Patient Safety Protocol in a Deployed Setting

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☐ Minor Changes (or)	■ New Document That Requires Thorough Reading
☐ Significant Changes	OPR: CCSG

1. CONTENTS

2. PURPOSE

The development of an operational Patient Safety Program (PSP) ensures the delivery of "world class healthcare anywhere, at any time". PSPs examine systems and processes to prevent errors or events before they cause harm to patients. The challenging and unique environments that deployed Military Treatment Facilities (MTFs) and personnel experience require the streamlining of recommended practices that are in line with National Patient Safety Goals (NPSG's), National Quality Safety Forum (NQSF), the Agency for Healthcare Research and Quality (AHRQ), and the Department of Defense (DoD) Medical Quality Assurance and Patient Safety procedures. Ultimately, the goal is the delivery of high quality and safe care in a sustained patient safety culture across the full spectrum of deployed, en route, and home station settings by eliminating medical errors and preventing harm. All USCENTCOM clinical operating protocols (CCOPs) are posted to the CCSG SharePoint site at https://intelshare.intelink.gov/sites/ccsg/SitePages/CCSG-CLINOPS.aspx. At the

main USCENTCOM sharepoint site go to "Special Staff/CCSG" on the left hand side. Login with CAC. Click "Clinical Operations" at the top of the page.

3. **BACKGROUND**

The establishment of a PSP in the operational theater ensures an organized structure for an integrated framework to objectively define, measure, assure, and improve the quality of care delivered in the operational setting. The goal is to ensure that the same level of healthcare delivered in our garrison facilities is replicated in the expeditionary setting (highest quality and safest care delivery) to improve systems and processes and, ultimately, provide the highest standard of healthcare delivery.

4. **APPLICABILITY**

This CCOP applies to all USCENTCOM medical and non-medical personnel (e.g., registered nurse, enlisted medical personnel, physician, nurse practitioner, physician assistant, sanitation staff, patients, or facility visitors), assigned/attached, allocated to perform duties or receiving care at the Role 1, 2, and 3 medical, dental, and veterinary facilities that involve direct or indirect patient care.

5. **REFERENCES**

a. 10 U.S. Code § 1102, *Confidentiality of Medical Quality Assurance Records: Qualified Immunity for Participants,* 3 January 12

b. Air Force Instruction 44-119, *Medical Quality Operations*, 16 August, 2011

c. AFI 48-301v1, *En Route Care and Aeromedical Evacuation Medical Operations*, 9 January 2017

d. AFTTP 3-42.57, *En Route Patient Staging System*, 10 August 2016

e. Army Regulation 40-68, *Clinical Quality Management,* 22 May 2009

f. CCR 40-1, Healthcare Operations, 31 March 2020

g. *Deployed Patient Safety Program (PSP) Guide,* Current Version

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

i. DHA-PM 6025.13, *Implementation Guide*, 24 October, 2019

j. MEDCOM Regulation 40-41, *Medical Services: The Patient Safety Program*, 28

April 2017

k. USTRANSCOM Handbook 41-1, Global Patient Movement Operations, 3 May 2016

6. **RESPONSIBILITIES**

a. USCENTCOM Service Component Command and Combined Joint Task Force (CJTF) Surgeons bears overall responsibility for clinical quality management/patient safety program execution in the area of operations, including all policies and procedures addressed by this protocol. CCSG is here to provide support to assist unit commanders/command teams with program development and execution.

b. Service level patient safety and quality consultants (Army, Navy, Air Force) will provide support to USCENTCOM with PSP execution as requested. This can be in the form of training on systems such as the Joint Patient Safety Reporting System (JPSR), comprehensive systemic analysis (CSA)/root cause analysis (RCA), concise incident analysis (CIA), and Defense Health System (DHA)TeamSTEPPS tools.

c. As outlined in CCR 40-1, all MTF Surgeons and Leaders that fall under USCENTCOM area of operations will ensure that their medical facilities develop and execute a PSP that addresses all aspects of a PSP to include but are not limited to:

(1) Defining DoD reportable events (REs) and delineation of how to report through their Service component clinical operations as well as to USCENTCOM clinical operations concurrently.

(2) Identify the Patient Safety Manager (PSM) prior to deployment.

(3) Training of the PSM prior to entry into a theater of operations. This can be accomplished virtually, in a conference call format, with the Air Force Deployed Patient Safety Classes: Basic (9 hours) or Executive Level (5 hours). To register, email the Deployed Patient Safety Consultant attached to Air Force Medical Services (AFMS) Air Combat Command (ACC) Command Surgeon Staff at acc.sg@us.af.mil. Another training option is the DHA Patient Safety Professionals' Course (5 day in-residence course with limited seats available). To register, email the PS Ongoing Learning Team at pspcourses@bah.com.

