



Headquarters Air Mobility Command



INTRODUCTION TO PATIENT SAFETY

**AMC/SGK
2013**

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OBJECTIVES



- Understand DoD patient safety mission
- Integrate AFMOA mission and vision statements
- Relate patient safety goals within the AE system
- Understand patient safety regulation
- Be aware of the 2008 CRAA
- Define patient safety
- Understand Patient Safety Culture/Just Culture



PATIENT SAFETY REGULATION



| DATE | EVENT |
|-----------------------|---|
| 1999 IOM REPORT | Report: cites 44,000-98,000 preventable deaths yearly; national cost \$ 17-29 billion yearly; 10-35% pts suffer preventable adverse drug events yearly; nosocomial infections result in 2M\$ cost and 90,000 deaths annually. |
| 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 | DoDI 6025.17 “Military Health System Patient Safety Program: defined DoD requirements for MHS PS Program; addressed NDAA 2001 requirements; assigned responsibilities; defined structure; established patient safety managers; set requirement for compliance with Joint Commission |
| 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 & Jul 2004 DoD | DoDD 6025.13 and DoD 6025.13-R Military Health System Clinical Quality Assurance Program Regulation |



DoD PATIENT SAFETY PROGRAM-OVERVIEW



VISION

The DoD PSP supports the military mission by building organizational commitment and capacity to implement and sustain a culture of safety to protect the health of the patients entrusted to our care.



MISSION

The DoD PSP promotes a culture of safety to eliminate preventable patient harm by engaging, educating and equipping patient-care teams to institutionalize evidence-based safe practice.



DoD Guiding Principles:

- Encourage an evidence-based systems approach to create a safer patient environment
- Engaging MHS leadership in the importance of patient safety and the establishment of an organizational culture that supports it
- Fostering trust, transparency, teamwork, and communication

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REGULATORY REQUIREMENTS



DoD Directive 6025.13

- Issued 17 February 2011
- Establishes DoD policy on issues related to Medical Quality Assurance (MQA) and clinical quality management activities in the Military Health System (MHS)

DoD 6025.13-R

- Issued 11 June 2004
- Implements DoD Directive 6025.13
- Must reading for all MTF Patient Safety Managers!
- DoD 6025.13-R is available online at:
<http://www.dtic.mil/whs/directives/corres/pdf/602513r.pdf>



REGULATORY REQUIREMENTS



■ HIGHLIGHTS: DoD 6025.13-R requires the following

- Maintain facility accreditation
- Maintain risk management and patient safety programs
- Receive reports of patient safety events
- Conduct root cause analyses (RCA's)
- Report patient safety events to DoD
- Determine ways of improving patient safety
- Communicate solutions to stakeholders



REGULATORY REQUIREMENTS



AFI 44-119 MEDICAL QUALITY OPERATIONS

- Issued 16 August 2011, *Medical Quality Operations*
- Patient Safety, Ch. 2 / Healthcare Risk Mngmnt, Ch. 10
- Highlights:
 - Clinical Quality: Patient Safety, Risk Management, Performance Improvement
 - Providing a Safe Care Environment:
 - ◆ Improved communication and cooperation
 - ◆ Systems and processes rather than individuals
 - ◆ Prevention rather than punishment



REGULATORY REQUIREMENTS



-
- **AFI 44-119 MEDICAL QUALITY OPERATIONS (cont)**
 - **Root Cause Analysis (RCA) on Events**
 - **Medical Incident Investigation (MII)**
 - **Sentinel Event Review and Reporting**
 - **Risk Management Program**



REGULATORY REQUIREMENTS



-
- **AFI 41-307 AE Pt Considerations & Standards of Care**
 - **Issued 20 August 2003 (presently being revised)**
 - **Pt Movement Safety Program for AE, Attach 14**
 - **Highlights:**
 - **Provides Patient Safety Objectives in PM/AE**
 - **Outlines Responsibilities (USTC/SG, AMC/SG, AMC Pt Safety Manager, HQ AMC/A3, etc)**



