2011 Military Health System Conference

The Patient Safety Reporting System (PSR)

The Quadruple Aim: Working Together, Achieving Success

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TRICARE Management Activity Office of the Chief Medical Officer
Department of Defense Patient Safety Program

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Session Objectives

- Become familiar with the Patient Safety Reporting System that is currently being deployed across the direct care facilities.
- Understand the capabilities of the system and the importance of capturing both medication and non-medication patient safety events in a standardized format which facilitates event capture, analysis, trending and learning from patient safety occurrences.
- This session will consist of the following:
  - 1. Discussion of the PSR application, application benefits, planned product enhancements, aggregate data to date
  - 2. Service representatives will discuss PSR use and implementation from the Service Headquarters perspective
  - 3. Lessons learned from an experience PSR user at the local MTF level
  - 4. Roll out schedule of pending site implementations

DoD Patient Safety Program

- A comprehensive, centralized program with the goal of establishing a culture of patient safety and quality within the MHS
- Established under the 2001 Department of Defense Instruction (DoDI) 6025.17
- DoD PSP identifies and reports actual and potential problems in medical systems and processes and to implement effective actions to improve patient safety and health care quality throughout the MHS

Our Mission *is to promote a culture of safety to eliminate preventable patient harm by engaging, educating and equipping patient-care teams to institutionalize evidence-based safe practices.*

Our Vision *is to support 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.*

MHS Quadruple Aim

Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

Experience of Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

Population Health

Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

Per Capita Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

Why is Reporting Important?

- It's important – to keep our patients safe
  - 44,000 – 98,000 deaths/year (IOM 1999)
  - $17 – $29B annually Lost income, production, disability and healthcare costs
    - Over half healthcare costs
  - 1.5M preventable adverse drug events annually in U.S. (IOM 2006)
    - $3.5B annual estimate
- In the DoD:
  - Approximately 128,000 potential and actual events reported in 2009

