



# Patient Safety in the AMEDD



**1 JAN 2012**

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## Communication

“we have the evolution of technology that helps us communicate and sometimes prohibits us.... I’m not quite sure that we maximize and utilize it to our best advantage”

-COL Karen Grace,  
Army PSP Manager

## RCA Process Review Changes

By LTC Cindy Renaker

MEDCOM Patient Safety changed the Root Cause Analysis Internal Review Process. Our goal is to provide additional support, revised resources, standardized identification and analysis of data and improve transparency of information to all Medical PSMs and Dental PSOs.

Enhanced support will be provided to the Patient Safety Managers/Officers throughout the RCA event process. Each submitted RCA will have an assigned Nurse Consultant available for guidance and support from the event notification to the final 6-8 month follow-up review. Our personalized service is designed to improve consistency, product quality and overall customer satisfaction.

Revised QMO/PS website will contain relevant resources available at your fingertips. Located within the PS Section, the RCA tab will house a variety of products to include: RCA Team Member Educational Pamphlet designed to give basic instructions to the newly formed RCA team members, SE Reference lists submitted by PSMs, SE Checklists: (Suicide, WSS, RFO and general questions, based on causative/ contributing factors from actual cases), updated forms, download instruction overviews for TapRooT© Version 5 and a revised RCA Process Step Guide. Standardized identification, analysis and trending of submitted RCA

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## At Ease With COL Grace

By Cheryl Brown, DBA, RN

COL Grace and I met to discuss reasons for failed communication. She spoke on the “many initiatives that have contributed over the last 10 years” towards communication challenges.



She stated, “We have been an Army at war trying to manage multiple tasks” adding, “we have folks that are going in many different directions”.

COL Grace pointed out that, “we have the evolution of technology that helps us communicate and sometimes prohibits us.... but, I’m not quite sure that we maximize and utilize it to our best advantage”.

She reflected on her 25 years of nursing, highlighting face-to-face communication as a generational lost art taken over by, “great technology to help us communicate”. She expressed that, “we tend to say, ‘I sent you an email’, ‘I left you a voice message’, and ‘I texted you’”, without conducting consistent, necessary follow-up communication. COL Grace added, “whereas, those of us who’ve been around for awhile prefer to get on the phone, ‘let’s talk about this’”.

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## ***Wrong Site Surgery***

By LTC Cindy Renaker

Wrong Site Surgeries for CY 2010 and 2011 were reviewed to identify potential patterns and/or trends. This category includes surgeries or procedures involving wrong side or site and surgeries/procedures on the wrong patient. The most common causative/contributing factors yielding trends were: (1) Management System and (2) Communication failures (written and verbal).

Management System failures include a failure to follow standards, policies, or administrative controls. The identified areas of concern were: failure to ensure positive patient identification and an improper/incomplete employment of the Universal Protocol. Patient identification events included: (a) errors made during order transcription, (b) chart labeling (patient identification placed on wrong chart) and (c) while obtaining surgical consent. Universal Protocol errors included: (a) an absence of or inadequate time-out and (b) an absence of or confusing site markings.

Written and verbal communication failures continue to be one of the most common trends in sentinel events. Written communication errors mimic Management System failures by: ambiguous site markings, orders placed in wrong patient's chart, transcription errors and mislabeling. Verbal communication failures included: (1) poor hand-offs between medical staff, (2) team members not speaking up when issues arose, (3) staff not verbally verifying with patient the surgical/procedural consent and (4) staff not conducting a time-out prior to the procedure/surgery.

MEDCOM is committed to establishing an environment of trust, transparency, teamwork and communication to improve safety and prevent adverse events. It is our hope that by sharing this information, it will aid in the prevention of Wrong Site Surgeries in the future.

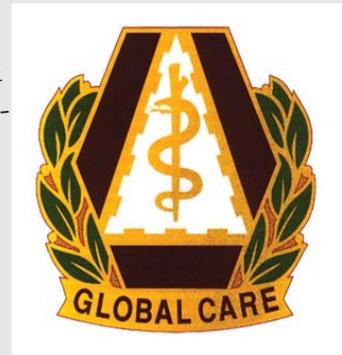


***Working Today for a Safer Tomorrow***

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

By Mrs. Wanda Kavanaugh & MAJ D. Worrell, MD

Northern Dental Regional Command implemented a TeamSTEPPS® communication initiative to reduce ineffective relay of information and follow ups.



At Fort Drum we implemented Brief and De-Brief Cards. Brief Cards contain specific questions for the provider/assistant teams. During morning briefs the teams make sure they are focused on the same treatment expectation. De-Brief Cards catch details that were beneficial or not. The Cards are filled out by provider/assistant teams at the end of each day during the De-Brief sessions.