REGULATORY REQUIREMENTS



-
- **AFI 41-307 AE Pt Considerations & Standards of Care (cont)**
 - **Event Classification Descriptions**
 - **Event Category Descriptions**
 - **Reporting a Medical Class A or B Event**
 - **AE Event Review Process and MII**
 - **Patient Safety Resources**



2008 CRRA PS MODERNIZATION PLAN



- **CRRA: AF process to assess current and future capabilities, identify potential shortfalls and estimate operational risk to the Joint Warfighter**

- **2007 AFMS CRRA: Patient Safety was #1 shortfall**

- **2008 PS Modernization Plan:**
 - Write definitive AFMS Patient Safety doctrine & policy
 - Revise AFI 44-119 (simplify) and new AFMS PS manuals
 - Report AES PSP events to AFMOA
 - Standardize PS training requirements
 - Adjust all AFMS leadership training courses (SQ/CC & above) to include PS elements



WHAT IS PATIENT SAFETY?



- Patient Safety is the **identification** and control of **hazards** that could cause harm to patients.
- Patient Safety is the **prevention** of harm or injury to patients.
- Patient Safety includes actions undertaken by patients and staff to **protect** patients from being harmed by the effects of health care services.

Figure 1. HHS Patient Safety Model

Cornerstones, Connections and Caring





PATIENT SAFETY CULTURE



PROACTIVE:

- Orientation & Training
- CRM/TeamSTEPPS
- Safety Culture Survey
- Patient Safety Goals
- Near Miss Reporting
- Patient Centered Strategies

REACTIVE:

- Event Reporting
- RCA (Root Cause Analysis)
- MII (Med Incident Investigation)
- NOTAMs & Alerts

**SUPPORTS LEARNING &
IMPROVING**



DEFINITION OF A SAFETY CULTURE



-
- Enduring, shared beliefs and behaviors that reflect an organization's willingness to learn from errors

(Weigmann, 2002)

- Four key beliefs present in a safety culture (IOM 2004)

- Our processes are designed to prevent failure
- We are committed to detect and learn from error
- We have a just culture that disciplines based on risk
- People who work in teams make fewer errors



WHAT DOES A SAFETY CULTURE LOOK LIKE?



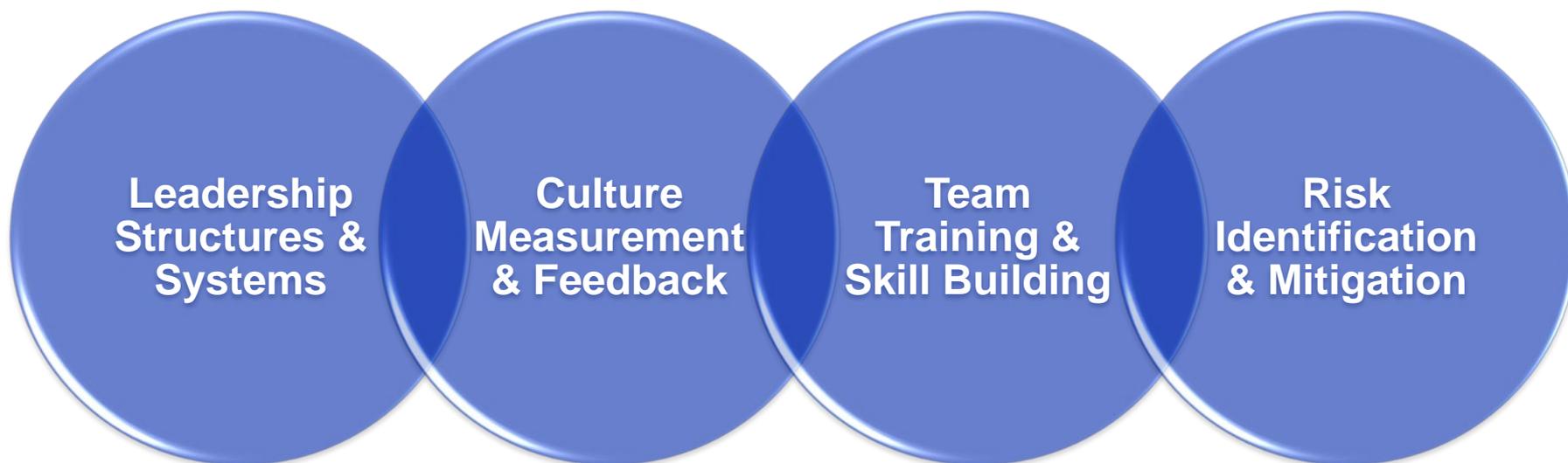
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- Teamwork
 - Open Discussions
 - Internal and external reporting of safety issues
 - Focus on systems
 - Reckless behavior/disregard NOT tolerated
 - Organizations are committed to on going learning and have the flexibility to accommodate changes in technology, science and the environment



