Uploaded to VFC Website

February 2013

This Document has been provided to you courtesy of Veterans-For-Change!

Feel free to pass to any veteran who might be able to use this information!

For thousands more files like this and hundreds of links to useful information, and hundreds of "Frequently Asked Questions, please go to:

Veterans-For-Change

Veterans-For-Change is a 501(c)(3) Non-Profit Corporation
Tax ID #27-3820181

If Veteran's don't help Veteran's, who will?

We appreciate all donations to continue to provide information and services to Veterans and their families.

https://www.paypal.com/cgi-bin/webscr?cmd=_s-xclick&hosted_button_id=WGT2M5UTB9A78

Note: VFC is not liable for source information in this document, it is merely provided as a courtesy to our members.

Officials Step Up Patient Safety Efforts

Elaine Wilson | American Forces Press Service

March 31, 2010

While most people may shy away from broadcasting their on-the-job errors, Air Force Col. Christian Benjamin hopes his employees take a different stance.

Benjamin, commander of the 99th Medical Group at Nellis Air Force Base, Nev., encourages his staff to report their errors and "near misses," an effort he believes has boosted patient safety in his hospital.

"We have one core belief: If you wait for an error to investigate a process, than you are behind," he said. "We are very proactive at tracking near misses -- errors that never happened because they're caught in time. The more you pay attention to near misses, the more actual issues will be avoided.

"It's OK to make and identify an error," he added, "It's not OK to cover up an error."

Benjamin's thinking marks a shift toward a more proactive approach to patient safety, one that's being echoed throughout the Defense Department. And it's paid off for his group, which was recognized with the 2008 and 2009 Air Force Medical Service Best Inpatient Facility Patient Safety Program awards and the 2010 Military Health System Patient Safety - Culture Measurements, Feedback and Intervention award.

"We need to get out of the shame-and-blame system and get into what the rest of the world is doing," said Army Lt. Col. (Dr.) Donald W. Robinson, director of the Defense Department's patient safety program, "and that's providing information on near misses, providing information on what's going on with patients, and then looking at the severity."

Defense officials have adopted several new initiatives and programs aimed at bolstering patient safety at all levels — from the caregivers on up to the hospital leadership.

As an example, Robinson described an "off-the-shelf" computerized error reporting system, called Patient Safety Reporting, which in the initial implementation stage. Users input their errors or near misses into the program, and the data is sent to the hospital and on to service headquarters for analysis. This information can be used to drive new programs and initiatives to decrease the numbers of errors and near misses, he added.

"Right now, [error reporting is] a paper system," he said. "We need to get away from that and go to a computer system. The data will be way more voluminous than what we have now, and the data will be able to really drive a change." The reporting system is slated to begin full deployment in late summer, he added.

Defense officials also have launched a patient safety learning center Web site designed to bring everyone who has a role in patient safety together, Robinson said. The site, which features a chat room and vaults for file sharing, offers a "great space" for health professionals to collaborate and share best practices from their hospitals and service branch.

Robinson also described a complete revamping of the basic patient safety managers course, which is designed for patient safety managers on the "front lines" at the hospitals.

For more than a year, officials have examined standards across the states and within universities and master's programs. "Whoever is doing it better, we emulated and then advanced what they were doing," he said. "We've come up with a brand-new, world-class program."

The new, five-day course will begin next month, and feature topics such as proactive risk analysis and statistical analysis.

Along with new initiatives, Robinson expressed his confidence in existing programs such as Team Strategies and Tools to Enhance Performance and Patient Safety, also known as TeamSTEPPS, a collaboration between the departments of Defense and Health and Human Services. This system emphasizes the value of teamwork to ensure the best patient care. Health care teams work together to establish situational awareness, solve problems and resolve conflicts.

"It looks at the processes that are most important to teams, and it looks at … the necessary competencies to be a high-reliability organization, a high-functioning team, and it meshes all those together in a health care environment," he explained.

At Nellis, Benjamin said, the TeamSTEPPS concept plays a significant role in the operating room and during patient handoffs. In the operating room, the medical team “huddles” to discuss the surgery as well as during a handoff, whether it’s from the OR to intensive care unit or emergency room to ICU. “We want to ensure everyone is on the same page,” he said. These huddles enable medical team members to point out potential errors or misunderstandings in patient care.

“What we’re trying to do is develop a culture where folks aren’t afraid to say what they see,” Robinson said. “Not ducking errors because we’re going to be chastised. It’s not about the provider, it’s about the process. TeamSTEPPS helps to strengthen the process in such a way that we decrease the severity of errors.”

Robinson gave an example of an error that can arise when people decline to speak up. He recalled when he was an instructor for the Army Trauma Training Center at the University of Miami. In a simulated training scenario, he had a patient with a mock mangled lower right extremity that would require a below-the-knee amputation. When his Army students were in the room, he announced, “I’m going to do a left, above-the-knee amputation.” Although the injury was on the right leg and he had identified the wrong leg for the procedure, no one spoke up.

“I did that to illustrate a point: I make mistakes like everyone else,” he said. “The purpose of TeamSTEPPS is to ensure that if mistakes are made, they’re caught early. It teaches folks to speak up right away to catch errors like that. It gets folks to communicate.”

Communication is a key component, yet medical professionals have strayed into habitually using too-complicated terminology, Robinson said, noting that it’s a culture he’s working to change. “Now we’re going back to Square One, back to something very simple. We want physicians to be able to talk to physicians and then talk to nurses and technicians. We need to break it down so everyone is using a common language.”

This also extends to the patients, who have the biggest stake in their care. “Patients have to be actively involved in their care,” Robinson said, which covers everything from medications to precautionary measures to treatment options.

“I put everything on the table so they can understand their options,” he explained, “and then say, ‘You are going to make the decision.’”

Patients’ input also is solicited. At Benjamin’s hospital, patients are asked for the feedback by patient safety representatives both during and after their care. “We take patient comments to heart,” he said. “We ask, ‘Are there areas where we can do better?’”

With understanding at all levels of care, the possibility for errors and near misses is bound to decrease, Robinson said.

“Error is inherent in our DNA,” he said. “Everyone makes errors. But we’ve seen a decrease in severity of errors and an increase in reporting. And that’s exactly what we want.”

The bottom line, he noted, is that “everyone in our country, leaders at all levels, want to ensure the best possible care is provided to our servicemen and women. And that’s how it should be.”