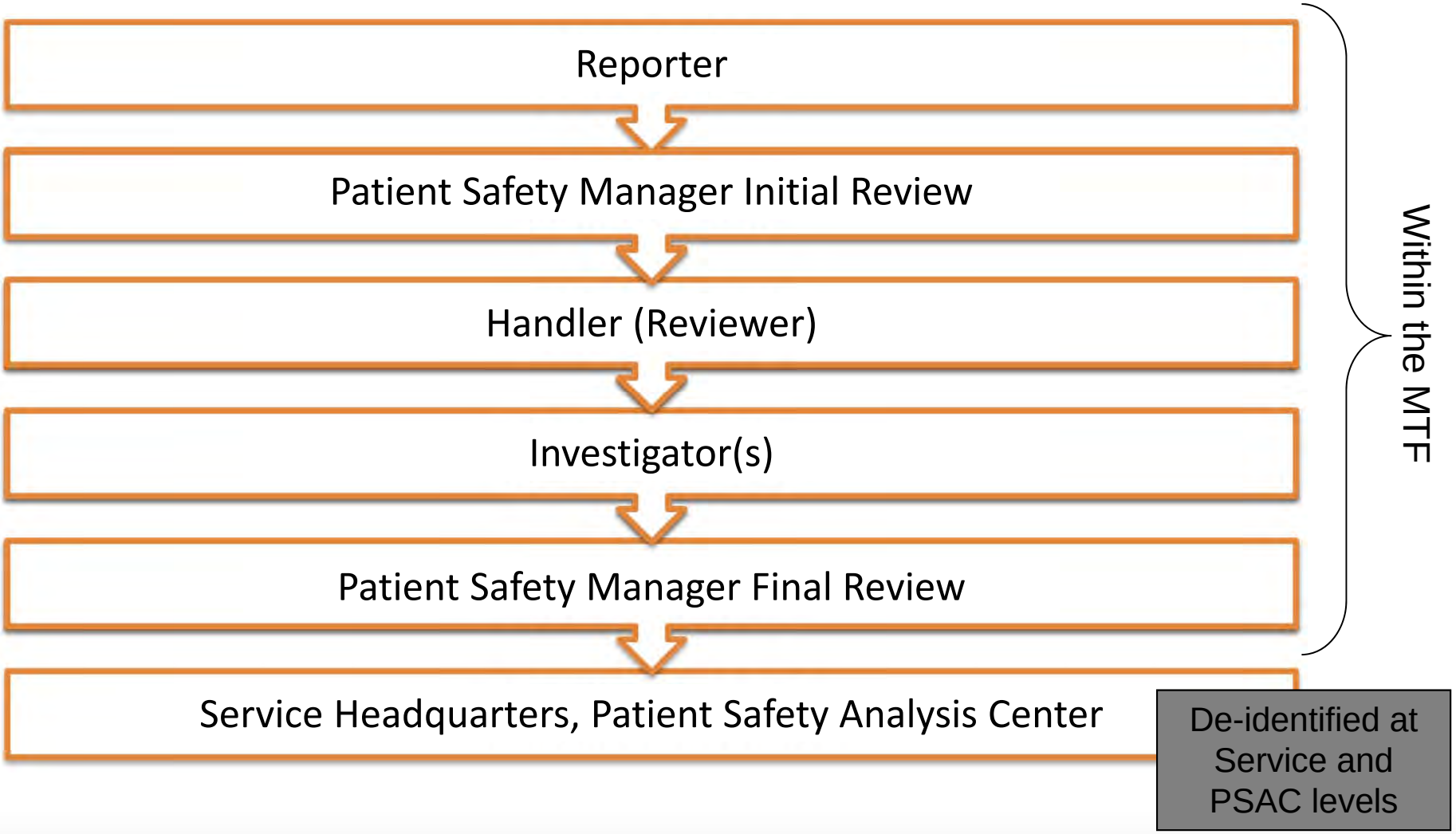
Capabilities

- **Broadly applicable:** Commercial Off-the-Shelf (COTS) reporting system
- **Maintains confidentiality:** Supports anonymous reporting
- **Easily Assessable:** Web-based application
- **Secure:** Supports role-based security; CAC enforced
- **Simple to use:** Intuitive point and click, drop downs, text for the user
- **Promotes information sharing:** Automates the non-standardized paper-based systems

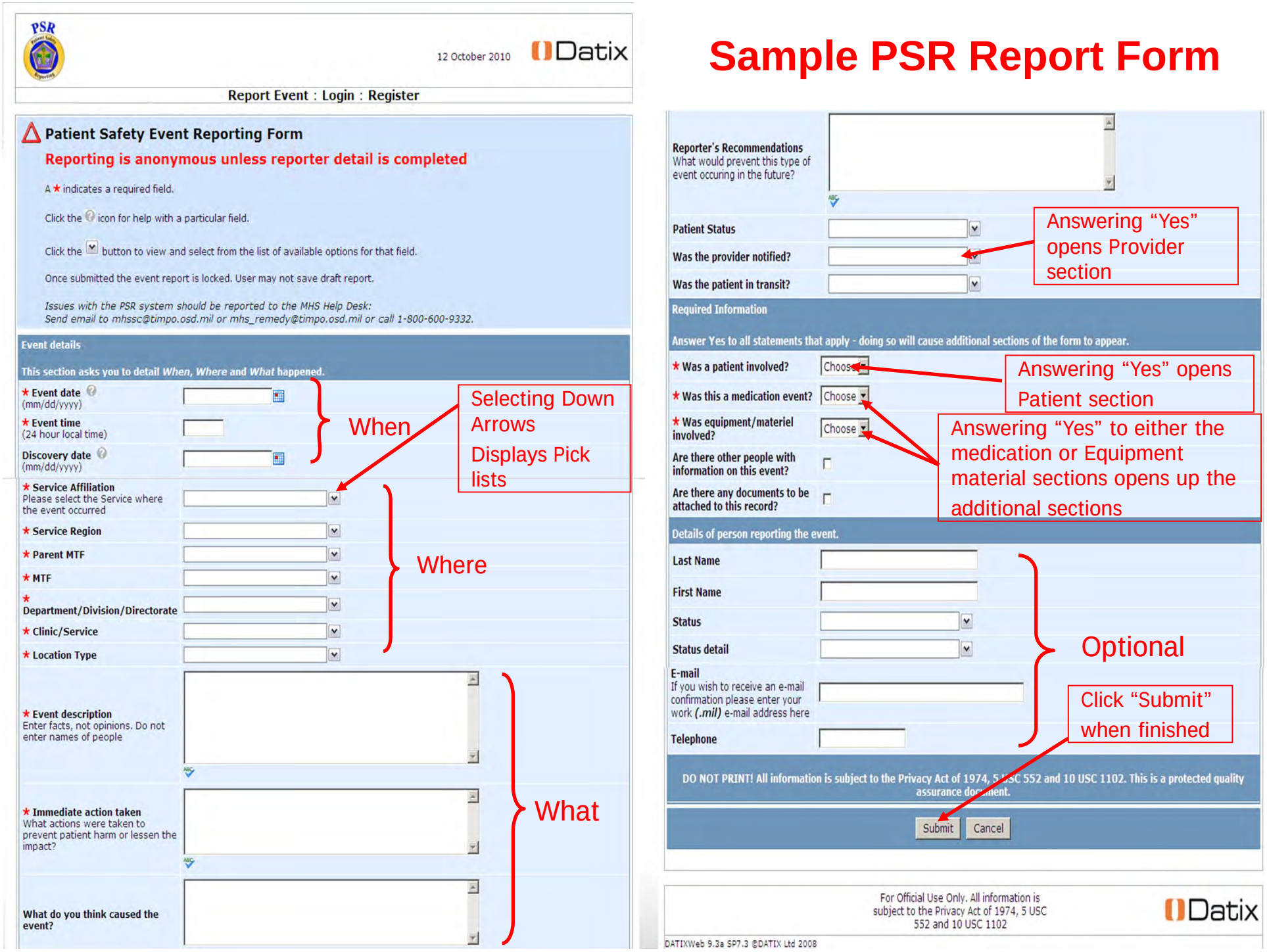
Benefits

- **Helps improve patient safety**
  - Promotes depth of information necessary for the proactive improvement of patient safety
  - Supports the local, Service and enterprise-wide safety improvement strategy through systematic methodologies and comprehensive analytic tools
- **Enables greater ability to learn and share safety information**
  - Consolidates both medication and non-medication events in one tool
  - Standardizes data capture and taxonomy
  - Centralizes capture, collection and aggregation of event level data
  - Begins alignment with AHRQ Common Formats
- **Promotes fiscal responsibility**
  - Facilitates cost avoidance by reduction of preventable and avoidable health care events
- **Addresses DOD and Congressional Requirements**
  - Responds to the 2001 National Defense Authorization Act (NDAA) and DoD 6025.13

Typical Event Flow



Sample PSR Report Form



Major Implementation Milestones

- 44 sites online, 93 sites scheduled between now and 30 June 2011
- Completing and submitting hierarchy
- Determining who will have PSM and Reviewer roles
  - Get them registered
  - Complete AARF
- 45, 30, 15 day Pre-implementation meetings
  - Provide information
  - Assess readiness for training and implementation
- Training
  - Typically 3 – 5 days depending on facility size
    - Instructor led
      - PSM (8 hrs)
      - Reviewer/Investigator (4 hrs)
  - Web-based training available for all roles including reporter
- Implementation
  - Immediately following training

Planned Enhancements

- Next version 10.2
- Overall enhancements
  - Approval status fields
  - Type ahead
  - Enhanced e-mail notifications
- Improvements to Searching and Reporting
  - Extra fields
  - Stacked bar, stoplight, gauges, change orientation etc
  - Define listing reports

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PSR Reporting – Air Force Perspective

Implementation & Early Lessons Learned

The Quadruple Aim: Working Together, Achieving Success

Lt Col Beverly Thornberg, USAF, NC, DHA(c), MHA, RNC

January 24, 2011

United States Air Force

Overview

- Limited Deployment Sites
- Full Deployment Sites
- Challenges
- Successes

Limited Deployment

- Limited Deployment Sites:
  - Wilford Hall Medical Center: San Antonio, TX
  - Malcolm Grow Medical Center: Joint Base Andrews, MD
  - Davis-Monthan Medical Group: Tucson, AZ

Full Deployment

- Full Deployment Sites Implemented to date:
  - Bolling Air Force Base (AFB)
  - Langley AFB
  - Hanscom AFB
  - MacDill AFB
  - Wright-Patterson AFB
  - Seymour Johnson AFB
  - Whiteman AFB
  - Robins AFB
  - Little Rock AFB
  - Patrick AFB
  - Cannon AFB
  - Keesler AFB
  - Dover AFB
  - Maxwell AFB
  - McGuire AFB
  - Altus AFB

Challenges

- Aggressive Training Schedule: Increased man hours on regional managers
- MTF Leadership Support Early In The Process: Support in completing security forms
- Sustainment After Training Is Completed: Recommend a recorded DCO/Continued WBT
- Transition From MMSR & JAMRS to PSR
- Role of Champions (Reviewer/Handler or SuperUser): Key to complete & accurate reporting for usable analysis
- Local Access Issues: Not the PSR system

Successes

- Regional Managers at *Air Force Medical Operations Agency* Involvement With Each MTF (75 total): Working together for success
- Reporting Increased Already!
  - 3 facilities reporting 4-52% more
- Tier 3 Support to Resolve Issues Rapidly
- PSR Has Broadened the Number of Reporters
- New Staff Involvement: Significant increase in reporting
- Already Using the Data

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PSR Reporting – Navy Approach

The Quadruple Aim: Working Together, Achieving Success

Carmen C. Birk, RN, MS

January 24,2011

Navy Bureau of Medicine and Surgery

Navy Implementation Strategy

An Implementation Strategy to Ensure Success!

Ensure Leadership Commitment and Support	**Set Benefits Expectations and Targets**	**HQ Staff Participation in Site Training**	**Monitor Progress and Document Lessons Learned**

Navy Implementation Strategy

- Ensure Leadership Commitment and Support
  - High visibility at SG Level
  - Championed by Command Leaders
  - Ownership and involvement by RM/PS
  - Support for staff training and transitioning to new reporting requirements

Navy Implementation Strategy

- Set benefits expectations and targets for an improved Event Reporting process
  - Increase in events reported
  - Expedite review and referral timeline
  - Consolidated record of problems and issues
  - Ability to perform real-time event tracking and trending at MTF level
  - Comprehensive data available at HQ level for event analysis

Navy Implementation Strategy

- Include HQ staff participation in site training
  - Support RM/PS ownership of and involvement in PSR implementation and use
  - Reinforce communication policies and procedures
  - Address and resolve issues as they arise

Navy Implementation Strategy

- Monitor progress and document lessons learned
  - Coordinate with site to ensure implementation schedule stays on target
  - Incorporate training updates into implementation process
  - Compile site experiences to share

Navy Implementation Strategy

- Next Steps
  - Follow up on progress of implemented sites
    - Continue to troubleshoot user problems and resolve issues
  - Establish new baseline for Navy Medicine event reporting
    - Define HQ process for receipt and analysis of aggregate data

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PSR Reporting – A Military Treatment Facility's Perspective

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Suzie Farley

January 24, 2011

National Naval Medical Center, Bethesda

MTF Pre Implementation

- Plan
  - Develop the communication algorithm for flow of an event
  - Determine reviewers/investigators
  - Establish a contingency plan
  - Brief Leadership on benefits of the PSR system
  - Involve Middle Managers in process flow
- Market
  - Announce the PSR deployment to staff
  - Accessing the PSR
  - Review what to report


PATIENT SAFETY REPORTING PROGRAM
How To Report
5 Easy Steps for Using the Patient Safety Reporting System
1. Open your NNMC intranet browser and Click on PSR icon
2. Fill out the When? Where? & What? sections.
3. Enter other information as required.
4. Optional: Enter your information, or leave blank if you wish to remain anonymous.
5. Submit your report.
What To Report
Near Misses An event or situation that did not reach the patient but could have resulted in harm but didn't, either by chance or timely intervention.
Adverse Events An event that reached the patient and either did or didn't cause harm.
Sentinel Events Unexpected occurrences involving death or serious physical or psychological injury or risk thereof
Patient Safety Event Reporting Form
The Patient Safety Reporting System (PSR) icon located at the top of the intranet homepage gives you access to the electronic event reporting form.
What To Report On Patient Safety Forms
(Events are QA protected, confidential & privileged under 10 USC 1102)
Delay in diagnosis
Patient identification errors
Unanticipated surgical intervention required
Increased length of stay or level of care
Operative/other procedure related
Hospital acquired infections
Unanticipated outcomes of care Near misses
Lessening of function (sensory, motor, physiologic, intellectual)
Medication errors
Policy not followed
Falls
Disfigurement
Documentation errors
If in doubt, report
Sentinel Event (report within 24 hours)
Unanticipated death
Surgery on the wrong patient or wrong body part
Unanticipated death of a full-term infant
Radiation overdose or radiation to wrong body region
Severe neonatal hyperbilirubinemia (> 30 mg/dl)
Hemolytic transfusion reaction
Infant discharged to the wrong family
Rape
Unintended retention of a foreign object in a patient after surgery or other procedure
Major permanent loss of function (sensory, motor, physiologic, intellectual)
Abduction of any patient receiving care, treatment, and services Suicide inpatient or within 72 hours of discharge
Patient Safety is Everyone's Responsibility
Handling our patients with safety and care
PSR
Patient Safety Reporting Launch Party
Date: 1 April 2010
Location: Clark Auditorium
Time: 1000 - 1400
DHSS
PSR
Patient Safety
Reporting

MTF Training

- Train
  - Middle Managers on event process
  - Reviewers and investigators on roles and responsibilities
  - New harm classification definitions

Go Live

- Throw a kick off party
  - Engaged Commander and leaders
- Held weekly meetings with reviewers and investigators
  - Supported and problem solved
- Attended Department Head meetings
  - Established checks and balances

Sustainment

- Updating reviewers/investigators regularly
  - Account Authorization Request Forms (AARF)
  - Continuous training

- Disseminating lessons learned
  - Prepare to be flexible
  - New users already requesting customized data reports
    - Excel proficiency essential
  - Increase focus on training on event categories

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PSR Reporting – Army Approach

Medication Safety Focus

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LTC Jorge D. Carrillo, PharmD, MS, BCPS

January 24,2011

US Army Medical Command

Army Implementation Strategy

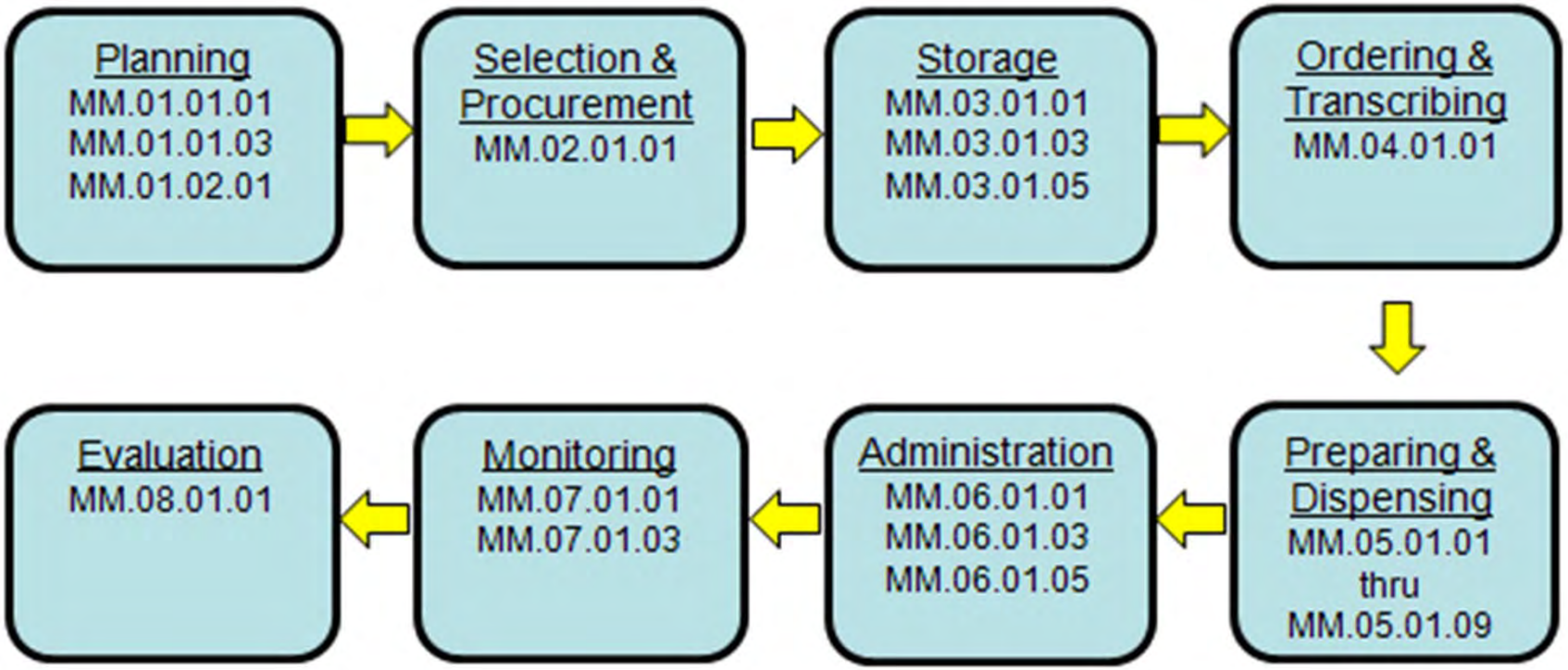
- Limited Deployment Sites:
  - Madigan Army Medical Center, Ft Lewis, WA
  - Martin Army Community Hospital, Ft Benning, GA
  - Kimbrough Army Ambulatory Health Clinic, Ft Meade, MD

Army Implementation Strategy (Cont)

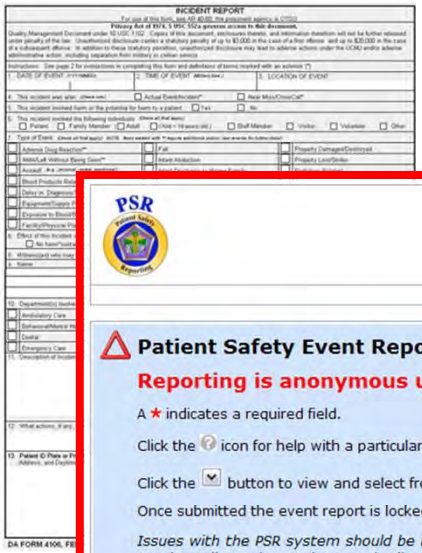
- Partnership with Regional Medical Commands
- CoS Implementation Memo – Nov 2010
- Full Deployment Schedule
  - NRMC – Nov to Dec 10
  - SRMC – Nov 10 to Feb 11
  - WRMC – Jan to Apr 11
  - PRMC – Apr to May 11
  - ERMC – May to Jun 11
  - DENCOM – May to Jun 11
- Transition of PS Data Reporting to HQ

Medication Safety Focus

- Medication Use Process



Medication Safety Focus



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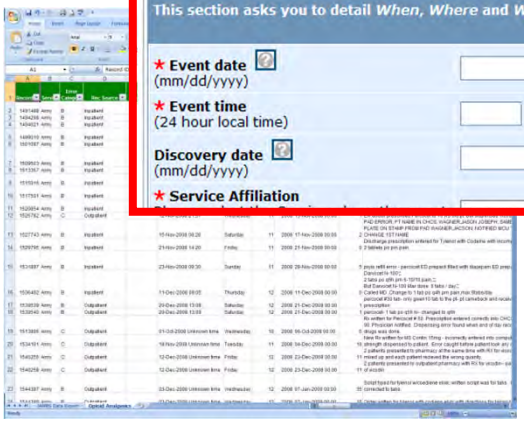
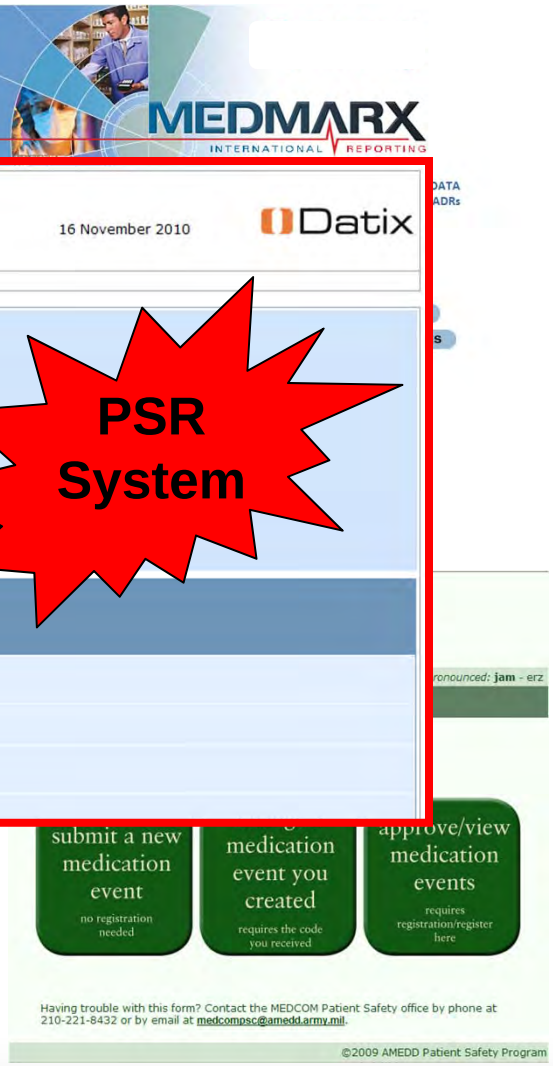


Spreadsheet



JAMRS

Medication Safety Focus

- Pharmacy & Patient Safety Collaboration
- Increased Visibility of Medication Events
- Reporting of Adverse Drug Events
  - Medication Errors & Adverse Drug Reactions
- Standard Pharmacy Reports
- Pharmacy-Specific PSR Training
- Collaboration with the Institute for Safe Medication Practices (ISMP)

PSR Reporting – Conclusions

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TRICARE Management Activity Office of the Chief Medical Officer
Department of Defense Patient Safety Program

Implementation Challenges

- Transparency and Trust
- Three Services with very different cultures
- Existing reporting culture
  - Paper based reporting vs. electronic
  - "Tick-mark" reporting vs. text-based
- Expectation management
  - Customization
  - Transition to standardization
    - Agreement on taxonomy
    - Appropriate use of that taxonomy
    - Efforts to ease the transition
- Aggressive (8-month) full deployment schedule

Lessons Learned

- Leadership engagement
- User Buy-in
- Methods to accelerate integration process
  - Webinars
  - Weekly Office Hours
- Understanding implications of reporting culture shift from paper-based to web-based
- Importance of getting the site hierarchies correct

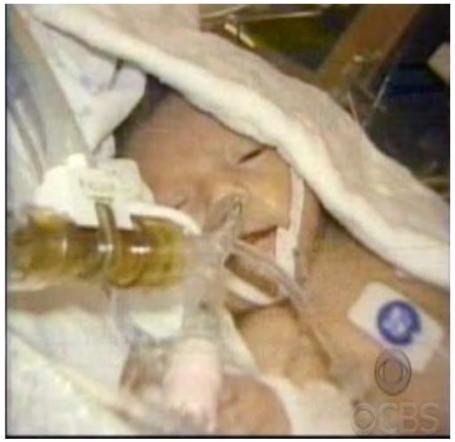
PSR Success Story

- A system that provides the data granularity necessary to implement change and make our facilities safer for our patients
- Functional community engaged
- Good functional/IT community partnership
- Good Government/Vendor partnerships

Conclusions

- Reporting is good!
- Encourage reporting
- Routinely review and discuss trends
- “If you don’t report them you can’t fix them”
- The culture of safety begins with all of us!

McClinton died after being injected with chlorhexidine, an antiseptic, during a procedure for a brain aneurysm. The antiseptic was mistaken for another substance to be used in the procedure.



A third premature baby has died after being given an overdoes of an anti-clotting drug in an Indianapolis hospital.

Laurie Johnston, Ontario, Canada healthy breast removed in error…

Questions?

For more information, contact your Service POC:

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http://health.mil/dodpatientsafety