(4) PSM roles and responsibilities. The current version of the Deployed Patient Safety Program Guide provides in-depth, detailed guidance with many tools to help clarify roles and responsibilities. It can be found at: https://kx.health.mil/AFMOA/ClinicalQuality/PS/SitePages/Home.aspx (log in using your CAC PIV, from the left-sided menu select "A-E" under "Subject Titles", select "Deployed Patient Safety Program (PSP) Guide and Acronyms Pamphlet" under the EMEDS section on the bottom right of the page, under the files listed is the Deployed PSP Guide).

(5) Collaboration of patient safety professionals with internal and external entities/partners.

(6) Align and integrate patient safety (PS) initiatives with relevant DOD and national patient safety and quality improvement programs.

(7) The Joint Patient Safety Reporting System (JPSR); how to access JPSR, report near miss and harm events and analyze and report data collected.

(8) Understand how and when to use CSA/RCA, and CIA when evaluating near miss and harm events.

(9) Implement standardized PS data collection, reporting, and metrics to monitor and evaluate program compliance and effectiveness.

(10) Ensure execution and use of the DHATeamSTEPPS tools in all operational environments.

(11) Creating and sustaining a Just Culture/Trusted Care environment and programs that recognize good catches in the operational setting. Offer safety and support through 2nd victim advocacy for all healthcare providers involved in patient harm events.

d. Unit PSMs will execute the PSP in all aspects for the facility. Role 3 PSMs may assist with covering down on Role 2 program execution (can be the lead PSM) by working with Role 2 personnel to ensure timely execution of program duties.

(1) PSMs will make all attempts to attend the necessary training (Air Force Deployed Patient Safety Basics Class or Patient Safety Professionals Course) prior to arrival in the theater of operations.

(2) PSMs will request access to applicable systems (JPSR) and request access to all MTF records. Access should be requested via the Account Activation Request Form (AARF).

(3) PSMs will participate in USCENTCOM monthly CLINOPs Quality Assurance (QA)/Quality Management (QM) crosstalk and be prepared to discuss Performance Improvement (PI) projects and PS trends.

e. All healthcare personnel providing care to patients or support to healthcare providers will understand the basic components of the PSP and how to execute in their area of operations. All personnel will be active participants in the unit's PSP.

7. The proponent for CCOP-04 is the USCENTCOM Command Surgeon.

J. SCOTT CALDER
Col, USAF, MC, SFS
Command Surgeon

Appendix A: Establishing a Deployed Patient Safety Program

1. **Purpose:** To prescribe guidance and some tools to aid the PSM in establishing and sustaining a Patient Safety Program in expeditionary environments (Deployed MTFs).

2. **Background:** Preferably trained in advance of deployment, as discussed above in section 6 (Responsibilities), the appointed PSM should use the below procedures and attachments. If not yet trained, classes (as referenced in para 6, c (3)) may be completed upon arrival but this on-site training alternative is severely limited in effectiveness since it does not allow for the follow-on mentoring with MTF subject matter experts (SMEs) and hands-on experience and training, as recommended before deployment.

3. **Procedures:**

a. Upon arrival, the PSM should use the Deployed MTF Pt Safety Mgmt. Tool located in the resources section of this appendix to develop, manage and sustain a PSP.

b. PSM should also establish a PS Team which convenes routinely as a committee to implement the program (see sample Pt Safety Team Appt Memo and sample PS Committee (Function) Agenda found in the resources section of this Appendix). Refer also to Appendix E regarding establishing JPSR Accounts for all required PS Team members.

c. The key to a successful PSP is sustaining a "Safe Culture" with clear communications and networking (refer to Appendix B on Teamwork and Appendix C on High Reliability Organizations).

d. For ongoing operations and routine staff rotations, outgoing and incoming PSMs should complete a hand-off using the Deployed MTF Pt Safety Mgmt. Tool and the HRO Assessment Tool (included in the resources section of Appendix C).

e. Patient Safety is heavily dependent on transparency, as discussed in Appendixes B and C and self-reporting as addressed in Appendix D. Regardless of whether JPSR is available, all staff should be familiar with PS reporting criteria and use some method to standardize immediate collection information related to the event (see sample Pt Safety Incident Form in the resources section of this Appendix). The Pt Safety Incident Report Form can be used as an excellent input tool for JPSR and/or all other subsequent types of local investigations (as addressed in Appendices F and G).

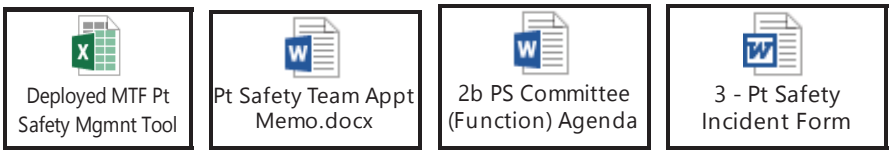
f. Regardless of all PS efforts to prevent harm, PS errors will occur and will be reported and investigated as addressed in Appendices F and G. It is imperative that key staff do not overlook responsibilities to recognize circumstances which requires the Risk Management Team (not the PS Team) to perform a Standards of Care (SOC) investigation (separately from PS investigations.

g. Some patients in Deployed MTFs cannot be Returned-to-Duty (RTD) and will need to be evacuated. It is imperative that the referring MTF prevents any harm to the evacuating patient by preventing errors locally and following guidance in Appendix H, Patient Movement Safety Reporting.

h. Lastly, anytime a patient harm event occurs, our own staff members involved in the

event are affected in various levels of emotional and physical ways and thus become the "Second Victim(s)". Every PSM should try to ensure all medical staff are familiar with the term "Second Victim". Regardless of whether the event is reported and becomes knowledgeable to the PSM or other staff members, all medical unit staff should be able to seek assistance in their recovery. Refer to Appendix I.

4. **Resources:**



*****To open an Excel, Word, or pdf document double left click on the mouse. To open a PowerPoint presentation, right click on the mouse, scroll over "Presentation Object", then click on "open".**

Appendix B: Teamwork: Team Communication and Networking

1. **Purpose:** To help facilitate team collaboration and communication in order to improve patient outcomes.

2. **Background:** Communication and teamwork failures continue to be the leading cause of adverse events in healthcare systems. Communication and other teamwork skills are essential for the provision of quality healthcare and for the prevention and mitigation of medical errors and of patient injury and harm.

3. **Procedures:**

a. All healthcare personnel will know and utilize the communication tools and strategies outlined in the DHATeamSTEPPS Program in order to improve teamwork, empower staff, improve communication, and improve patient safety. DHATeamSTEPPS tools may be found on at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-healthcare/Patient-Safety/Patient-Safety-Products-And-Services/TeamSTEPPS. You will find the link under the section titled "Accessing TeamSTEPPS Curriculum and Materials on the Patient Safety Learning Center".

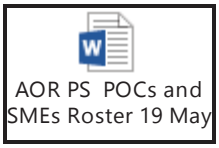
b. At minimum leadership will role model and ensure the use of team Briefs, Debriefs, "Situation, Background, Assessment, Recommendation" (SBAR), "I am concerned, this is unsafe, stop" (CUS), and "describe the situation, express concerns, suggest alternatives, consequences stated" (DESC IT).

c. Briefs and Debriefs will be conducted for all surgical cases (see Surgical Brief Debrief Tool in the resources section of this Appendix). Shift change huddles or daily briefs/debriefs should also be used to assess open concerns, plans, and resources for the incoming shift and capture any concerts (PS events) which occurred during the outgoing shift.

d. Networking with other MTFs is encouraged. MTF PSMs are requested to sustain the PS point of contacts (POCs) and subject matter experts (SMEs) roster (see example labeled AOR PS POCs and SMEs Roster in the resources section of this Appendix). AFCENT is the delegated service that provides the USCENTCOM Patient Safety Webinars for deployed units and thus have accepted the responsibility to maintain the theater PSM rosters. Send updates to the roster to the AFCENT Command Surgeon's Office or Expeditionary Medical Support System (EMEDS) POC. The latest contact roster is posted at the EMEDS PS website: https://kx.health.mil/AFMOA/ClinicalQuality/PS/SitePages/Home.aspx (log in using your CAC PIV, from the left-sided menu select "A-E" under "Subject Titles", and select respective folder).

4. **Resources:**


Surgical Brief
Debrief Tool.docx


AOR PS POCs and
SMEs Roster 19 May

Appendix C: High Reliability Organizations

1. **Purpose:** The goal of a High Reliability Organization (HRO) is to promote the highest level of safe, effective, quality care. These principles are vital to the success of PSPs within deployed units.

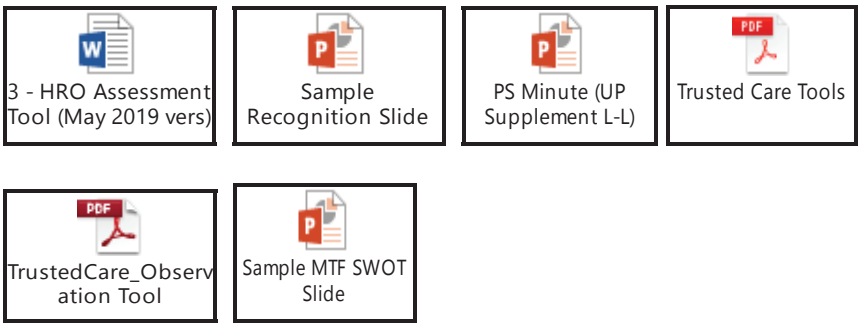
2. **Background:** Leaders recognize that HRO principals must be adopted at all levels of the enterprise and fundamental culture change is expected to build and support a culture of safety.

3. **Procedures:**

a. MTFs are encouraged to assess their unit's maturity against HRO criteria and at a minimum use the attached HRO Assessment Tool during each rotation of staff or at least annually to monitor process improvement initiatives using various leadership tools, including huddle boards, recognition programs, and lessons-learned products.

b. Networking with other MTFs is highly encouraged and facilitated by the Quarterly CrossTalks (hosted by USAFCENT/SG). A simple Quad Chart Slide (SWOT-Strengths, Weaknesses, Opportunities, Threats) is submitted by each MTF for quarterly PS updates. See the sample MTF SWOT Slide in the resources section of this Appendix.

4. **Resources:**



Appendix D: Joint Patient Safety Reporting

1. **Purpose:** JPSR is the DoD electronic system used to capture data for all types of PS events in MTFs and other applicable healthcare environments, as well as PS events identified in other quality data programs to promote a comprehensive and accurate view of PS events across the Military Health System (MHS).

2. **Background:** The PSM is responsible for JPSR data management, the review of facts associated with the PS event, and for ensuring an appropriate evaluation is performed as required per this protocol. JPSR usage is the only authorized method for the reporting of adverse events, no-harm events, near miss events, and unsafe/hazardous conditions. Individual MTF/organizational developed applications are not authorized.

3. **Procedures:**

a. The PSM at the deployed location must acquire an account as "PSM-at-Parent-MTF" and establish accounts for all key staff (see Appendix E).

b. PSRs are QA documents and will be protected from disclosure according to reference a and will not be released without written consent of USCENTCOM.

c. All PS events (adverse events, no-harm events, near miss events, or unsafe/hazardous conditions) must be reported in JPSR as soon as possible. JPSR can be found at DoD site NIPRNet at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Joint-Patient-Safety-Reporting. If unable to access the JPSR system, unit personnel will follow their Service-specific guidelines for submission of PS events during deployment and provide copies to the appropriate Service Component and/or CJTF Command Surgeon's office.

d. Immediate action must be taken to make sure all affected, or potentially affected patients and staff are protected from additional injury and to minimize the effects of the event.

e. JPSR consists of three major processes and forms: PS event reporting form, investigation and analysis form, and aggregation and reports design/development.

f. All CAC authenticated users can access and are expected to report PS events in JPSR. JPSR allows the reporter to self-identify or report anonymously. The staff member who identified the event will complete the electronic PS event reporting form. This form must be completed and submitted in one sitting due to system requirements associated with the anonymous reporting capability.

g. The investigation and analysis form will be completed by the PSM or assigned staff. This form allows the PSM to assess the event, assign a handler and investigators if needed, and complete an analysis of the PS event.

h. The roles of handler and investigator and the development of aggregation and trending reports are controlled by role-based security authorized by the PSM.

i. All PS events require assessment and action. The PSM will actively and regularly review all events reported within JPSR to identify risks or potential problem areas for focus. The ultimate goal of reporting is to prevent harm.

j. If the event meets DoD RE criteria (see DHA-PM Appendix DoD RE Matrix in the resources section of Appendix F), a CSA is required.

k. For adverse events that do not meet DoD RE criteria, further action may be considered according to their Risk Assessment Grade (RAG) as determined by the Probability/Severity matrix in JPSR. The Probability/Severity Matrix is a useful way to assign priority to events based upon their risk. The Probability/Severity Matrix must be used for all PS events. CSAs are strongly encouraged, along with implementation of a corrective action plan, for events with a RAG scored as high.

l. PSMs are encouraged, but not required, to conduct CSAs on other adverse, no-harm, and near miss events. PSMs are required to conduct CSAs as directed by leadership.

m. All CSAs are to be submitted in the DHA approved format to USCENTCOM personnel for review and organizational learning.

n. An aggregate review and analysis may be performed quarterly for more common non-DoD RE event types that do not result in a RAG scored as high. The outcome should drive further action, if warranted. Aggregate review products should be shared with the USCENTCOM Surgeon.

o. Similarly, for PS events that do not reach the patient (near miss events or unsafe/hazardous conditions), the decision may be to track, trend, and complete an aggregate review and analysis. The outcome should drive further action, if warranted.

p. If the event involves physical safety issues, hazardous environment of care conditions, or staff, the event response will be coordinated with the Senior Administrator and the Facility Manager for a multidisciplinary response.

q. Closure of PSRs will be monitored with the goal of 80 percent for closure within 30 calendar days of the PS event reported date. PSRs more than 30 calendar days old will be monitored weekly by the PSM.

r. Timely closure with appropriate action of PSRs will be tracked by the PSM and USCENTCOM.

4. **Resources:**


PDF
Reportable Event
Process Flow Chart -


PDF
Patient Safety
Reporting System Pr

Appendix E: JPSR Account Activation Request Form

1. **Purpose:** To prescribe the procedures necessary for the PSM to register and gain access to the JPSR system.

2. **Background:** Gaining access to the JPSR system through submitting the AARF before arrival to theatre allows the PSM to gain familiarity with the JPSR system and helps facilitate a seamless transition between units.

3. **Procedures:**

a. Complete the following training before requesting the AARF: Health Insurance Portability and Accountability Act (HIPAA) and Privacy Act Training at https://jkodirect.jten.mil/Atlas2/page/desktop/DesktopHome.jsf (log in with your CAC PIV, type HIPAA in the search bar of the Course Catalog, and select Course Number –US001) and Cyber Awareness Training at https://cyber.mil/ (log in with your CAC PIV, click the training drop down tab at the top of the page and select Cyber Awareness Challenge, last, click the yellow tab labeled "Launch Training").

b. Fill out the AARF pdf in the resources section of this Appendix (you can use the JPSR Account Request Instructions to help if you have questions filling out this form) then send the filled out AARF along with your completed training to the DHA Global Service Center at DHAGSC@mail.mil.

4. **Resources:**

Appendix F: DoD Reportable Events Definition and Reporting

1. **Purpose:** To define DoD Reportable Events and establish reporting criteria.

2. **Background:** A DoD RE is any patient safety event resulting in death, permanent harm, or severe temporary harm, as per the AHRQ Harm Scale; or meeting The Joint Commission's (TJC) sentinel event (SE) or the NQSF's serious RE definitions. DoD REs require a CSA and follow on Corrective Action Implementation (CAI) Plan Report. TJC defined a SE in 2015 as a patient safety event (not related to the natural course of illness or underlying condition) that reaches the patient and results in death, permanent harm or severe temporary harm. Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual but requires transfer to a higher level of care/monitoring, additional surgery, procedure, or treatment to resolve (The Joint Commission Accreditation, 2018). DoD REs require a CSA and follow on CAI Plan Report. A list of the NQSF's serious REs can be found at http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx. However, DHA has published a matrix which goes beyond SEs and serious REs. See DHA-PM Appendix DoD RE Matrix in the resources section of this Appendix.

3. **Procedures:** All DoD REs will be reported to the USCENTCOM SG within 24 hours of identification.

4. **Resources:**

Appendix G: Comprehensive Systemic Analysis and Concise Incident Analysis

1. **Purpose:** To provide the PSM with the criteria and tools for REs requiring a CSA or CIA in order to improve systems for better patient outcomes.

2. **Background:** A CSA is a thorough, credible, and acceptable analysis following a PS event that seeks to identify system vulnerabilities so that they can be eliminated or mitigated in a sustainable manner to prevent reoccurrence. An RCA is the most common type of CSA. CSAs can also be conducted for PI purposes for those events that have the potential to be catastrophic. The following guidelines support the identification of causal factors in CSAs:

(a) Clearly show cause and effect relationships.
(b) Use specifics and accurate descriptions of events.
(c) Human errors must have a preceding cause.
(d) Violations in procedure must have a proceeding cause.
(e) Failure to act is only causal when there is a pre-existing duty to act.

3. **Procedures:**

a. All CSA methodologies determine how and why an RE incident occurred, what was learned from the event, and what can be done to reduce the risk of recurrence to make patient care safer. Units involved in REs should report the event to their respective CENTCOM Service Component Headquarters (HQs).

b. The RCA process is still applicable in most expeditionary setting investigations. The CIA process (see paragraph e below) is still in a pilot stage and currently used in Dental "Mild Harm" events.

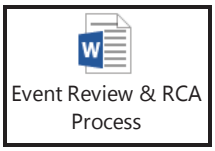
c. Army units may contact the RESET team at usarmy.jbsa.medcom.list.medcom-psc@mail.mil if the need for a CSA has been identified. A member of the RESET team will help your organization conduct the CSA.

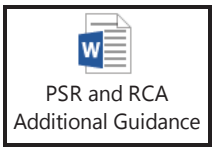
d. Air Force (AF) units will follow Service direction in coordination with AFCENT/SG for conducting RE Investigations using the RCA process. AF PS Professionals and locally trained PSMs are still leading the RCA process for AF Internal RE Investigations. A Medical Incident Investigation (MII) Team (externally sourced) may be identified to help in the RCA process if requested and approved by the AFMS; until DHA Market Leads are fully established. See detailed guidance on RCAs in the imbedded documents in the resources section of this Appendix.

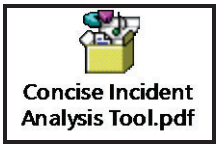
e. The CIA Process (a pilot initiative and not approved for Service-wide use) is used to determine what, how, and why an incident happened, what can be done to reduce the risk of recurrence to make care safer, and what was learned from the incident. The CIA tool is used as a standardized evaluation of targeted near misses or low no harm events. It requires less time and resources than an RCA (3-4 people and hours vs days). See the CIA

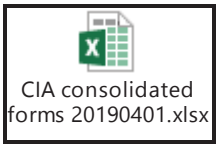
tools in the resources section below.

4. **Resources:**









Appendix H: Patient Movement and Reporting

1. **Purpose:** To maximize safety during patient movement.

2. **Background:** Aeromedical Evacuation (AE) from theater involves many different organizations to communicate and synchronize. An effective PSP encompasses a system-wide approach to identify events during the AE process in order to take corrective actions and monitor progress ensuring effective, safe patient transport.

3. **Procedures:**

a. EMEDS/En Route Patient Staging System (ERPSS)/Medical Units/AE Squadrons will include USTRANSCOM and HQ Air Mobility Command En Route Care/AE Patient Safety Goals as part of their safety program where applicable (see 2017-2019 AE Crew Member Goals, 2017-2019 En Route Pt Staging Goals, and 2017-2019 Tri-Service Med Unit documents located in the resources section of this Appendix). En Route Care/AE Patient Safety Goals remain in effect until superseded/replaced. Units will include USCENTCOM's Patient Movement/Evacuation Safety Goals as part of their safety program when possible (see Patient Movement Safety Goals for theater located in the resources section of this Appendix). Additionally, EMEDS/ERPSS/Medical Units must provide a patient handoff report to the receiving AE medical crew (see Pt Movement Inpatient Handoff Report and Pt Movement Outpatient Handoff Report located in the resources section of this Appendix).

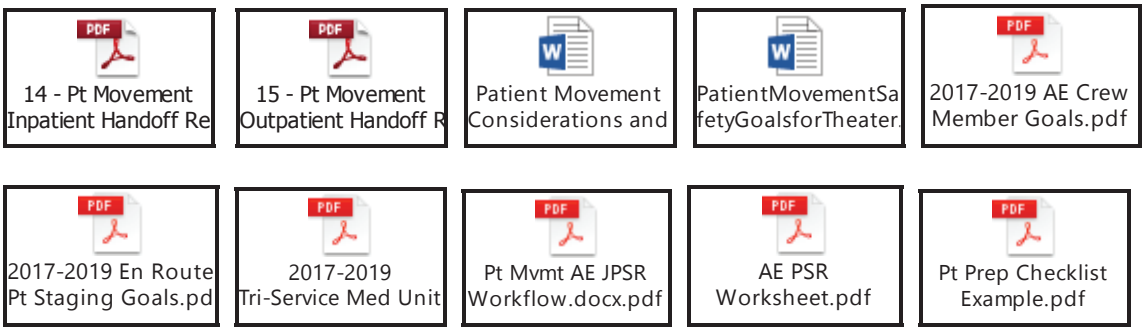
b. PSRs for patient movement (PM) will be completed in the JPSR system within the Transportation Command Patient Movement domain. Information such as mission number, patient cite number, enplaning, and deplaning locations are some of the additional required elements in reporting. The PM Patient Safety Coordinator (PSPC) will assign the handler(s). AE PSPCs are attached to HQ AMC (at Scott AFB) and HQ USAFE (Ramstein) for guidance on all PM related PS incidents and reporting. After an event is entered in the Transportation Command JPSR system, the event will first be viewed by HQ Air Mobility Command /USTRANSCOM PSPCs and then assigned an MTF/Unit. The MTF/EMEDS/Unit PSM can then view and assign a handler to investigate the event. MTF/EMEDS/Unit PSM instructions for managing an assigned PM event is located in the resources section in this Appendix and is labeled Pt Mvmt AE JPSR Workflow.

c. If the JPSR system is not accessible, an AE Patient Safety Reporting Worksheet can be filled out. Once JPSR connectivity is regained, the information on the worksheet can be inserted into JPSR. A local copy of the document with all event information should be kept in a secure manner on file or uploaded to the JPSR documents section for back-up and reference. All AE Squadrons will use the AE Patient Safety Reporting Worksheet for reporting all events. The event worksheets will be turned in to the AE Squadron Patient Safety Office to be input into JPSR. This allows for AE Squadron leadership awareness of AE events. The AE Patient Safety Reporting Worksheet can be found in the resources section of this Appendix labeled AE PSR Worksheet.

d. Most AE related patient safety events involve some aspect of the patient not being properly

prepared before flight by the sending facility. An example of a PM patient preparation checklist can be found in the resources section of this Appendix entitled Pt Prep Checklist Example. This can be a helpful aide for sending facilities to use.

4. **Resources:**



Appendix I: Safe Culture vs Just Culture and 2nd Victim Resiliency

1. **Purpose:** To foster a Safe Culture of Patient Safety and Just Culture of Risk Management accountability.

2. **Background:** A successful PSP ensures a balance between human and systems accountability through the implementation of a Safe and Just Culture across the continuum of care and fosters an interdisciplinary approach to decrease unanticipated adverse healthcare outcomes. PS Safe Culture embraces the commitment to provide safe, high quality care by focusing on blame-free reporting and promoting effective teamwork, and focusing on communications with a systems emphasis and development of strong, consistent corrective actions to improve procedures preventing human errors. Risk Management Just Culture must ensure protocols or Evidenced-Based Practices (EBPs) were followed and whether deviations occurred from human errors (and can be distinguished as mistakes) or due to intentional non-compliance or taking negligent risks at the expense to the patient (requiring accountability and/or credentialing actions). In both Safe Culture and Just Culture events, leadership must recognize staff involved as potential Second Victims who will need a strong support network to ensure a route for recovery and resiliency.

3. **Procedures:**

a. Encourage a systems approach to create a safer patient environment by fostering trust, transparency, teamwork, and communication.

b. Some events, unfortunately, involve Active Duty deaths, suicidal events, or staff not following approved protocols or EBPs. In these cases, the incident needs to be brought to the attention of the Risk Manager (RM) to determine if the SOC was consistently sustained, and if not, determine if inappropriate risks (intentional negligence) of the SOC by specific staff member(s) will require intervention and be held accountable.

c. The RM may use the AFMS AD Death or Suicide Memo or CENTCOM SOC Review Form located in the resources section of this Appendix to help in their investigation. Be aware, the limit of involvement of the PSM should only be to alert the RM if it is determined the SOC has been intentionally ignored. The PSM will not provide the RM with any information gathered through the PS investigation process so as not to compromise the PSM or PSP's promise of confidentiality and no-blame reporting principles. RM Safe Culture investigations may lead to perceived disciplinary (de-credentialing) actions and necessarily deviates from the PS blame-free approach in order to hold professional staff accountable for inappropriate intentional deviations.

d. Leaders recognize that healthcare workers involved in harm events, either from PS error(s) or Just Culture SOC violations, should be afforded the opportunity to seek assistance towards resiliency. All available resources (Behavioral Health, Chaplain, or online) shall be made accessible to any involved staff. See the Second Victim help kits located in the resources section of this Appendix.

4. **Resources:**


Just Culture Training.pptx
16A - 2nd Victim Kit (Supervisor or Peers)
16B - Second Victim Self Help Kit
CENTCOM SOC Review Form.pdf
AF AD Death or Suicide Memo.docx

Appendix J: VITAL-T

1. **Purpose:** The VITAL-T Program (Virtual Inspection and LINKUP in Theater) provides "real time" virtual access to Quality and Safety (QS) expertise through pre-existing Virtual Health (VH) capabilities. USCENTCOM began implementing this platform since September 2019.

2. **Background:** This innovative initiative leverages pre-existing virtual health capabilities to conduct "real time" synchronous Virtual Site Assisted Visits (VSAV's) at remote clinical sites. It was piloted within RHC-Europe to address challenges with geographic remoteness of clinical sites and resource constraints that potentially limited access to quality and safety subject matter experts (SMEs). Initially developed as a Continuous Survey Readiness tool (VITAL), the program has since been tailored to address the needs of the remote clinical sites of the Operational Environment.

The goal of the VITAL-T Program is to maximize access of remote and deployed clinical units to Quality and Safety SMEs, such as Infection Prevention and Control and Patient Safety specialists, as well as other SME's who are responsible for processes that affect patients (e.g. Immunization Healthcare Division), in order to enhance the safety and readiness of our Service Members. In addition to Virtual SAVs, VITAL-T has also demonstrated success with virtual coaching/education, and is being further developed to enhance Patient Safety within the Operational Environment.

On 13 September 2019, the first known successful Infection Prevention and Control VSAV occurred at a role 3 as part of the US Central Command's pilot of the VITAL-T program. On 30 October 2019, AQSC facilitated the first successful VITAL-T VSAV continuous quality immunization improvement process assessment (CQIIP) at a role 3. Several have been conducted since at different locations. In December 2019, AQSC Patient Safety partnered with JTS and the RESET team to conduct the first Virtual Root Cause Analysis in a Deployed MTF.

The VITAL-T Program was tailored to deliver "On-Demand" virtual consult support for multiple missions supporting COVID-19 Response, including the DSCA mission. Additionally, the Program was invited to partner with the Tri-Service/DHA Infection Prevention and Control Tiger Team to deliver virtual consult support to the MTFs.

On 16 June 20, AQSC's VITAL-T Program facilitated an unprecedented Infection Prevention and Control (IPC) USCENTCOM-wide COVID-19 "Best Practices" Virtual Round-Robin. During the USCENTCOM-led call, more than 30 CONUS-based and deployed personnel from all Services/DHA, dialed in to participate on the virtual platform. Three USCENTCOM Role 3's demonstrated and shared their "Best Practices for COVID-19 Response" virtually in "real time", to include sterilization process and COVID-ICU configurations and technology (e.g. tele-monitoring), which maximized patient and staff safety during the pandemic.
On 19 June, the VITAL-T Program conducted its first "On-Demand" Consult in the Operational Environment, delivering virtual consult support within 24 hours of the request.

We are actively developing VITAL-T for Patient Safety in the Operational Environment, to include maximizing virtual support for coaching/education, Patient Safety Event Analysis, and team development (e.g. TeamSTEPPS). Additionally, this platform is being considered to deliver valuable teaching as new technology aimed at improving Patient Safety (e.g. RFID) is being rolled out.

3. **Procedures:**

a. The program currently offers virtual support from the following Quality and Safety experts:

(1) Infection Prevention and Control (IPC)

(2) Patient Safety (PS)

(3) Medication Safety (MS)

b. The following services are currently offered:

(1) Virtual Site Assisted Visit (VSAV), or site/process evaluation

(2) Virtual coaching/education

(3) Virtual Patient Safety support, to include support with Patient Safety Reporting, Patient Safety Event analysis, Root Cause Analysis

4. **Resources:**

a. The Virtual Consult Service will be conducted through an approved Virtual Health platform on currently approved devices for that site. For USCENTCOM sites, coordination with IT/S6 components at that site is required.

b. **SUBMIT A CONSULT to CONUS QS SME in 2 Easy Steps:**

1. USCENTCOM to CONUS: Arrange a Virtual Consult or Service through your component or JTF ClinOps with the appropriate CONUS QS expert via:
   Email: usarmy.jbsa.medcom.list.medcom-vitalt@mail.mil or
   24-hour VITAL-T hotline: (210)-307-0923

2. Virtual connectivity may be achieved by one of the following approved means; (availability will depend on location):
   - GVS
   - CMS/webRTC
   - Microsoft Teams

c. **How to contact us for Questions/Requests for Virtual Consults**: Email: usarmy.jbsa.medcom.list.medcom-vitalt@mail.mil, or call **24-hour VITAL-T hotline: (210) 429-4204**.