Defense Health Agency

ADMINISTRATIVE INSTRUCTION

NUMBER 6025.36
May 30, 2024

DAD-MA

SUBJECT: Ready Reliable Care Safety Communication Bundle

References: See Enclosure 1

1. PURPOSE. This Defense Health Agency-Administrative Instruction (DHA-AI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (x), establishes the Defense Health Agency's (DHA) procedures to assign responsibilities and establishes procedures for implementing, measuring, and sustaining the Ready Reliable Care (RRC) Safety Communication Bundle (SCB).

2. APPLICABILITY. This DHA-AI applies to the DHA Enterprise (components and activities, under the authority, direction, and control of the DHA) to include assigned, attached, allotted, or detailed personnel.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (d) through (x), that the RRC Safety Communication Bundle policy will be implemented in all military medical treatment facilities (MTFs) in the DHA, which includes both medical and dental facilities. This policy:

a. Establishes clinical quality management (CQM) procedures in the DHA to provide an integrated framework for implementation, measurement, and sustainment of the RRC SCB.

b. Strengthens DHA CQM accountability, transparency, and standardization related to the RRC SCB.

c. Affirms the DHA's unwavering commitment to safe, high-quality health care for our beneficiaries.

4. CANCELED DOCUMENTS. This DHA-AI cancels the following document, DHA Procedural Instruction 6025.45, "Ready Reliable Care Safety Communication Bundle."

5. RESPONSIBILITIES: See Enclosure 2.

6. PROCEDURES. See Enclosure 3. A comprehensive Implementation Guide is available through the Patient Safety Learning Center. The Implementation Guide contains more detailed descriptions of the implementation, measurement, and sustainment processes, related to the RRC SCB. It may be accessed by emailing the Patient Safety Program at: dha.ncr.j-3.dod.patient-safety-program@health.mil. References to non-federal entities do not constitute or imply Defense Health Agency or Department of Defense endorsement of any company or organization.

7. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director (DAD), Medical Affairs (MA). When Defense Health Networks and MTFs are unable to comply with this publication the activity may request a waiver that must include a justification, to include an analysis of the risk associated with not granting the waiver. The Director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if Director, DHA or their designee may grant the waiver.

8. RELEASABILITY. **Cleared for public release**. This DHA-AI is available on the Internet from the Health.mil site at: https://health.mil/Reference-Center/Policies and is also available to authorized users from the DHA SharePoint site at: https://info.health.mil/cos/admin/pubs/DHA%20Publications%20Signed/Forms/AllItems.aspx.

9. EFFECTIVE DATE. This DHA-AI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (c).

10. FORMS. The following DHA forms can be found on the internet at: DHA Forms Library.

a. DHA Form 205, Dental Universal Protocol Checklist

b. DHA Form 228, Universal Protocol Checklist Operating Room Version

c. DHA Form 229, Universal Protocol Checklist Procedural Version

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REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013, as amended
(c) DHA Procedural Instruction 5025.01, "Publication System," April 1, 2022
(d) Department of Defense Instruction 6025.13, Medical Quality Assurance and Clinical Quality Management in the Military Health System, July 26, 2023.
(e) Dai M., Willard-Grace R., Knox M., Larson S.A., Magill M.K., Grumbach K., et al. "Team Configurations, Efficiency, and Family Physician Burnout" *Journal of the American Board of Family Medicine*, 2020 May-June; 33(3): 368-377[1]
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(g) DHA-Procedures Manual 6025.13, "Clinical Quality Management in the Military Health System, Volume 2: Patient Safety," August 29, 2019
(h) Military Health System Leadership Engagement Toolkit, Department of Defense Patient Safety Program, December 2017[3]
(i) National Academies of Sciences, Engineering, and Medicine; "Taking Action against Clinician Burnout: A systems approach to professional well-being" *National Academies Press* (US), October 23, 2019[4]
(j) Perez, