BY ORDER OF THE COMMANDER
59TH MEDICAL WING

59TH MEDICAL WING INSTRUCTION
44-130

3 NOVEMBER 2020

Medical

PATIENT SAFETY

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RELEASABILITY: There are no releasability restrictions on this publication.

OPR: 59 MDW/SGHP

Certified by: 59 MDW/SGHP
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Supersedes: 59 MDWI 44-130, 10 January 2017

Pages: 28

This instruction implements Air Force Policy Directive 44-1, *Medical Operations*. This medical wing instruction provides guidance on activities relative to Patient Safety. It outlines responsibilities and establishes procedures to comply with, implement, and sustain applicable to Department of Defense Patient Safety Program (PSP) standards and The Joint Commission National Patient Safety Goals (NPSG). The intent of this Medical Wing Instruction (MDWI) is to provide a centralized point of reference for all disciplines concerned. This instruction applies to all personnel assigned, attached, or on contract to the 59th Medical Wing (MDW). This instruction does not apply to personnel working at the 959th Medical Group, Brooke Army Medical Center (BAMC). This instruction does not apply to the Air National Guard or Air Reserve. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) listed above using the AF Form 847, *Recommendation for Change of Publication*. Requests for waivers must be submitted to the OPR listed above for consideration and approval. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW AFI 33-322, *Records Management and Information Governance Program*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

SUMMARY OF CHANGES

This publication has had significant revision, to include updated references, responsibilities, and procedures.

1. Program Overview.

1.1. The 59 MDW, PSP exists as a centralized program to promote quality healthcare by leading systematic, coordinated approaches that support a culture of safety, evidence-based best practices, and policies that lead to improved clinical outcomes.

1.2. Establishes a mechanism of decentralized execution to ensure all components of the PSP are integrated into all 59 MDW facilities. Manages a system to assess and reduce errors to achieve zero harm.

1.3. Fosters a culture of safety. Errors occur due to a breakdown in systems and processes. The 59 MDW promotes an interdisciplinary, non-punitive approach which fosters and supports an organizational environment of transparency within a just culture.

2. Goals.

2.1. Provide a safe environment for patients and staff. Comply with yearly mandated NPSG as required to maintain accreditation.

2.2. Prevent injuries to patients and personnel through a “systems approach” by using information reported through patient safety event reports as opportunities to improve our health care system and processes impacting medical errors and patient safety.

2.3. Systematically identify patient safety issues and implement policy/activities that will inform patients and families about patient safety, then design and implement methods to prevent their occurrence or reoccurrence.

2.4. Prevent or decrease events and manage injuries that do occur so as to minimize negative outcomes.

2.5. Build a safety-oriented organizational culture in which improving systems and processes to prevent harm is a part of everyday life by promoting identification, reporting, and analysis of events/near misses in a non-punitive, interdisciplinary environment to create a "blame-free" workplace.

2.6. Reduce the likelihood of a safety event reaching the patient by using a proactive system of process review, standard procedures, and crosschecks across the organization. Promote reporting of "near-miss" or "good catch" events to evaluate weaknesses in systems or processes that could lead to a patient safety event.

2.7. Engage patients/staff/visitors as active members of the healthcare team by encouraging them to report unsafe conditions or acts to support a Learning Organization.

2.8. Support the dissemination of patient safety alerts, Notice to Airmen (NOTAM), and other information pertaining to sentinel events and high-risk issues in collaboration with the Performance Improvement/Accreditation and Risk Management Offices.

3. Responsibilities.

3.1. The 59 MDW Commander**:**

3.1.1. Support strategies and principles of Trusted Care/High Reliability Organization (HRO) and Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®).

3.1.2. Have system-wide responsibility for the implementation and sustainment of a centralized patient safety program with decentralized execution.

3.1.3. Lead a culture of safety and set the tone by encouraging an organizational shift from a reactive response to a proactive stance to patient safety.

3.1.4. Allocate the necessary resources to sustain a comprehensive and integrated PSP.

3.1.5. Designate the OPR to direct the 59 MDW PSP.

3.1.6. Ensure PSP activities receive support from 59 MDW Group Commanders.

3.2. 59 MDW/SGH:

3.2.1. Support strategies and principles of Trusted Care/HRO.

3.2.2. Manage the implementation and sustainment of a centralized PSP with decentralized execution across 59 MDW.

3.2.3. Manage an effective marketing plan to promote a culture of safety and encourage an organizational shift from a reactive response to a proactive stance to patient safety.

3.2.4. Delegate tasks and authority as appropriate.

3.2.5. Charter Root Cause Analysis (RCA) teams when indicated.

3.2.6. Manage the 59 MDW PSP.

3.2.7. Ensure all centralized patient safety (PS) training is conducted by the PSP.

3.2.8. Review and analyze data from PSP Manager and Data Analyst in order to reduce errors and serious patient harm.

3.2.9. Chair the Patient Safety Function (PSF)/ Event Review Team (ERT) meetings

3.2.10. Chair the Patient Safety Working Group meetings.

3.2.11. Brief the Board of Directors on Patient Safety updates on a monthly basis or as needed.

3.3. 59 MDW Group Commanders will:

3.3.1. Ensure quality and continuity in the decentralized execution of the 59 MDW's centralized patient safety program.

3.3.2. Support strategies and principles of Trusted Care/HRO and TeamSTEPPS® to keep patients safe and free from harm.

3.3.3. Ensure all staff attend TeamSTEPPS training IAW AFI 44-119, *Medical Quality Operations* and Defense Health Agency (DHA) Procedures Manual (PM) 6025.13, *Clinical Quality Management in the Military Health System, Volume 2: Patient Safety.*

3.3.4. Promote use of the approved PSR system.

3.3.5. Identify and recognize individuals who prevent harm through the practice of safe behaviors and the use of error prevention tools. Examples of recognition include the Good Catch Award, Air Force Medical Service (AFMS) Patient Safety Award, and Patient Safety Champion Recognition Program.

3.3.6. Charter Corrective Action Implementation (CAI) Plan Team OPRs to track and report compliance with the Measures of Success (MOS) at the fourth month post CSA review and every two months concluding at the twelfth month once a CSA has been adjudicated by 59 MDW Patient Safety, AFMRA, and if appropriate TJC. If at any point during this period an MOS is found to have less than favorable compliance, the OPR will review the implementation process and if necessary modify the CA, coordinate changes with Wing Patient Safety, and then report to the group commander and the appropriate committee why the modification(s) was/were necessary and subsequent success or additional actions required to achieve compliance.

3.4. 59 MDW Flight Commanders will:

3.4.1. Promote the practice of safety behaviors and the use of error prevention tools to enhance a culture of safety and facilitate an organizational shift from a reactive response to a proactive stance to patient safety.

3.4.2. Support strategies and principles of Trusted Care/HRO/TeamSTEPPS®.

3.4.3. Ensure orientation and ongoing education for all staff.

3.4.4. Ensure compliance with the Wing PSP.

3.4.5. Ensure all personnel recognize that they are responsible for identifying and reporting events through the JPSR system.

3.4.6. Approve/sign-off on the adequacy of the investigation and the solution set(s) linked to each JPSR event related to their flight prior to advising their Group/Squadron PSM to move the event to "events with final approval status".

3.4.7. Advise their squadron commanders at least monthly on event trends such as recurring and difficult to resolve events and request assistance when additional resources might be required to solve.