DRIVERS OF SAFE PRACTICE



National Quality Forum Safe Practices Safe Practices #1-4



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SAFETY CULTURE COMPONENTS



Source: Reason, J. from *Managing the Risk of Organizational Accidents*, 1997



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COMPONENTS OF A CULTURE OF SAFETY



-
- **Commitment to safety articulated at the highest levels**
 - **Necessary resources, incentives support commitment**
 - **Safety is valued as the primary priority, even at the expense of “production” or “efficiency”**
 - **Communication between workers and across organizational levels is frequent and candid**
 - **Unsafe acts are rare, despite high levels of production**
 - **There is openness about errors; they are reported when they do occur**
 - **Organizational learning is valued**
 - **Response to a problem focuses on improving system performance rather than on individual blame**
-



SHIFTING CULTURE AND THINKING



■ A Shift in Culture Requires a Shift in Thinking:

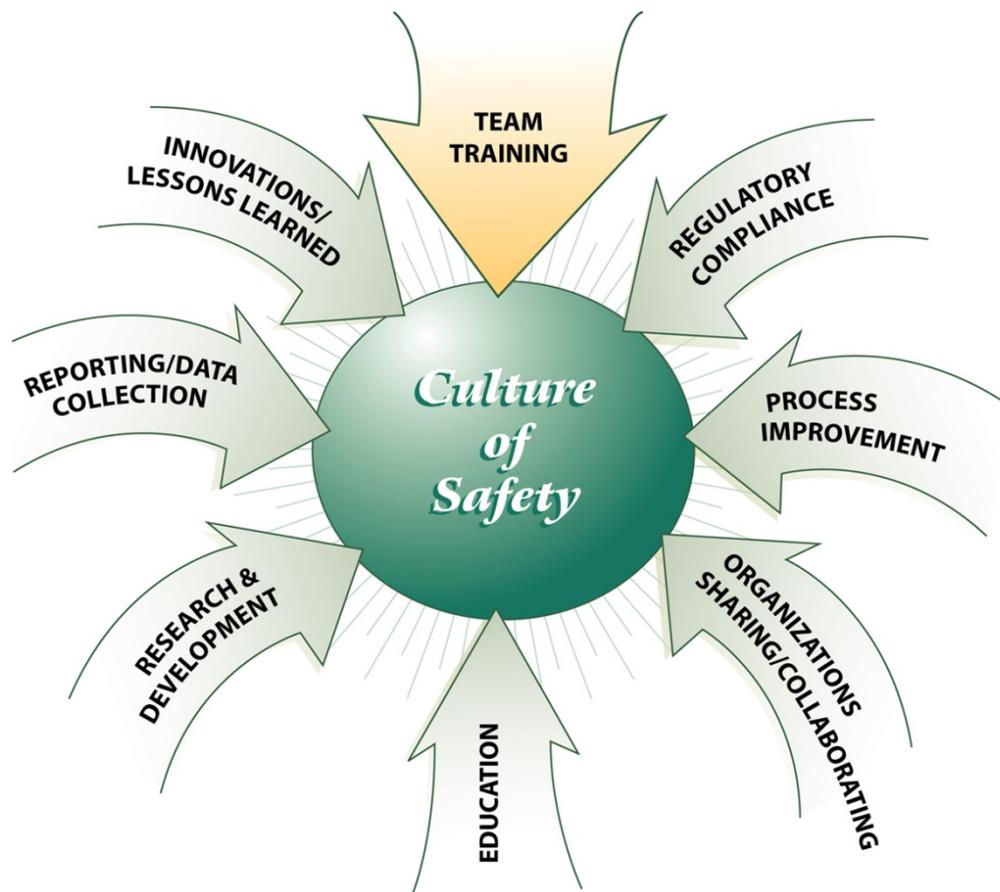
| A Culture of Blame | A Culture of Safety |
|-----------------------|--------------------------------------|
| Who did it? | What happened? Why? |
| Punitive | Fair and just |
| Bad people | Bad systems |
| Penalize the reporter | Thank the reporter |
| Confidential | Transparent learning |
| Investigation | Root Cause Analysis |
| Independent silos | Inclusive and interdisciplinary team |



