



PATIENT SAFETY

IN THE AMEDD



1 September 2013

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Upcoming Events

PS Quarterly DCO Meeting:
17 October 2013
16 January 2014

Basic Patient Safety Managers Course:
4-8 November 2013
7-11 April 2014
Approval to attend: By your RMC PSO/PSM and your immediate supervisor

Dental Sterilization and Infection Control Events – A Dirty Topic By Mr. Suwaid Khan

Lately, there have been many reports submitted to the Patient Safety Reporting (PSR) System related to sterilization and infection control. The reports fell into the categories of either reportable events not requiring a Root Cause Analysis (RCA) or adverse events which require an RCA. Either way, in some form or fashion, all these events had consistent commonalities.

During many times, as both providers and ancillary personnel, we get into a routine which may eventually lead to some degree of complacent behavior. That's simply called human nature. We do it in our personal lives and sometimes it follows us to work. So, the question is, "how do we ensure our complacency doesn't affect our patients?" The simple answers are self and situational awareness.

Be aware of yourself and what is going on. Get into the routine of checking things in some progressive or sequential order and follow those steps to maintain the continuum. Situational awareness comes into play when assumptions play a role with errors. Assumptions are one of the major factors which lead to continued errors. We all love to trust each other, however, trust is not the issue here. As vigilant providers and ancillary personnel, we should effectively communicate



and cross check to ensure that assumptions are delineated and not just assume that an individual has completed the required task. If corrections are made, make them professionally, and don't be demeaning about it or take it as a personal attack. Remember, the focus here is one team.

Some key questions to ask yourself when viewing your sterilization process are:

- 1) Is there a memorandum posted that distinguishes who is authorized to work in the sterilization room and trained to an acceptable efficiency level? Note the key words are "acceptable" and "efficiency." Anyone can be trained but was the training received appropriately and can the task be retained and accomplished by the individual?
- 2) Are proper handoffs being conducted between organizational personnel during periods of absences? Troubleshoot potential situations that could go

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wrong and put measures in place to prevent those situations.

3) Does your team view the outer and inner sterilization indicator tapes/strips prior to opening and setting up for the next patient? Is the action noticeable or is it done in an unnoticeable fashion?

4) Are biological indicator tests utilized in accordance with manufacturer's guidelines and logged within sterilization books?

5) Are sterilization logs "actually" monitored and reviewed by an entity outside of the sterilization room?

6) Are all of your personnel aware of the proper reporting process when a sterilization or infection hazard is recognized?

Key elements that could drastically reduce or mitigate potential or actual sterilization and infection errors from occurring are: communicate effectively; trust one another for oversight; and notice and address complacency.

For additional guidance, please contact your DENTAC/DCC Patient Safety Officer/Manager and DENTAC Infection Control Officer/NCO. DENTAC and DCC Patient Safety personnel may contact their regional Patient Safety Managers for guidance.



We are in milSuite. Visit us to discuss, comment and collaborate on Patient Safety subjects. <https://www.milsuite.mil/book/groups/usa-patient-safety-program>

Oral Maxillofacial Surgery and Adverse Events in the OR

By Mr. Suwaid Khan

Recently, there was confusion when an adverse event occurred with oral surgeons and ancillary personnel conducting a clinical/surgical procedure in the operating room of a servicing medical center/activity.

The location of this event ultimately made the event a "Joint Commission Reportable Event" and required Root Cause Analysis (RCA). This didn't automatically exclude dental personnel from participating in the RCA. In this instance the DENTAC Patient



Safety Officer assigned to investigate the issue partnered with the RCA team and with the Medical

Center/Activity's Patient Safety Office.

A Commander's Critical Incident Report (CCIR) was submitted through both channels in an Executive Summary (EXSUM) format along with a copy of the MEDCOM Form 732 and Charter Letter. This ensured that both reporting channels were in the loop.

However, only one Patient Safety Report needed to be submitted into the system. The submission may be done by the oral surgeon who witnessed the event or was part of the event. The submission can also be done by ancillary personnel that were part of

the event. Both teams developed a "joint venture" and conducted the RCA process together.

HINT: Once the RCA is complete, the original goes through the Medical Command PS channels and the other copy flows through the Dental Command Patient Safety channels.

The Root Cause

By LTC Cindy Renaker

The Root Cause is a 2-page quarterly information paper, created by MEDCOM Patient Safety.



The benefits of *The Root Cause* include: providing transparency of sentinel events; educating all medical staff levels (beginner to expert); providing tools to mitigate medical error risk; reinforcing AMEDD policy and practices; and decreasing overall sentinel events through continuous education and culture change.

