



# Patient Safety in the AMEDD



**1 NOVEMBER 2012**

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### *Medication Concentration* By COL Kimberly Kesling

I attended a lecture where a very well respected quality manager from a large mainstream healthcare system was talking about what her organization was doing to improve medication administration safety on the inpatient wards. She described that the nurses administering medications wear a vest or a sash. Are you kidding me? Have we really gotten to the point where we have to dress our nurses up like crossing guards or parade grand marshals in order to pass medications safely? Unbelievable!!! After I finished imagining one of my nurse friends with balloons tied to their waist and party hats while passing medications, I started thinking about the things I have learned about the nature of mistakes.

In a healthcare setting, it is very unusual that a care giver thinks through a situation and then decides to do the wrong thing. It is far more common to have a routine procedure interrupted and steps missed or done incorrectly. When researchers watched work flow in emergency rooms, they found a large number of tasks, both patient care and administrative, are interrupted by a conversation or another task with up to a third of those never completed. Undoubtedly, at least some of those tasks are truly important to the health of the patient.

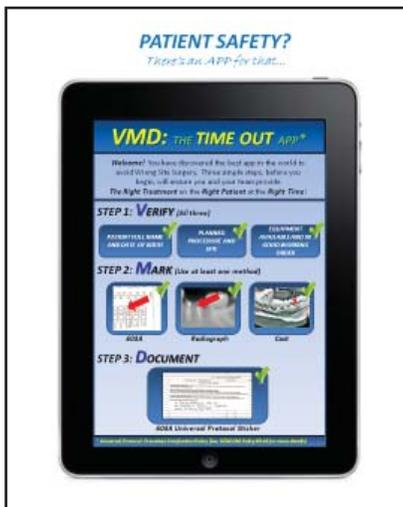
I also know that the human brain can only be aware of so many things at once and actually concentrate on even fewer. How many of you have tried to hold a conversation with a teenager who is texting or playing a video game? That is a great example of “multi-tasking”. However, my bet is

that the conversation was very one-sided. One cannot fully participate unless your attention is directed toward the task at hand. The human brain is not nearly as good at dividing our concentration as we think it is. It seems that we are actually serial taskers rather than true multi-taskers. Multiple studies have shown that the brain actually jerks between tasks. We skip back and forth between tasks and try to give each its due diligence, and that is exactly how things get missed.

We also believe that if we practice enough then we will reduce errors. That is absolutely true. However, if you are distracted during the task you can still miss steps. How many of us have been rooting for our favorite football team, seen the ball thrown to a completely open receiver only to watch the ball fall out of their hands? The announcers always say that they tried to run before the catch. We don't know if that is true, but we do know that the receiver did not concentrate on the catch until it was completed. Steps were missed and the result was not what was intended.

So, back to dressing up the nurse to highlight that (s)he is engaged in an important task that must not be interrupted... the rules that go along with the vest are: (1) no one, except the patient of course, is allowed to ask a question, (2) nobody assigns another task, or (3) nobody diverts the attention of the nurse wearing the vest towards another patient. That nurse is allowed to completely concentrate on making sure the patient has the right

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**First Place  
General Dental Patient Safety  
Fort Bragg DENTAC  
2012 Poster Contest**



**Best Practice: TeamSTEPPS** By Christina Smith, RN



You might recall a recent article by Ms. Phyllis Toor related to a pilot TeamSTEPPS Training Through Simulation that was conducted at

Reynolds ACH June 2012. Many times we hear of new initiatives and wonder if these good ideas really work. So, have we hardwired TeamSTEPPS into practice? Picture this...0715 surgical team meets to conduct a daily huddle. Universal protocol is conducted prior to each case with active participation by the entire team. At the conclusion of each case the team conducts a standardized debrief identifying any issues that need to be addressed. This information is documented within an electronic debrief form. This standardized process allows the team to communicate issues

**TapRoot® Hints** By Dana Rocha

Just a few quick best practice points today to use when analyzing a Causal Factor using the Root Cause Tree®, Root Cause Tree® Dictionary and your created SnapCharT® ...

You are looking for Root Causes that contributed to the person's, equipment's or process' inability to successfully perform a specific task (Causal Factor). The Causal Factors led to an Incident or made the Incident worse.

For example, the investigator needs to find Root Causes for why the Surgeon and the Anesthesiologist chose to not follow the policy related to the site marking according to Universal Protocol an MEDCOM Reg 40-54 which then caused the wrong site/ wrong side to become marked and the wrong site to be anesthisized prior to the actual procedure being performed.