3.5. Wing Patient Safety Program Manager will:

3.5.1. Implement the 59 MDW centralized PSP under the direction of the 59 MDW/SGH.

3.5.2. Track recent Joint Patient Safety Reporting System (JPSR) trends and report data to 59 MDW/SGH and all required regulatory entities and internal committees.

3.5.3. Identify and prioritize quality initiatives under the direction of the OPR based on data from the JPSR system, Comprehensive Systematic Analysis (CSA), Proactive Risk Assessment (PRA), Patient Safety Alerts, DHA Patient Safety Learning Center (PSLC) or The Joint Commission (TJC).

3.5.4. Analyze and extrapolate JPSR data in order to advise OPR on significant trends.

3.5.5. Coordinate and facilitate annual PS PRA.

3.5.6. Ensure reporting and compliance with NPSG.

3.5.7. Promote the decentralized execution of the PSP by providing guidance to group Patient Safety Managers.

3.5.8. Conduct TeamSTEPPS® Train-the-Trainer course.

3.5.9. Coordinate and facilitate written requirements as outlined in AFI 44-119, *Medical Quality Operations* and DHA-PM 6025.13, *Clinical Quality Management in the Military Health System, Volume 2: Patient Safety.*

3.5.10. Coordinate and facilitate the completion of CSAs.

3.5.11. Review and approve all work products and documentation from Group PSMs before sending to outside agencies.

3.5.12. Process the required paperwork needed for all staff leadership to gain JPSR investigator access in absence of Group PSM.

3.6. Patient Safety Assistant Coordinators (PSAC) will:

3.6.1. Assist in the administration of the 59 MDW centralized PSP under the direction of the 59 MDW PSP OPR and the Wing Patient Safety Manager.

3.6.2. Analyze and extrapolate JPSR data in order to advise OPR on significant trends.

3.6.3. Provide assistance in processing JPSRs when necessary.

3.6.4. Perform quality checks of the investigative reports and ensure standardized classification.

3.6.5. Assist Wing Patient Safety Manager with all components of the 59 MDW PSP.

3.6.6. Process the required paperwork needed for all staff leadership to gain JPSR investigator access in the absence of Group and Wing PSM.

3.6.7. Serve as facilitator for CSA when required.

3.6.8. Review and approve all work products and documentation from Group PSMs before sending to outside agencies.

3.6.9. Conduct TeamSTEPPS® training.

3.7. Group/Squadron Patient Safety Managers will:

3.7.1. Ensure compliance with 59 MDW PSP.

3.7.2. Ensure implementation and evaluation of the NPSG by documenting the observations in the web based Accreditation Manager Plus (AMP) Joint Commission Resources Tracers and Observation tool.

3.7.3. Maintain Group JPSR data. Use tools and metrics provided by the Wing PS, Air Force Medical Readiness Agency (AFMRA) and Defense Health Agency (DHA). Report group JPSR data to Wing PS on a monthly basis.

3.7.4. Ensure information regarding patient safety priorities, activities, and error prevention is proactively disseminated via the Group/Squadron PS huddles to all assigned staff.

3.7.5. Notify Wing PSM of a possible Sentinel Event (SE)/Reportable Event (RE) within 24 hours of discovery of the event.

3.7.6. Assist Wing PSM and PSAC in the coordination of CSAs.

3.7.7. Route all work products and documentation to Wing PS staff for review and approval before sending to outside agencies.

3.7.8. Conduct TeamSTEPPS® training.

3.7.9. Process the required paperwork needed for staff to gain JPSR investigator access.

3.7.10. Process JPSRs to include assigning an initial harm level, select an investigator based on location of event, and perform quality checks of the investigative reports.

3.8. Chief of Department/Service or Clinic will:

3.8.1. Promote the practice of safety behaviors and the use of error prevention tools to enhance a culture of safety and facilitate an organizational shift from a reactive response to a proactive stance to patient safety.

3.8.2. Support strategies and principles of Trusted Care/HRO/TeamSTEPPS®.

3.8.3. Ensure orientation and ongoing education for all staff.

3.8.4. Ensure compliance with the Wing PSP.

3.8.5. Ensure all personnel recognize that they are responsible for identifying and reporting events through the JPSR system.

3.9. All 59 MDW personnel are encouraged to:

3.9.1. Actively participate in creating a culture of safety by following organizational standards, evidence-based practices, and proactively intercept unsafe practices.

3.9.2. Utilize the JPSR system to voluntarily report all PS events to include near-misses.

3.9.3. Report adverse incidents and sentinel events to their leadership or PSM.

3.9.4. The staff member or the supervisor of the staff member who identified the event will preserve related materials.

3.10. PSR Event reporting.

3.10.1. Staff members will immediately attend to the needs of the patient upon identification of PS event.

3.10.2. The staff member or the supervisor of the staff member who identified the event will preserve related materials.

3.10.3. Please refer to the 59 MDW Patient Safety SharePoint for detailed information and instructions on the PSR system.

4. Joint Patient Safety Reporting (JPSR):

4.1. Patient Safety Events:

4.1.1. JPSR System:

4.1.1.1. All Military Health direct care facilities must report qualifying patient safety events to the DoD Patient Safety Program through JPSR. Self-reporting is one of the key components in the Military Health System (MHS) effort to achieve high reliability, and continuously improve and provide the safest patient care possible. Events that are reported encompass all levels of severity and types of medical and dental care.

4.1.1.2. Patient Safety Events will be reported IAW AFI 44-119 *Medical Quality Programs,* DHA-PM 6025.13, *Clinical Quality Management in the Military Health System, Volume 2: Patient Safety,* and JSPR Datix Business rules.

4.1.1.3. Patient Safety Event to be submitted in the JPSR system include untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided by the 59 MDW. Patient safety events may be due to acts of commission or omission.

4.1.1.4. Examples of patient safety events (not all inclusive) include patient falls, medication errors, attempted or completed patient suicides, wrong site procedures, equipment/utility system failure that impact patients/patient care, delay in treatment/procedure (to include delayed receipt of results), treatment/procedure problems, lack of informed consent or final time out, patient identification issues, medical record errors, and any other event with an adverse impact on patient care.

4.1.1.5. Patient Comments/Concerns. Patient comments/concerns are monitored by the Patient Advocate Office. Any event that may rise to the level of a Patient Safety Event will be reported in the JPSR system by the Patient Advocate or PS Office upon relay of details.

4.1.1.6. Staff injury and staff sharps incidents are monitored and tracked by the Wing Safety Office/Public Health and should not be entered into the JPSR system IAW JPSR Datix Business Rules

4.1.2. JPSR Event Investigations:

4.1.2.1. Staff members witnessing an event are responsible for initiating a JPSR within 24 hours of the event. Reporting may be anonymous, but a name is encouraged to allow feedback to the person reporting the event. Once an event or good catch report has been completed, no one has the authority to determine its validity prior to review by the Wing/ Group PSM.

4.1.2.2. In order to establish timely process improvement efforts, each group is responsible for establishing patient safety event routing plans within their group chain of command. Each group's PSM is responsible for overseeing the routing within their group.

4.1.2.3. Group PSMs route all patient safety event forms to all involved departments/services/units for review, process improvement actions, and education on the performance improvement efforts of all involved departments.

4.1.2.4. Wing PS will perform at least a monthly analysis of all reported patient safety events and report the aggregated data to the appropriate function or committee in cooperation with the Group PSM.

4.1.2.5. Wing PS will review every event reported in JPSR to ensure the harm scale rating and categorization is appropriate to the event.

4.1.2.5.1. If there is an inconsistency between the Group Patient Safety Manager's interpretation and Wing PS Office, no changes will be made until the event is placed in final approval status (closed).

