline

Mr. Dave Vreeland, PRDC Director of Strategy and Innovation, the PRCD is extremely proud to be the first regional dental command to initiate a Lean Six Sigma Green Belt project focusing on PSRS.

## ***Department of Defense 2012 Patient Safety Awards***

The Bassett Army Community Hospital and Ms. Teresa Hrubes were selected to receive this year's award for Teamwork Training and Skill Building for an inpatient Facility with their project: Fixing the Unfixable Through the Power of TeamSTEPPS®.

Congratulations to all. Thank you for your projects and your team's dedication to Patient Safety improvements.

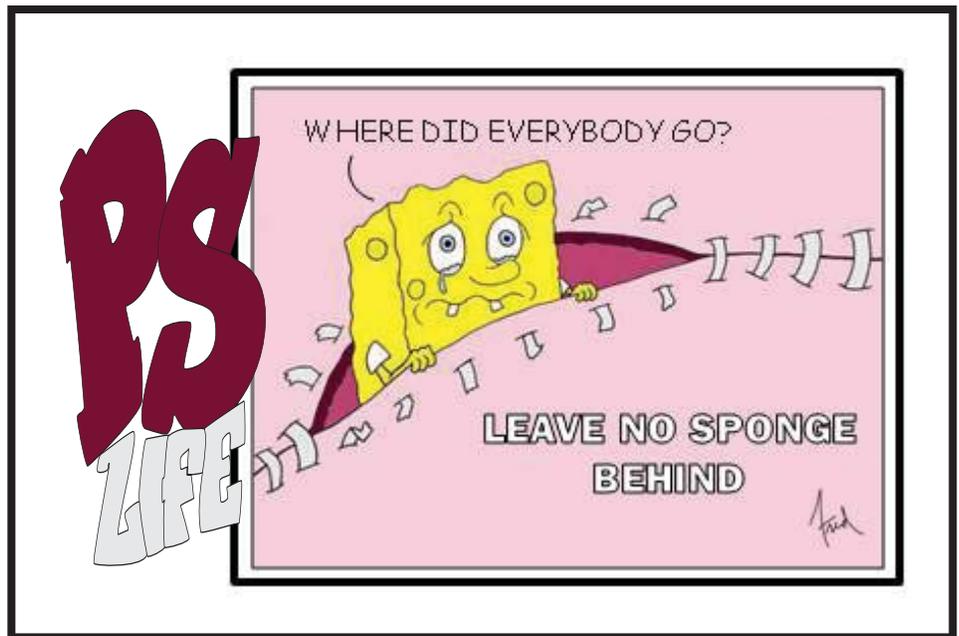
providers' attitudes about leadership, educates leaders on clinical issues and safety hazards, provides staff resources mitigating hazards, and holds staff accountable reducing patient risks; (4) Staff learn from unit defects. A "drilldown" tool is used to learn how patients acquire VAP by asking: (a) what happened; (b) why it happened; and (c) how to reduce the risk; and (5) Staff use tools improving teamwork, communication, and other systems. Develop tools to improve teamwork and communication.

CUSP works because it recognizes the central importance of culture in sustainable PS improvements. A unit's safety culture can reliably predict a wide range of complications, infections, plus operational outcomes such as nurse turnover. Local culture must be targeted at the unit level with support at the organizational level.

## Patient Safety Poster Contest

The Army Patient Safety Program 2012 National Patient Safety Awareness Week poster contest continues through March 16th. The theme for this year's contest is "Be Aware for Safe Care". A 1st, 2nd and 3rd place will be selected for each category and will be announced on 1 April. The categories are Medical general Patient Safety, Medical theme related, Dental general Patient Safety and Dental theme related.

Entries may be submitted in any format but all entries will be printed in color on letter sized sheets for judging. Winning poster from previous years may be viewed on the Army Patient Safety website. Questions and entries may be directed to Mr. Fred Del Toro.



Please send us your newsworthy information to be included in future editions of the Patient Safety newsletter. Give us the who, what, when, where and why and we will add it after editing. The POC for newsletter items is LTC Cindy Renaker, 210-221-6622.

## PS Educational Opportunities

### DoD Patient Safety Program News and Publications

<http://www.health.mil/dodpatientsafety/News.aspx>

### Products and Services

<http://www.health.mil/dodpatientsafety/ProductsandServices.aspx>

### The Joint Commission Education Resources

<http://www.jcrinc.com/View-All-Products>

### Mosby's Nursing Consult: AMEDD Virtual Library US Army Medical Command

<http://www.nursingconsult.com/nursing/index>

### 2012 NPSGs (Powerpoint) by TJC

<http://www.beckersasc.com/asc-accreditation-and-patient-safety/joint-commission-publishes-2012-national-patient-safety-goals-slide-presentation.html>

## PATIENT SAFETY PROGRAM CONTACT INFORMATION

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