1. You must use the Root Cause Tree®, Root Cause Tree® Dictionary

to the appropriate POC.

The data from the debrief tool allows us to analyze trends and develop solutions for ongoing systemic problems in a timely, efficient way. Here is what TeamSTEPPS has done doing for Reynolds in just four short months:

- 50% reduction in case delays**
- 18% reduction in instrumentation/ equipment issues**
- 60% reduction in preference card issues**
- 50% reduction in scheduling errors**

Since TeamSTEPPS integration an additional benefit is that staff members speak about the overall improvement in the team concept and staff morale. One staff member stated, "People who never spoke up about anything are doing so now". That staff member explained that the briefs assist people who communicated very little to

and SnapCharT® together. NO EXCEPTIONS. NO ASSUMPTIONS.

2. Treat the bullets in the Root Cause Tree® Dictionary as black and white. No reading between the lines. If there is failure to agree during the analysis, you must get further clarification of your Condition and Events on your SnapCharT®. Clarify the facts, identify the bullets in the dictionary, and then verbally repeat the Causal Factor that you are analyzing. If the logic still does not match, then it is not a Root Cause.
3. Select the Root Cause if it is a fact. DO NOT ignore a valid Root Cause and fail to select it because you think it can not or will not be changed. You can prioritize what does get fixed or what does not get fixed during steps 5 and 6 of our 7-Step Process.

speaking up and take ownership in making their department more safe and more efficient. The Department of Surgery shares their success stories with all levels of leadership within Reynolds through our Performance Improvement Committee. We are able to provide other leaders within the organization concrete data as to what TeamSTEPPS can do for their departments.

Other Success Stories: MAJ Chris Daly, Chief of Peri-Operative Services describes the significant change that he experienced since TeamSTEPPS implementation. He stated, "Before we began using TeamSTEPPS there wasn't a day that went by that I wasn't dealing with staff conflict, but now it is rare to have my day tied up with those kind of issues."

*Medication Continued from page 1*

medications at the right time. It seems so simple, and yet there have been multiple episodes in the Military Health System where the nurse was distracted or interrupted and the patient received the incorrect medication. This can have disastrous results.

Therefore, I encourage your organizations to examine what precautions you take to make certain that medication administration is treated as an activity that requires full attention from the nurse. It is critical for mission accomplishment and may mean the difference between life and death for the patient.



## **Medication Safety Corner: Meningitis Outbreak Rises to 317 Cases, 24 Deaths** By LTC Gwendolyn Thompson

As of 25 October 2012, the meningitis outbreak has been growing by leaps and bounds. There have been 317 illnesses, including five joint infections, and 24 deaths linked to the Massachusetts-based New England Compounding Center. The Center for Disease Control identified 17 states where patients were injected with the tainted steroid: Florida: 19 cases, including 3 deaths; Georgia, 1 case; Idaho, 1 case; Illinois, 1 case; Indiana 41 cases, including 3 deaths; Maryland 17 cases, including 1 death; Michigan: 73 cases, including 5 deaths; Minnesota: 7 cases; New Hampshire: 10 cases; New Jersey: 18 cases; New York: 1 case; North Carolina: 2 cases, including 1 death; Ohio: 11 cases; Pennsylvania: 1 case; Tennessee: 70 cases, including 9 deaths; Texas: 1 case; Virginia: 43 cases, including 2 deaths. The Food and Drug Administration has released a list of the NECC's customers which include approximately 3,000 doctors and hospitals around the country. Here is a link to the sites who received products from the NECC: <http://www.fda.gov/Drugs/DrugSafety/ucm322734.htm>

How well is your facility prepared for a drug recall, from compounded products prepared by outside sources? The Joint Commission standards MM 05.01.17 EP 1-4 and EC 02.01.01 EP 11 state that a hospital should have a written policy describing how it will retrieve and handle medications within the hospital that are recalled or discontinued for safety reasons by the manufacturer or the U. S. Food and Drug Administration (FDA).

Is there a process in your facility to easily identify those patients who may have received a recalled, compounded product? Check to see if there are medication orders for all compounded drugs dispensed or administered to patients.

Does your patient identification process include the manufacturer, lot number and expiration date of the product? Before a compounded medication is dispensed or administered to a patient, the appropriate information about the compounded product should be documented in the patient's medical record, in a field retrievable by the pharmacy. Your Department of Pharmacy receives drug recalls through a variety of sources and can match these recalled drugs to the products which have been procured by your facility.