AF PATIENT SAFETY FRAMEWORK



AFI 44-119, Chap 2



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“JUST CULTURE”



-
- **The single greatest impediment to error prevention:**

“we punish people for making mistakes”

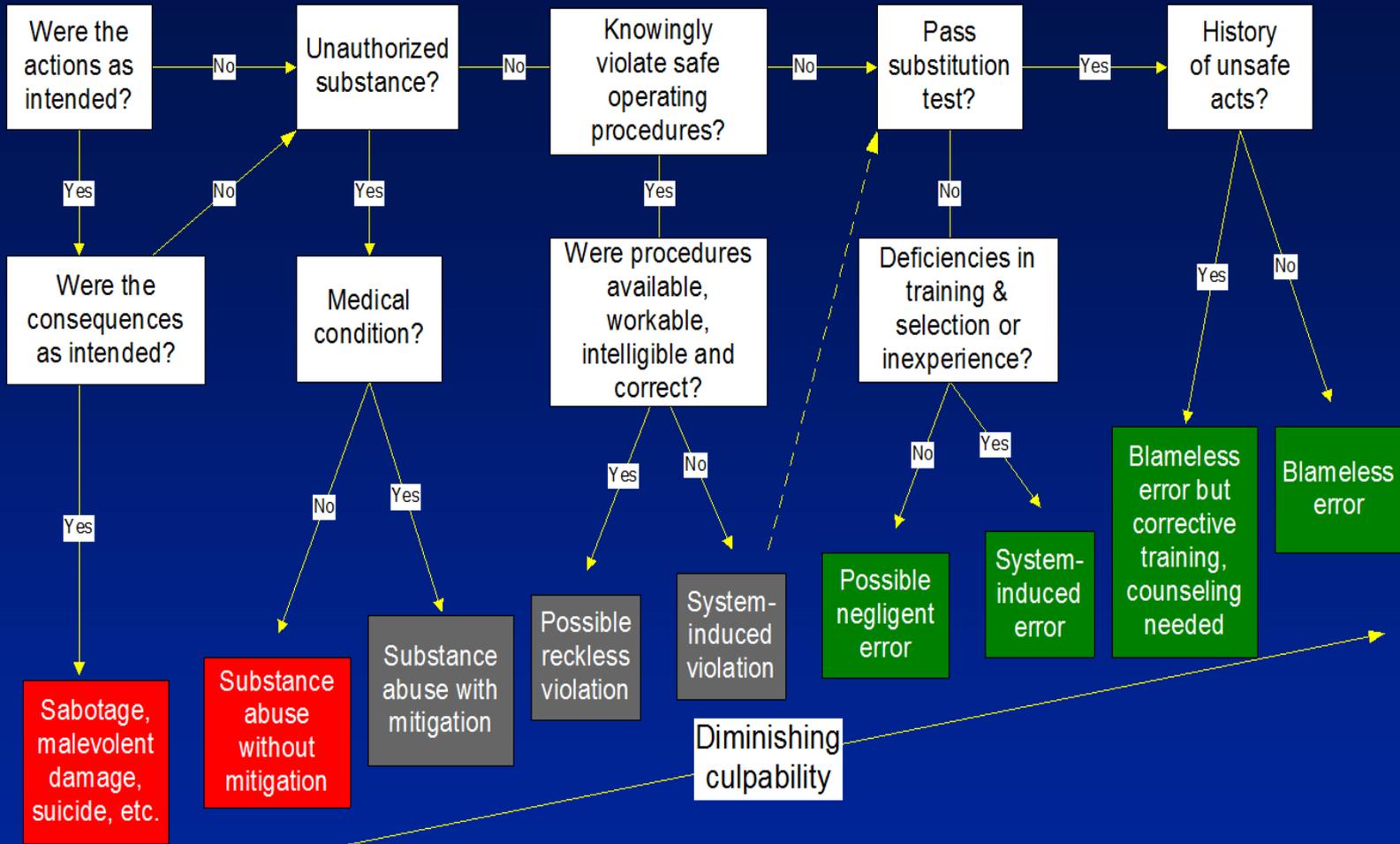
- **A safe culture allows reporting events in the interest of safety for ALL**
- **Blame-free reporting includes disciplinary actions when indicated**
- **A Just and Safe Culture occurs with the willingness to report events as soon as they happen**