The DENTAC is striving to achieve a greater culture of safety where communication is improved, patient safety issues are reported, and preventable errors are minimized to the greatest extent possible. It's become an excellent communication tool and a means to guide us in our culture change by the message - "It's OK to report patient safety events". Communication between team members, providers and patients is at an all time high and creates an atmosphere of support and increased patient safety.



## *RCA Process (continued from page 1)*

information is essential for reducing variance, improving processes and preventing medical errors. MEDCOM PS analyzes all submitted RCAs. A standardized approach will be used to gather data, identify trends, best processes and opportunities for improvement.

Increased transparency of RCA results will promote shared accountability. Learning from our mistakes only occurs if we are made aware of them. MEDCOM PS is committed to sharing information that will help improve processes, while continuing to protect the primary and secondary recipients of medical errors. MEDCOM PS will use the following venues to share pertinent trends, safety alerts, best processes and opportunities to improve: PS Newsletter, Annual PS/RM Conference, Safety Alert, Quarterly PS VTC, QMO/PS website and SE Checklists.

MEDCOM PS is excited to start the New Year with a new RCA Process. On behalf of the RCA PI Team, LTC Cindy Renaker, Cheryl Brown, Becky Jordan and Dana Rocha, we look forward to working with each of you this year.

## *Patient Safety Poster Contest*



The Army Patient Safety Program will once again be conducting a poster contest in support of the NPSF National Patient Safety Awareness week, 4-10 March 2012. The contest will run from 1 January - 16

March 2012. The winners will be announced on 2 April 2012.

This year's theme is "Be Aware for Safe Care" and one category will be based on it. A general patient safety category will also be part of the contest.

More information about the contest will be sent out by email.

The POC for this contest is Mr. Fred Del Toro, 210-221-6966.

## *COL Grace (continued from page 1)*

"Communication is not just verbal but also written," reflected COL Grace.

On the subject of policies, COL Grace reiterated, "everything goes into a policy; we tend to overemphasize the made-to-have policies without really going back and seeing how things have changed." She added a reminder to update all policies along with the ever-changing technology. COL Grace's staff is actively updating MEDCOM Regulation 40-41 and adds, "we've had established programs for 5+ years and we haven't updated that policy; it's time to make it consistent with where we are today."

As a final comment regarding communication, COL Grace, a staunch proponent for Team-STEPPS, stated, "TeamSTEPPS© is a mechanism that provides us with tools to learn how to communicate" and added, "we've seen the pockets of excellence".

## *PSRS Data Collection and Analysis*

By Mr. Rafael Whispell

The Patient Safety Reporting System (PSRS) is a secure, web-based system permitting healthcare facilities to submit Patient Safety events. Most Patient Safety events reported are related to Medication, Clinical Process and Documentation which account for almost 70% of reported harm events.

Patient Safety and Quality are among the many factors that influence the number of submitted reports. Additional factors include: (1) facility size, (2) utilization or volume, (3) patient case mix, (4) severity of illness, (5) differences in facilities' understanding of what occurrences are reportable, and (6) differences in facilities' success in detecting actual and potential adverse events.



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## TapRoot® Tips and Tricks...

By Ms. Dana Rocha

1) Where can I download the TapRoot® v5 software?

Download the v5 software from the Patient Safety Learning Center at:

<https://www.us.army.mil/suite/files/26377940>

or from the System Improvements website at:

<http://www.taproot.com/ts5download>

using “ts5238” as both the username and password and choosing “Download the TapRoot Software Version 5.” You must have administrative rights in order to download the software and install the program.

2) What serial number should I use when installing TapRoot® software?

The serial number assigned to the Military Health System is: 501109-01129

## PS Educational Opportunities

Basic Patient Safety Manager (BPSM) Courses:

9 – 13 January 2012

23 – 27 April 2012

4 – 8 June 2012

10 – 14 September 2012

### PSLC Learning Opportunities:

Basic Patient Safety Manager Course

Monday, January 09, 2012 7:00 AM

Category: Patient Safety Workshops

Patient Suicides

Thursday, January 12, 2012 2:00 PM

Category: Patient Safety Learning Circles

2012 Military Health System (MHS) Conference

Monday, January 30, 2012 7:00 AM

Category: Patient Safety Connection

Information about upcoming DoD events can be found in the DoD PSP Learning Update, in the DoD PSP eBulletin, and on the Calendar of Events on the DoD PSP website!

## Input for the Newsletter

Please send us your newsworthy information to be included in future editions of the Patient Safety newsletter. Give us the who, what, where, why and when and we will add it although we may edit for space considerations. Please contact Mr. Fred Del Toro for assistance with formatting of any images.

The POC for newsletter items is LTC Cindy Renaker, 210-221-6622.

### PS Quiz

What do the yellow socks communicate?



Yellow socks identify patients at risk for falls.

### PATIENT SAFETY PROGRAM

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