To request access to *The Root Cause*:

<https://www.milsuite.mil/book/groups/the-root-cause>

For non PSMs Link to pdf file in QMD group:

<https://www.milsuite.mil/book/docs/DOC-114674>

For those that don't have a milSuite account they can register at: www.milsuite.mil

10 USC 1102: "Quality Assurance Document under 10 USC 1102. Copies of this document, enclosures thereto, and information there from will not be further released under penalties of the law. Unauthorized disclosure carries a minimum \$3,000 fine".



National Patient Safety Awareness Week Posters

Congratulations to all of the winners and thanks to all who submitted posters. We will continue to display as many posters as possible in this and future editions of the newsletter. In this edition we highlight "Theme" related posters. Please contact Mr. Fred Del Toro if you wish to use any poster for your facility.

Time Out!
Take the Time Out to find out!!!

7/365
7 Days of Recognition
365 Days Committed
To Safe Care

Washing Hands is the best plan!!!

PATIENT SAFETY

Infection Control is the way to go!!!

Follow the description for your prescription.

Medication safety

Patient Safety Is The Key... Just Ask DENTAC, They'll Agree!!!

Fort Meade DENTAC

Are you always safe with Patient Safety?

7/365

Baynes-Jones ACH

Make sure to always cover your bases:
Communication
Identification
Hand Washing/Infection Control
Medication Safety



Korea MEDDAC

Fort Bragg DENTAC

**7 Days Of Recognition
365 Days Of Commitment To Safe Care**

don't give up **Patient Safety is** worth it in the end.

chibird @ tumblr

Joel Dental Clinic, Fort Bragg, DENTAC

McChord DENTAC

7/365 7 days of recognition
365 days committed to safe care

PATIENT SAFETY AWARENESS WEEK
March 3-9, 2013

Sponsored by the National Patient Safety Foundation® NPSF

STOP

Avoid Mistakes When You Hit the Brakes!

Patient Safety Awareness Week

7/365

THIS WEEK
"7 days of RECOGNITION."
365 days of COMMITMENT to SAFE CARE!"

Fort Sam Houston DENTAC

NATIONAL PATIENT SAFETY AWARENESS WEEK 2013

7/365
7 DAYS OF RECOGNITION

$E^3 = mc^2$

365 DAYS OF COMMITMENT TO SAFE CARE
The Theory of Patient Safety

- E¹ - ENGAGE**
Really know your area, your staff and patients.
- E² - EDUCATE**
Knowledge is power, understand the purpose and goal.
- E³ - EMPOWER**
Yield your potential to the max, trust and execute.

The Result

- M - MENTAL MODEL**
This is shared and acknowledged by everyone, staff and patient.
- C¹ - CONFIDENCE & CONSCIENCE**
Ability and courage to act upon the task and knowing why they are doing it!

TeamSTEPPS = Patient Safety

W. Beaumont AMC

General Leonard Wood Army Community Hospital

G.L. Wood ACH

Taking Care of People
Providing Safe, Exceptional Patient care & Services

Always Safe
Every day. Every way.

Engaged & Committed
Healthy, Professional & Resourceful Staff

7/365: 7 days of recognition, 365 days of commitment to safe care



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://store.jcrinc.com/>

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>

Root Cause Tips & Tricks

(Custom Details Data Fields)

When printing Investigation Reports; consider displaying the following:

- (1) an Executive Summary section, near the front, giving an overview of the incident [some commanders request this];
- (2) specialized data for later trending;
- (3) pictures taken during the investigation; and (4) electronic copies of pertinent documents [word docs, pdfs, etc].

The TapRooT® software allows you to create Custom Details fields for these functions. Decide what data you wish to collect for each of your investigations, then create these Custom Fields. To create these fields, select Admin > Setup > Custom Details Fields. On this screen, select:

- (1) the name of the item (Field Description);
- (2) the order to display on your reports (Sort Order); and
- (3) the type of data to be stored there (Data Type).

Hails and Farewells

Hails:

Ms. Deneen Archer, Kenner AHC
(Ft Lee, VA)

Ms. Juliann Marchbanks, SAMMC
(Ft Sam Houston, TX)

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NEW

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“Working Today for a Safer Tomorrow”

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. Do you have a ‘near miss’ or ‘good catch’ story? We want to hear from you! Please contact MEDCOM Patient Safety to share your story at usarmy.jbsa.medcom.list.medcom-psc@mail.mil