“JUST CULTURE”



-
- Behavioral concepts between the inter-relationship of discipline and patient safety
 - Human Error
 - Negligent Conduct
 - Reckless Conduct
 - Knowing Violations
 - We all must be held accountable for our efforts to make the system safer
-



Decision Tree for Determining Culpability of Unsafe Acts



NO BLAME / ACCOUNTABILITY



- **“No Blame” culture does not mean “No Accountability”**
- **Leadership and/or Professional Accountability**
- **Risk behaviors can be managed to reduce harm**
- **Repetitive Errors**
- **Qualification**



PATIENT SAFETY RESOURCES



| ORGANIZATION | ACRONYM | WEB ADDRESS HYPERLINK |
|---|---------|---|
| Agency for Healthcare Research & Quality | AHRO | http://www.ahrq.gov/ |
| AMEDD Knowledge Exchange | KE | http://www.cs.amedd.army.mil |
| American Medical Association | AMA | http://ama-assn.org |
| American Society for Health Risk Management | ASHRM | http://www.ashrm.org/asp/home/home.asp |
| DOD Patient Safety Center | DOD PSC | http://health.mil/dodpatientsafety |
| ECRI | ECRI | http://www.ecri.org |
| Health Affairs | HA | http://www.ha.osd.mil/ |
| Institute for Healthcare Improvement | IHI | http://www.ihl.org/ |

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PATIENT SAFETY RESOURCES



| ORGANIZATION | ACRONYM | WEB ADDRESS HYPERLINK |
|--|---------|---|
| Institute of Medicine | IOM | http://www.iom.edu/ |
| Institute for Safe Medication Practices | ISMP | http://www.ismp.org |
| National Patient Safety Foundation | NPSF | http://www.npsf.org |
| National Quality Forum | NQF | http://www.qualityforum.org/ |
| Quality Interagency Task Force | QuIC | http://www.quic.gov/index.htm |
| The Joint Commission | TJC | http://www.jointcommission.org/ |
| TRICARE Management Activity | TMA | http://www.tricare.osd.mil/ |
| Veterans Administration National Center for Patient Safety | NCPS | http://www.va.gov/ncps |



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http://health.mil/dodpateintsafety//AboutUs_1.aspx
 - Patient Safety Regulation:
 - DoD 6025.13-R: the “Medical Quality Assurance in the Military Health System Regulation.”
 - ◆ <http://www.dtic.mil/whs/directives/corres/pdf/602513r.pdf>
 - AFI44-119, Medical Quality Operations, Chap 2
 - ◆ <http://www.e-publishing.af.mil/shared/media/epubs/AFI44-119.pdf>
 - AFI41-307 Aeromedical Evacuation Patient Considerations and Standards of Care, Attach 14
 - ◆ <http://www.e-publishing.af.mil/shared/media/epubs/AFI41-307.pdf>



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 - Safety Culture Components: Reason, J. from *Managing the Risk of Organizational Accidents*, Ashgate 1997.
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QUESTIONS?

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