4.1.2.5.2. The Wing Patient Safety Office will then discuss the disparity prior to changing. This disparity will also be discussed at the weekly/biweekly Wing Patient Safety Manager's Meeting. The goal of this process will be to ensure standardization across the 59 MDW.

4.1.2.5.3. The Wing Patient Safety Office will maintain a change log that will allow tracking and trending of similar type events and will allow future 59 MDW PSMs to review this log (excel spreadsheet) to see why certain changes were made.

4.1.3. Safety Assessment Code (SAC) scoring is used to classify single or aggregate patient safety events. The SAC score is calculated based on the frequency and severity of an actual or near miss event. The SAC score is a ranked risk score

4.2. Other Event Categories:

4.2.1. Potentially Compensable Event (PCE). PCEs are conducted IAW AFI 44-119 *Medical Quality Operations* and DHA-PM 6025.13, *Clinical Quality Management in the Military Health System, Volume 2: Patient Safety.*

4.2.2. DoD RE/SE.

4.2.2.1. All official communication and work products regarding RE/SE for the 59 MDW will be reviewed and approved by the Wing PS Office before being sent to AFMRA, DHA, and TJC.

4.2.2.2. Adverse events resulting in a patient injury/SE/suspected SE must be reported to the respective Group SGH or 59 Dental Group Chief of Dental Services (SGD) and Wing RM immediately but not more than 24 hours after the event. The Group SGH or SGD and Wing RM will notify the Wing SGH. At any time this can be accomplished by an immediate verbal report to Group SGH or SGD, PSM or Wing RM and then in JPSR.

4.2.2.3. Verbally notify Risk Manager by email or calling via telephone, 292-6004. Wing RM will notify Wing PSM of an event for appropriate action and analysis. If Wing RM is unavailable, contact Wing SGH or Wing PS Office. JPSR is submitted as soon as possible following the verbal notification.

4.2.2.4. A Comprehensive Systematic Analysis is accomplished on each DOD RE, SE, or SAC 3 event utilizing the DHA prescribed methodology appropriate to the scale/magnitude of the event. Wing PS Office coordinates all RE/SE reviews in collaboration with the Wing SGH, RM, and the respective Group SGH or SGD and PSM.

4.3. CSA:

4.3.1. Root Cause Analysis:

4.3.1.1. A root cause analysis (RCA) is performed for every identified DHA RE and all patient safety events that are identified as SAC 3, whether a single event or in aggregate

4.3.1.2. If a root cause analysis suggests that the competence or performance of a provider is lacking, a referral should be made for an inquiry in accordance with DHA-PM 6025.13, *Clinical Quality Management in the Military Health System*, Volume 3: *Healthcare Risk Management*. It is not the role of a RCA team to make decisions regarding peer review, only to suggest that such a review should be initiated.

4.3.1.3. Once the 59 MDW/SGH determines an event requires a CSA, the 59 MDW Patient Safety Office will initiate the 59 MDW Form 48, *59 MDW Comprehensive Systematic Analysis*, a tool used to ensure suspense deadlines are met and appropriate flow of information occurs throughout the lifecycle of a CSA. This form will be placed in the corresponding CSA folder on the patient safety section of the restricted access 59 MDW G:\ common drive and will be maintained IAW with applicable records management directives.

4.3.2. Other approved methodologies as listed in DHA-PM 6025.13, *Clinical Quality Management in the Military Health System, Volume 2: Patient Safety* may be used.

4.4. PRA:

4.4.1. PRA's are conducted IAW AFI 44-119, *Medical Quality Operations* and DHA-PM 6025.13, *Clinical Quality Management in the Military Health System, Volume 2: Patient Safety.*

4.4.2. Failure Mode Effect Analysis (FMEA):

4.4.2.1. One type of PRA is the FMEA.

4.4.2.2. Each year Executive Committee of the Medical Staff (ECOMS) recommends to the Board of Directors (BOD) a systems/processes that may best benefit a FMEA. The selection takes into consideration aggregated data analyses, frequently occurring events, high risk events, problem prone events, patient safety goals, and national information on frequent occurring events found in sources such as the TJC SE alerts, AF/SG NOTAM/Alerts, and Veterans Administration (VA) Patient Safety resources.

4.4.2.3. SGH appoints the FMEA team, Wing PS provides support and appropriate tools to the team to complete the task (forms, format and facilitator). The FMEA team provides monthly reports to PSF and then ECOMS. The FMEA team provides monthly reports to PSF and then ECOMS.

4.4.2.4. See **Attachment 4** for FMEA process.

4.5. Good Catch Award:

4.5.1. Good Catch Award is designed to recognize 59MDW personnel who demonstrate their commitment to keeping patients safe by utilizing Trusted Care tools and principles to prevent potential harm to patients and create a highly reliable organization. The 59 MDW encourages leadership and other staff to nominate individual and teams that are focused on process improvement efforts that were made to prevent near misses and good catches from reaching patients.

4.5.2. See **Attachment 5** for the Good Catch Award process.

4.6. PS Equipment or Supply Alerts/Notifications follow guidance in AFMAN 41-209, *Medical Logistics Support*, Chapter 7.2.4.

4.7. Wing Patient Safety Manager's Meeting:

4.7.1. Purpose of this meeting is to review plans for the patient safety improvement strategies. Review the policies and procedures developed to promote quality patient care and patient safety prior to placing on the monthly Patient Safety Function (PSF)/Patient Safety Event Review Team (PSERT) agenda.

4.7.2. Composition. All Wing and Group Patient Safety Managers/Consultants and those who are appointed as additional duty PSMs.

4.7.3. The Wing and Group PSMs/PSACs will meet weekly/biweekly or at such times as it is deemed appropriate. A simple majority of the PSM/PSACs shall constitute a quorum to transact business.

4.7.4. Members of this meeting may participate by means of telephone conference call or similar communications equipment by means of which all person participating in the meeting can hear and understand each other.

4.8. Patient Safety Function (PSF)/ PSERT Meeting:

4.8.1. Patient Safety Function is a cross functional team to include Risk Management, Group, Leadership, Clinic Leadership and other appropriate subject matter experts (SME) as needed. The PSF is designed to share information on events, leverage expertise to

help close events and improve the quality of JPSR investigations and standardize the classification of events across the Wing.

4.8.2. Clinical Leadership needs to be aware of the PSRs submitted within the MTF. The PSF is a mechanism to ensure Leadership is aware of the reported events as well as providing insight to trends, culture and systems issues. The benefits of this monthly meeting cannot be stressed enough. It is a time when key personnel are in a room receiving/giving information and providing guidance and gaining situational awareness. (See **Attachment 6**)

5. TeamSTEPPS®:

5.1. Human factors, such as miscommunication and inadvertent departure from policy are leading causes of error and have shown up as causal in many malpractice cases.

5.2. TeamSTEPPS® was developed to address the human factors in the medical setting that cause errors, and equip personnel with a set of concepts and tools to avoid errors and increase patient safety.

5.3. The focus of team training is to improve teamwork and communication among the personnel, especially caregivers within the 59 MDW.

5.4. TeamSTEPPS® training will be provided to all new employees at New Employee Orientation (NEO). Training is required for all 59 MDW personnel.

5.5. Team training material and facilitated discussions within individual medical teams is the core method used for training.

5.6. PS in collaboration with the 59th Training Function will manage and coordinate necessary activities for all team training classes.

6. National Patient Safety Goals (NPSG):

6.1. The 59th Medical Wing, as a TJC accredited organization, agrees to comply with their mandated NPSG (Attachment 7), Hospital. The goals are established guidelines to help accredited organizations address areas of concern in patient safety based on national trends. Each goal includes expert/evidenced-based recommendations.

6.2. The Wing PS office is responsible for development, implementation, deployment, and sustainment of plans/policy applicable for each specific goal with the integrated collaboration of our leaders at the wing, group, squadron, flight, and element levels.

6.3. The wing's implementation plans/policy are approved by the ECOMS/BOD and are effective policy at that time. The goals implementation plans will be posted and considered policy once they are posted on the intranet; immediate implementation and compliance with goals is expected from wing members. Applicable 59 MDW instructions are to be updated accordingly.

6.4. Education/training on the goals is provided by the Wing PS office during NEO, annual facility training as well as Graduate Medical Education (GME) orientation and at other opportune times.

D. KEVIN FLOOD, Colonel, USAF, MC
Chief of the Medical Staff

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFI 44-119, *Clinical Performance Improvement*, 16 August 2011

AFPD 44-1, *Medical Operations*, 9 June 2016

DHA-PM 6025.13, *Clinical Quality Management in the Military Health System, Volume 2: Patient Safety.* 29 August, 2019

DoD 5400.7-R/AF Supplement, *Freedom of Information Act Program*, 24 June 2002

The Joint Commission Ambulatory Accreditation Standards, Current Version.

The Joint Commission, National Patient Safety Goals, Current Version.
https://www.jointcommission.org/standards/national-patient-safety-goals/

Title 10 U.S.C., Section 1102 Chapter 55, *Confidentiality of Medical Quality Assurance Records: Qualified Immunity for Participants*, 29 November 1989

59 MDWI 41-102, *Medical Committees and Functional Reviews*, 6 January 2020

59 MDWI 44-107, *Blood Products*, 29 August 2019

59 MDWVA 44-107, *Do Not Use Abbreviations*, 12 July 2018

59 MDWI 44-115, *Pharmacy and Medication Management*, 17 May 2018

59 MDWI 44-139, *Anticoagulation Management Protocol*, 3 September 2019

59 MDWI 44-155, *Critical Test and Critical Value Management*, 27 October 2017

59 MDWI 44-157, *Infection Prevention and Control*, 8 May 2020

Adopted Form

AF Form 847, *Recommendation for Change of Publication*

Prescribed Form

59 MDW Form 48, *59 MDW Comprehensive Systematic Analysis (CSA) Checklist*

Abbreviations and Acronyms

ADR—Adverse Drug Reaction

BOD—Board of Directors

CDC—Centers for Disease Control and Prevention

CSA—Comprehensive Systematic Analysis

DHA—Defense Health Agency

ECOMS—Executive Committee of the Medical Staff

EOC—Environment of Care Committee

FDA—Food and Drug Administration

FMEA—Failure Mode and Effects Analysis

GME—Graduate Medical Education

HAI—Health Care-Associated Infections

HRO—High Reliability Organization

IV—Intravenous

JPSR—Joint Patient Safety Reporting System

MHS—Military Health System

MOS—Measures of Success

NOTAM—Notice to Airmen

NPSG—National Patient Safety Goals

P&T—Pharmacy and Therapeutics

PRA—Proactive Risk Assessment

PSAC—Patient Safety Assistant Coordinator

PSERT—Patient Safety Event Review Team

PSF—Patient Safety Function

PSM—Patient Safety Manager

PS—Patient Safety

PSP—Patient Safety Program

QA—Quality Assurance

ORC—Online Registration Center

RCA—Root Cause Analysis

SAC—Safety Assessment Code

SE—Sentinel Event

SGD—Chief of Dental Services

SGH—Chief of the Medical Staff

SGHP—Patient Safety

SGHR—Risk Management

SGN—Chief Nurse

TeamSTEPPS®—Team Strategies and Tools to Enhance Performance and Patient Safety

TJC—The Joint Commission

VA—Veterans Administration

WHASC—Wilford Hall Ambulatory Surgical Center

Terms

Accreditation—Determination by the Joint Commission's accrediting body that an eligible health care organization complies with applicable Joint Commission standards.

Action Plan (Corrective Actions)—The end product of a root cause analysis (RCA) that identifies the risk reduction strategies the facility intends to implement to prevent the recurrence of similar adverse events in the future.

Adverse Drug Reaction (ADR)—Any untoward, noxious reaction associated with drug used at normal doses. Procedures are in place for reporting these events to pharmacy services and the Pharmacy and Therapeutic Committee see 59 MDWI 44-115, *Pharmacy and Medication Policy.*

Adverse Events—Unexpected harm to a patient directly associated with the provision of medical care. They may stem from acts of omission as well as commission. Adverse events do not include intentional unsafe acts.

Aggregate Review—The process of analyzing recurring incidents, events, or good catches/near misses for trends and patterns. This information is utilized by the organization for process improvement interventions.

Contributing (Causal) Factors—Additional reasons, not necessarily the most basic reasons, for an event to be less than ideal, as planned, or as expected. Contributing factors may apply to individuals, systems operations, or the entire organization.

Data—Material, facts, or clinical observations that have not been interpreted.

Evaluation—Analysis of collected, compiled, and organized data pertaining to important aspects of care. Data are compared with predetermined, clinically valid criteria, variations from criteria are determined to be acceptable or unacceptable, and problems or opportunities to improve care are identified.

Event—The failure of a planned action to be completed as intended or the use of the wrong plan to achieve an aim.

Failure Mode and Effects Analysis (FMEA)—The FMEA process is a dynamic approach to proactive risk assessment and reduction. This healthcare specific FMEA is a systematic method of identifying and preventing product and process problems before they occur. A FMEA identifies the way a system/process can fail to produce the anticipated results so that corrections are made proactively. TJC and DoD require one FMEA per 18 months.

Failure Mode—Different ways that a process or sub-process can fail to provide the desired results.

Harm—Personal injury of a physical, emotional or psychological nature as a result of an event.

Hazard Analysis—The process of collecting and evaluating information on hazards associated with the selected process. The purpose of the hazard analysis is to develop a list of hazards that are of such significance that they are reasonably likely to cause injury or illness if not effectively controlled.

Hazardous Condition—Any set of circumstances (exclusive of the disease or condition for which the patient is being treated) that significantly increases the likelihood of a serious adverse outcome.

Intentional Unsafe Act—Any alleged or suspected act of commission or omission by a member, (such as a provider, staff member, contractor, trainee, or volunteer) pertaining to a patient that involves a criminal act, a purposefully unsafe act, patient abuse, or an event caused or affected by drug or alcohol abuse. Such acts are matters for law enforcement, disciplinary system, or administrative investigation. They will not be reviewed or acted upon by the Patient Safety Program.

Joint Patient Safety Reporting System—An Internet-based medication and non-medication error and adverse drug reaction reporting program.

Measure—Standard or indicator used to assess the performance of a function or process of an organization.

Measures of Success (MOS)—A four month and 12 month audit designed to measure the success of the corrective action.

Medication Event—Any prescribing, documenting/transcribing, administering, or dispensing of the wrong drug, dose, form, preparation, technique, monitoring.

Medication—Any substance other than food or devices, that may be used on or administered to persons as an aid in the diagnosis, treatment, or prevention of disease or other abnormal condition. This includes any product designated by the Food and Drug Administration (FDA) as a drug, including vaccines, diagnostic and contrast agents, oxygen and other medical and anesthetic gases, total parenteral nutrition, sample medications, prescription medications and over-the-counter medications. For the purposes of this definition, herbal remedies, vitamins, nutraceuticals and health supplements are considered over-the-counter medications.

Near Miss/Good Catch—An event, process variation, or situation that could have resulted in harm, but either did not reach the patient/ affect the outcome. A recurrence carries a significant chance of a serious adverse outcome.

No Harm Errors—Those unintended acts, either of omission or commission, or acts that do not achieve their intended outcome, that do not result in a physical or psychological negative outcome, or the potential for a negative outcome for the patient.

Notice to Airmen (NOTAM)—A means of identifying clinical or other concerns and lessons learned from malpractice claims, adverse actions, medical incident investigations (MII), and sentinel events.

Patient Safety Event—An incident or error that occurred or almost occurred that caused, or had the potential for causing, harm to a patient. These events may cause untoward, therapeutic misadventures, iatrogenic injuries, or other adverse outcomes directly associated with care or services provided by the 59 MDW. The events may be due to acts of commission or omission.

Patient Safety—The degree to which the risk of an intervention and risk in the care environment are reduced for the patient and others, including health care providers.

Patient—An individual who receives care, treatment, and services.

Performance Improvement—An approach to the continuous study and improvement of the processes of providing health care services to meet the needs of individuals and others. Synonyms include continuous quality improvement, performance/process improvement or total quality management.

Plan—A detailed method, formulated beforehand, that identifies needs, lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, policies and procedures, protocols, practice guidelines, clinical pathways, care maps, or a combination of these.

Process—A goal-directed series of actions, events, mechanisms, or steps. A series of actions that repeatedly come together to transform inputs into outputs (the service, care, or information).

Provider—Any military or civilian health care professional who, under regulations of a military department, is granted clinical practice privileges to provide health care services in a military medical or dental treatment facility or who is licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

Risk Assessment—A method used to proactively evaluate the probability of a patient safety event in order to minimize the risk of the event actually occurring.

Risk Management (RM)—Clinical and administrative activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff and visitors, and the risk of loss to the organization. It involves identifying risk potential, prevention of risk exposure, and the management of real or potential adverse incidents and medical malpractice claims.

Root Cause Analysis (RCA)—A process for identifying the basic or contributing causal factor(s) associated with an adverse event or good catch. The review is interdisciplinary and includes those who are closest to the process. It focuses on systems and processes, not individual performance. The analysis asks "why" until all aspects of the process are reviewed, and all contributing factors have been determined. It identifies vulnerabilities that could be made in systems and processes to improve performance and reduce the risk of patient safety events or recurrence of good catches.

Root Cause—The most basic reason a situation did not turn out ideally, as planned, or as expected.

Safety Assessment Code (SAC)—A numerical methodology used to proactively evaluate the severity and probability of a patient safety event in order to minimize the risk of the event actually occurring.

Safety—The degree to which the risk of an intervention (for example, use of a drug or a procedure) and risk in the care environment are reduced for a patient and other persons, including health care practitioners.

Sentinel Event—Defined by TJC as an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. (The term "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in a sentinel event.).

Standard—A statement that defines the performance expectations, structures, or processes that must be substantially in place in an MTF to enhance the quality of care or service. These may include professional, TJC, DoD, MAJCOM, utilization management, or other identified sources.

System—A group of interdependent processes and people that together perform a common mission.

TeamSTEPPS®—An evidence-based teamwork system designed to improve the quality, safety, and efficiency of patient care in an effort to optimize clinical outcomes by improving communication and other teamwork skills among healthcare professional.

Trusted Care/HRO—The Air Force Medical Service vision as a continuous learning and improving organization with a single-minded focus of safety and Zero Harm.

Unexpected Death—A death of an apparently stable patient without a known immediate threat to life. This differs from an unanticipated death of a patient with a chronic illness in the terminal stages, but death was not imminent.

Attachment 2

SAFETY ASSESSMENT CODE (SAC)

A2.1. Intent. The Safety Assessment Code (SAC) is a two-dimensional (severity and probability) matrix that is used to determine a "score." This process allows the organization to determine and prioritize those events indicating which should receive the quickest attention/scrutiny.

A2.2. Process.

A2.2.1. The SAC is calculated by using two matrices. The first is severity, which is divided into four categories: catastrophic, major, moderate, and minor. Factors for the severity category include extent of injury, length of stay, and level of care required for a remedy, and actual or estimated costs. The second factor is frequency; how often does it happen at this facility. For things we normally track such as falls and medication errors, this is easy to calculate. For other items, this may be just a "best guess." In defining severity and frequency of occurrence, use the worst case scenario—what could have happened.

A2.2.2. For actual events, assign severity based on the patient's actual condition. Some near misses may occur that have such an overwhelming potential for a catastrophic event that a high score will also be necessary.

Table A2.1. Severity Categories.

CATASTROPHIC	MAJOR
PATIENTS WITH ACTUAL: Death or major permanent loss of function (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying condition (i.e., acts of commission or omission). This is the same definition of a reviewable sentinel event as defined by the Joint Commission.	**PATIENTS WITH ACTUAL:** Permanent lessening of bodily functioning (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying conditions (i.e., acts of commission or omission).
Examples: Suicide (inpatient or outpatient) Rape Hemolytic transfusion reaction Surgery/procedure on wrong pat/wrong body part Infant abduction Death or major permanent loss of function that is a direct result of injuries sustained in a fall, or the result of an assault or other crime.	Disfigurement Surgical intervention required Increased level of care for three or more days
MODERATE	**MINOR**
PATIENTS WITH ACTUAL: Increased level of care for less than three days	**PATIENTS WITH ACTUAL:** No injury or increase in level of care

A2.3. Determine Severity. Once you have determined the severity of the event using above chart, determine the frequency of the event happening again using the following definitions.

A2.3.1. High – Likely to occur immediately or within a short period of time.

A2.3.2. Medium – Likely to occur several times in 1 to 2 years.

A2.3.3. Low – May happen greater than two years.

A2.4. How the SAC Matrix Works. When you pair a severity category with a probability category for either an actual event or close call, you will get a ranked matrix score (3 = highest risk, 2 = intermediate risk, 1 = lowest risk). These rankings or Safety Assessment Codes (SACs) can then be used for doing comparative analysis, and, for deciding who needs to be notified about the event.

Table A2.2. Safety Assessment Code (SAC) Scores.

	Severity on Patient and Facility (consequence)			
Probability of Recurrence (likelihood)	**Catastrophic**	**Major**	**Moderate**	**Minor**
Frequent - ***Likely to occur immediately or within a short period (may happen several times in a year***	**3**	**3**	**2**	**1**
Occasional - ***Probably will occur (may happen several times in 1 to 2 years)***	**3**	**2**	**1**	**1**
Uncommon - ***Possible to occur (may happen sometime in 2 to 5 years)***	**3**	**2**	**1**	**1**
Remote - ***Unlikely to occur (may happen sometime in 5 to 30 years)***	**3**	**2**	**1**	**1**

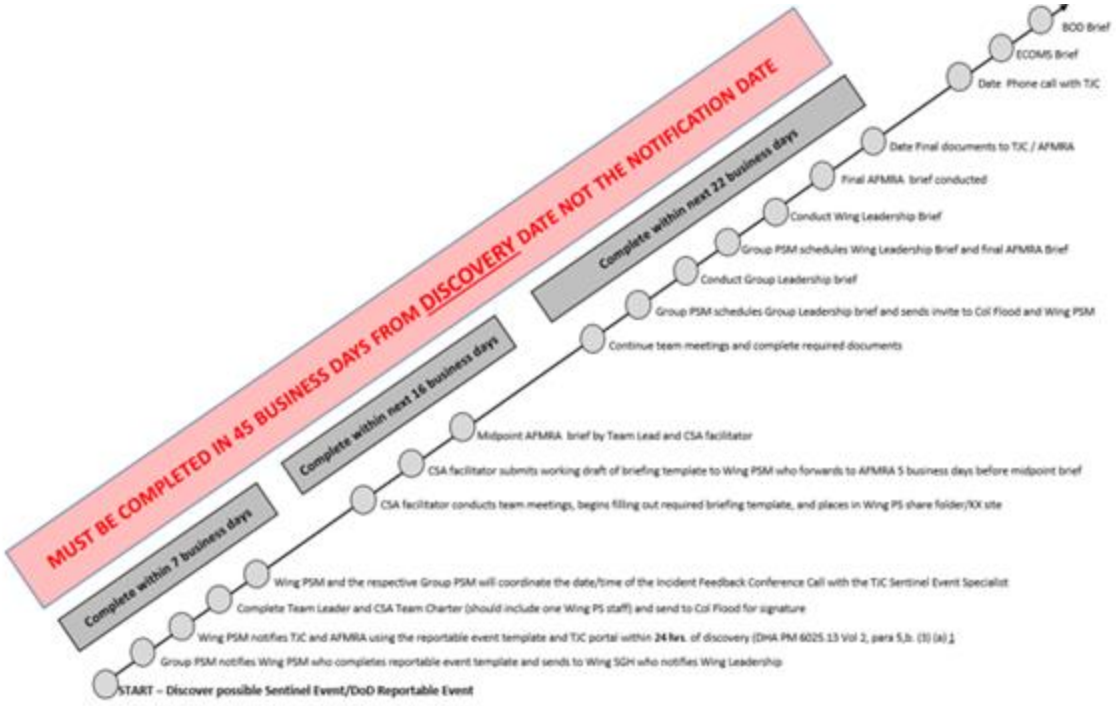
A2.4.1. Example – How to Use the SAC Matrix: A patient with an extreme allergy to penicillin brings a prescription for amoxicillin from a network provider to the pharmacy. The person accepting the prescription does not ask the patient any questions concerning drug allergies. The prescription is filled and just before giving the medication to the patient another pharmacy technician asks about allergies and realizes that it cannot be issued. How serious is this event? In terms of actual events, this would be minor because the patient was not injured. But had the error not been discovered, it could have been catastrophic. The potential severity of this incident, then, would be catastrophic.

A2.4.2. The SAC will be used to determine priority and resource utilization to correct potential or real problems with the highest codes receiving the most emphasis. **Note:** Any incident receiving a SAC score of 3 requires that we carry out a formal Root Cause Analysis.

Attachment 3

TIMELINE FOR COMPREHENSIVE SYSTEMATIC ANALYSIS

Figure A3.1. Timeline for Comprehensive Systematic Analysis.



Attachment 4

FAILURE MODE AND EFFECTS ANALYSIS (FMEA)

A4.1. Intent. The FMEA process is a method of identifying and preventing product and process problems before they occur. It is a straightforward, common sense methodology that has been around for many years and used by other industries and organizations prior to being adopted for use by the healthcare industry. It is a systematic way of examining a design prospectively to find possible ways in which failure can occur. The technique asks, "What if this were to happen," instead of "why did this happen," and it involves identifying potential mistakes before they happen to determine whether the consequences of those mistakes would be tolerable or intolerable. Potential failures are identified in terms of failure "modes," or symptoms. For each mode, the effect on the total system is studied. When potential effects are intolerable, actions are taken to eliminate the possibility of error, stop an error before it reaches people, or minimize the consequences of an error. Then the action being taken or planned to minimize the probability or effect of failure is reviewed.

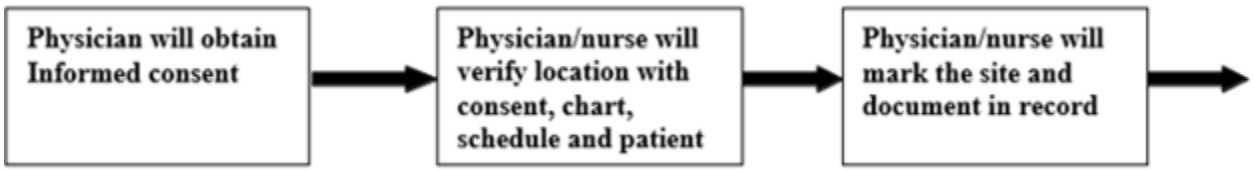
A4.2. Advantage. The obvious advantage of assessing risk prospectively is preventing adverse occurrences, rather than simply reacting when they occur. Also, barriers, such as fear of disclosure, blame, punishment, and intimidation, that are so prevalent in investigations following an actual bad outcome, are absent.

A4.3. Risk Assessment. At least one high-risk process is selected annually for proactive risk assessment, using this process.

A4.4. FMEA Steps. There are four steps for creating a FMEA:

A4.4.1. Create a process map. Diagram (flowchart) what was intended and the actual implementation of the process. Sample – surgical site identification:

Figure A4.1. FMEA Flowchart.



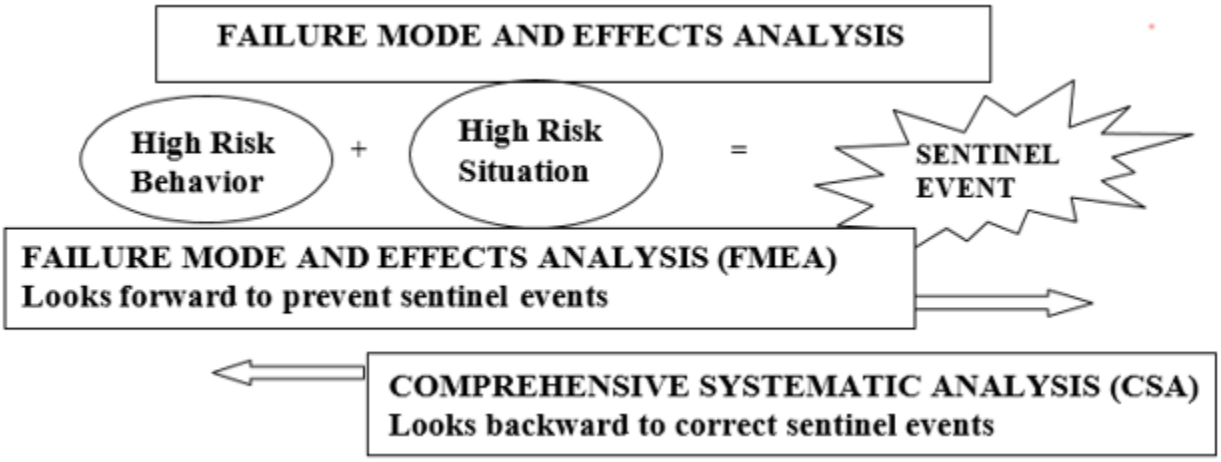
A4.4.2. Create a failure modes table and conduct an effects analysis. Identify the steps in the process where there is, or may be, undesirable variation (failure modes). Use the following abbreviations for the table: SEV (Severity) OCC (Occurrence) DET (Detectability) RPN (Risk Priority Number).

Table A4.1. Failure Modes Table.

ACTIVITY	FAILURE MODE	EFFECT	SEV	OCC	DET	RPN	ACTION

A4.4.3. Identify a prevention and/or correction strategy. For each identified failure mode, identify the possible effects on patients and the criticality of the failure mode.

Figure A4.2. Failure Mode and Effects Analysis.



A4.4.3.1. For the most critical failure modes, conduct a root cause analysis to determine when the variation (the failure mode) leading to that effect may occur.

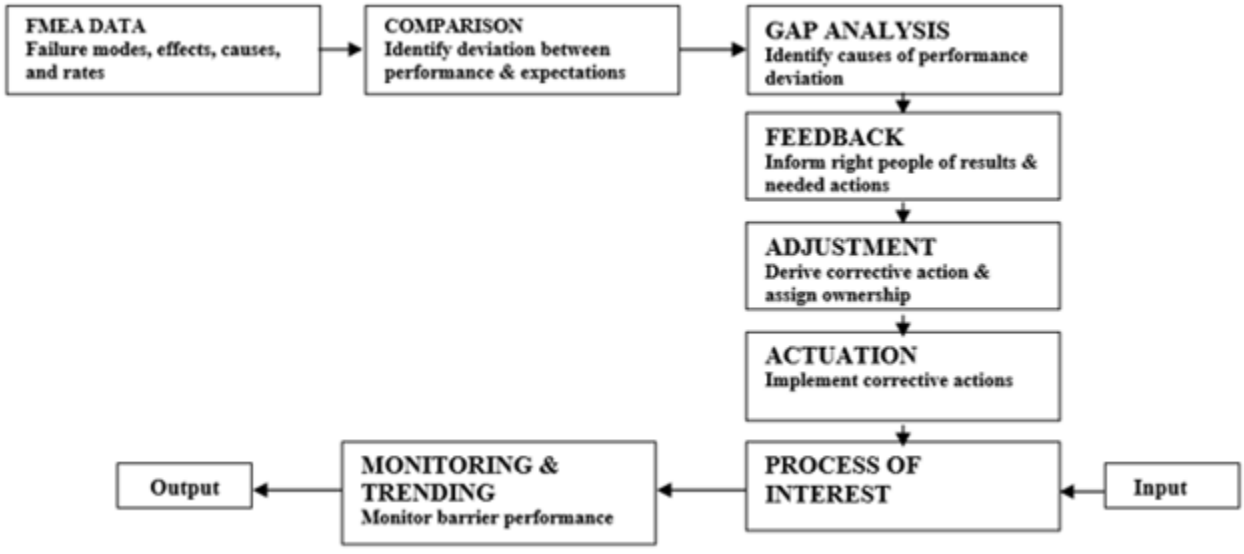
A4.4.3.2. Redesign the process and/or underlying systems to minimize the risk of that failure mode or to protect patients from its effects.

A4.4.3.3. Test and implement the redesigned process.

A4.4.3.4. Identify and implement measures of the effectiveness of the redesigned process.

A4.4.4. Implement strategy and monitor results. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

Figure A4.3. Monitor Results.



A4.5. A multidisciplinary team should be created to conduct the FMEA process. With each step or linkage, the team should ask:

A4.5.1. What can go wrong with this step or linkage (the failure mode)?

A4.5.2. Why would this failure mode occur (cause of failure)?

A4.5.3. What could happen if this failure mode occurred (effects of failure)?

A4.6. After Flowcharting. After flowcharting the actual and intended events, each failure should be assigned a risk priority number (RPN) based on its likelihood of occurrence (OCC), severity if it occurred (SEV), and detectability (DET). Undetectable failure modes present higher risk to patient safety than other modes. The RPN is calculated by the formula – OCC x SEV x DET. High numbers indicate a high priority to fix.

A4.7. Pairing a Severity Category. When pairing a severity category with a probability category for either an actual event or good catch, that will result in a ranked matrix score (3 – highest risk, 2 – intermediate risk, 1 – lowest risk). These rates, or SACs, may then be used for doing comparative analysis, and, for deciding who needs to be notified about the event. All individuals reporting events, regardless of the SAC score, will receive applicable and timely feedback.

Table A4.2. Sample Failure Mode and Effects Analysis (Hypothetical Medication Use Process in the Operating Room).

PROCESS	PHARMACY ↓	DISPENSE ↓	O.R. →	TRANSFER ↓	STERILE FIELD →	ADMINISTER	PATIENT
Potential failure modes	Look-alike drugs, multiple concentrations	Wrong drug Wrong concentration		Switched drugs. Contamination		Wrong drug Wrong	
Potential effect on patient	Potentially serious if dispensed	Potentially serious if administered		Potentially serious if administered		Potentially serious depending on	
Likelihood of reaching patient (probability)	Low (may happen > 2 years. **SAC=1**	Medium (likely to occur several times in 1-2 years. **SAC=2**		High (likely to occur immediately) **SAC=3**		High (likely to occur immediately) **SAC=3**	
Criticality of failure mode (severity)	Minor	Catastrophic		Catastrophic		Catastrophic	
Root causes (drill down)	Open formulary. Ambiguous labels	Alphabetical storage. Ambiguous labels		Unnecessary complex process. Approved procedure not consistently followed		No means of verifying drug/dose after transfer to sterile field	
Strategies & Action plan	P&T Committee review, redesign of formulary content & process	Redesign storage system. Introduce bar coding		Simplify procedure. Eliminate open vessels for IV drugs. Monitor compliance		No action needed. Risk eliminated earlier in process	

Attachment 5

GOOD CATCH AWARD

A5.1. Good Catch Definition: Any process variation, error or other circumstance that could have resulted in harm to a patient but through chance or timely intervention did not reach the patient. These events are also known as "near misses".

A5.2. Good Catch Award Mission: To recognize staff who demonstrate their commitment to keeping patients safe by speaking up and reporting in the Joint Patient Safety Reporting (JPSR) system to prevent potential harm to patients. The 59 MDW encourages individual and team nominations focused on process improvement efforts that were made to prevent near misses and good catches from reaching patients. It is because of actions taken every day by dedicated professionals that the 59 MDW continues to be front-runners in patient safety.

A5.3. Eligibility: Anyone in the 59 MDW may be nominated for the "Good Catch" award. All individuals or teams who speak up and act with urgency in reducing risks associated with patient safety and preventing patient harm to patients will be eligible for the "Good Catch" award. Entering the event into the JPSR system is highly encouraged but not mandatory.

A5.4. Frequency: To be awarded monthly by the 59 MDW Commander or his/her designated representative.

A5.5. Submission: All submissions should be emailed to the 59 MDW Patient Safety organization box **usaf.jbsa.59-mdw.mbx.59-mdw-patient-safety@mail.mil** by the 1st Friday of the month for review. If the first Friday falls on a Holiday or Family Day, nominations will be due the Thursday before. If the 1st Friday of the month is also the first day of the month, nominations will be due on Tuesday of the following week. Individual & team submissions must be in the "Good Catch" award template. The template can be found at Award Template (press Control+Click link to access).

A5.6. Selection: The individual & team award recipients will be decided by the Wing Patient Safety Team and the Group Patient Safety Managers. Once the votes have been tallied the Wing Patient Safety Team will coordinate with the Wing Executive Officer to the Commander for the presentation of the awards in the duty sections of those selected. The Group PSM will coordinate with the duty section of the individual winner to ensure that the member will be available for the presentation. If the member isn't available that day, another day will be scheduled. The Wing will deliver the certificates to the Wing Executive Officer to the Commander for signature prior to the presentation. Once the date has been selected by the Commander to present the Good Catch awards, the duty sections will be notified by the Group's PSM. Photos of these presentations will be uploaded on to the Patient Safety SharePoint. Award: The team award is a traveling trophy with a certificate signed by the 59 MDW Commander or his/her representative. The individual award is a certificate signed by the 59 MDW Commander.

Attachment 6

PATIENT SAFETY FUNCTION/PATIENT SAFETY EVENT REVIEW TEAM

A6.1. Goals.

A6.1.1. Share information on events, leverage expertise to help learn from and close events, ID contributing factors in JPSR, improve JPSR investigations by using standard questions and drive Continual process improvements. Create SA for the leadership as the PSR Review meeting is a mechanism to ensure they are aware of the reported events as well as providing insight to trends, culture and systems issues.

A6.1.2. Items to be discussed/tracked at the Wing PSF/ERT include, but are not limited to:

A6.1.2.1. New CSA.

A6.1.2.2. Status of current RCAs, to include MOS, SBAR Debrief for completed CSAs (lessons learned).

A6.1.2.3. PRA/FMEAs.

A6.1.2.4. JPSR and cumulative trends/data (Prado Chart).

A6.1.2.5. Evaluate - No Harms and above events for PCE with Risk Manager.

A6.1.2.6. DoD Reportable Events and PCE potential.

A6.1.2.7. Harm Score/SAC classification.

A6.1.2.8. PS Alerts.

A6.2. Items handled and tracked at the Group/Squadron PS level, with Wing PS oversight include.

A6.2.1. JPSR Data and Trends, to include Closure Data.

A6.2.2. All JPSR events submitted are provided.

A6.2.3. Unresolved/incomplete investigations are returned for review and discussion when additional information is provided.

A6.2.4. Review of both Harm and No-Harm Events. No Harm and above are reviewed by Risk manager for potential PCE.

A6.2.5. Group/Squadron PSR and cumulative trends/data (Prado Chart).

A6.2.6. Harm Score/SAC classification.

Attachment 7

NATIONAL PATIENT SAFETY GOALS

A7.1. Goal. Improve the Accuracy of Patient Identification.

A7.1.1. Use at least two patient identifiers when providing care, treatment, or services.

A7.1.2. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual.

A7.1.3. Use the patient's full name and Date of Birth (DOB) when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures.

A7.1.4. Label containers used for blood and other specimens in the presence of the patient.

A7.2. Goal. Eliminate Transfusion Errors related to Patient Misidentification.

A7.2.1. Blood and Blood product Transfusion will occur IAW 59 MDWI44-107, *Blood Products.*

A7.3. Goal. Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

A7.3.1. Anticoagulant therapy will occur IAW 59 MDWI 44-139, *Anticoagulation Management Protocol.*

A7.4. Goal. Improve the Effectiveness of Communication Among Caregivers.

A7.4.1. For verbal or telephone reports or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read- back" the complete order or test result.

A7.4.2. Communication of critical values/critical test will be handled IAW 59 MDWI 44-155, *Critical Test and Critical Value Management.*

A7.5. Goal. Implement a Standardized Approach to "Hand Off" Communications, Including an Opportunity to Ask and Respond to Questions.

Table A7.1. SBAR- Standardized Hand off Communication Technique.

S	Situation	Introduce yourself and your role/job. Include patient's name, identifiers, age, sex, and location. Current status/circumstances, identify uncertainties, differential diagnosis, recent status changes, and response to treatment.
A	Assessment	Chief complaints, vital signs/ symptoms, diagnosis, critical lab values/reports, allergies, alerts (falls, isolation, etc).
B	Background	Co-morbidities, previous episodes, current medications, family history, socio- economic factors

R	Recommendation	What actions were taken or are required (the Plan). If required actions, briefly explain why needed, level of urgency, explicit timing, and prioritization of actions, What is the PLAN? Contingency plan? Next steps? Discuss ownership, who is responsible for actions: include patient and family appropriately.

A7.5.1. All healthcare members responsible for accepting or transferring care of a patient must include all SBAR patient information in the table below when handing-off the patient. Documentation of handoff is not required. Hand-off using SBAR at patient transfer, shift/cross coverage change; initiated by outgoing member.

A7.5.2. SBAR -The wing's official standardized "hand-off" communication technique.

A7.5.3. SBAR serves as a checklist and template. Hand off include up to date information regarding the patient's care, treatment and service, condition and any recent or anticipated changes.

A7.5.4. The receiver of the hand off information must have an opportunity to review relevant patient historical data, which may include previous care, treatment, and services.

A7.5.5. Interruptions during handoffs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

A7.5.6. Hand offs are two-way interactive communications allowing the opportunity for questioning between the giver and receiver of patient information, as the patient's care moves from one caregiver to another.

A7.5.7. Hand offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.

A7.6. Goal. Improve the Safety of Using Medications.

A7.6.1. IAW 59 MDWI 44-115, *Pharmacy And Medication Management.*

A7.7. Goal. Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.

A7.7.1. IAW 59 MDWI 44-115 *Pharmacy And Medication Management*.

A7.7.2. The "do not use abbreviations" applies to all orders and all medication-related documentation that are handwritten, utilize free text entry or employ pre-printed forms (overprints). The minimum expected level of compliance for handwritten documentation and free text entry is reduced to 90%. The minimum expected level of compliance for preprinted forms (overprints) remains at 100%.

A7.7.3. Rationale. It is sometimes difficult to differentiate between certain abbreviations especially when they are handwritten**,** some examples include**:** 100U and 1000, between QD and QOD, between MS04 and MgS04, between 1.0 and 10 and between IU and intravenous (IV).

A7.7.4. It is estimated that one out of every ten medication errors is caused by misunderstood abbreviations of which some have resulted in catastrophic patient outcomes or a sentinel event.

A7.7.5. Compliance Expectation. There is no excuse for using "do not use" abbreviations or expressing doses in a manner that may cause confusion and or harm to patients.

A7.7.6. Required compliance to avoid using these abbreviations is 100%.

A7.7.7. Flight /squadron commanders will counsel all who are noncompliant.

A7.7.8. Providers must rewrite "do not use" abbreviation orders before they can be carried out.

Table A7.2. Do Not Use Abbreviations.

Abbreviation	Intended Meaning	Common Error	Correction
U, u	Unit	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU	International Unit	Mistaken for IV (intravenous) or number 10 (ten)	Write "International Unit"
Q.D.,QD, q.d., qd Q.O.D., QOD, q.o.d., qod	Daily Every Other Day	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (1.0 mg) Lack of leading zero (.5 mg)	Signifies 1 Signifies 0.5	Decimal point is missed	Write X mg (**Do not** use a decimal/zero after whole numbers) Write 0.X mg (Use zero before a decimal)
MS MSO4, MgSO4	Morphine Sulfate, Magnesium Sulfate	Mistaken for each other	Write "morphine sulfate" Write "magnesium sulfate"

A7.7.9. Information Management (IM 02.02.01). Caution: Important Notice. The following abbreviations contribute to healthcare errors and are not authorized for use at the 59 MDW on patient specific documentation IAW 59MDWVA 44-107, *Do Not Use Abbreviations*.

A7.8. Goal. Reduce the risk of health care-associated infections (HAI).

A7.8.1. IAW MDWI 44-157, *Infection Prevention and Control*.

A7.9. Goal. Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

A7.9.1. Process. Notify Risk Management Office immediately or within 24 hours of patient death from a health care acquired infection.