According to our newest staff member and Joint Commission Consultant, Mr. Tony Cabell, there is not a Joint Commission standard that specifically covers external compounding. However, external compounding companies are vendors and vendors are covered under Leadership Standard 04.03.09: Care, treatment and services provided through contractual agreement are provided safely and effectively.

My interpretation of how LD. 04.03.09 applies to external compounding companies is "leadership is responsible for insuring that the external compounding companies are providing quality assurance data on a regular basis. TJC recommends in the absence of quality assurance data that a USP bench test be performed, or send a sample out to a laboratory for analysis."

What is your policy and practice of monitoring vendors that provide compounded pharmaceuticals through a contractual relationship? There is no better time than now to review these contracts. The American Society of Health-System Pharmacists has excellent guidelines on outsourcing sterile compounding services. Check to see if your contract includes: (1) requirements that vendors will provide quality assurance documents on a scheduled basis, (2) direct and periodic

communication on recalls of base products will be provided to you, and (3) vendors and their pharmacists will demonstrate competency and maintain the appropriate licensure throughout the contract.

Patient Safety Managers can check with their Medication Management Committee, Pharmacy and Therapeutics Committee or the Department of Pharmacy to ensure these questions and more can be answered to the organization's satisfaction. Let's keep our patients safe.

## **Army Patient Safety Program Joins milSuite** By Fred Del Toro

The Army PSP has created a homepage on the milBook section of milSuite. The site was created initially to provide PSMs and PSOs a chance to make connections with other professionals online to facilitate communication.

milBook allows knowledge sharing using discussions, blogs, and virtual documents (used like a wiki) with members of the group. milBook is restricted to DoD personnel and requires CAC access. PSP group access is controlled plus membership is restricted (at this time) to PSMs, Dental PSOs and MEDCOM PS Team members. The site is monitored on a daily basis by the PSP staff. At this time the site is private and only members can view information and post items.

A pharmacists group was created and is managed by LTC Gwendolyn Thompson, our Medications Safety officer. She invites you to join that group as well.

We encourage all members of the PSM and Dental PSO groups to join in on the discussions. If you use public social media now you will find this very similar. Please post your

*Continued on page 4 milSuite*



**PSR Update: Top 3 PSR Reported Event Sub-Types FY12**

By Rafael Whispell

*milSuite Continued from page 2*

Event Sub-Types	Near Miss	% NM	No Harm	% NH	Harm	% Harm	Total
Medication	14045	71%	4811	24%	906	5%	19762
Chart / medical record / assessment / consultation	838	64%	450	34%	23	2%	1311
Treatment / procedure / intervention	157	14%	552	50%	394	36%	1103

(For Official Use Only. All information is subject to the Privacy Act of 1974, 5 USC 552 and 10 USC 1102)

The Top Three Reported Event Sub-Types account for 62% for all Medical and Dental events reported.

The new version of PSR was deployed during the weekend of 26-28 October 2012. Please keep us updated on any issues the staff may experience with the new version of PSR. DOD is currently working on a timeline to release the updated training materials

in MHS Learn. I will keep you updated when the new training guides are released in MHS Learn.

In the meantime DOD has a recording available on the new version at the following link:  
<http://www.health.mil/dodpatientsafety/Calendar/Archived/PSRDemo17Sept.aspx>

comments re: creative ways to use the various functions. If you need assistance please contact me with your questions. Better yet, post your question as a new discussion. You may be surprised about how many fellow PS warriors have knowledge and can help.

Our desire is to move forward to a more paperless world and minimize the amount of email landing in our mailboxes. Much of the information that is now sent out via email can be posted on milBook for users to view and comment at their leisure. Hope to see you be one of the first to join in.

**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>

**DoD/VA Shared Learning (Look for Grand Rounds)**

<https://mhslearn.csd.disa.mil/ilearn/en/learner/mhs/portal/dod.jsp>

**News from the Field**

Congratulations are due to Loma for getting married. Her new name is Loma Lohn. Her name has been changed in Outlook.

**Upcoming Events:**

Quarterly PSM Call 17 Jan 2013  
 1200-1400 Central Standard Time.

**PATIENT SAFETY PROGRAM CONTACT INFORMATION**

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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.



**Hails and Farewells**

**Hail**

Joseph "Tony" Cabell - Tony is a retired LTC Army Nurse Corps Officer, formerly the Chief of Quality at Baptist Health System in San Antonio. He is joining us as MEDCOM's Joint Commission/Performance Improvement Officer.

**Farewell**

Michaela Thornton - Ft Drum

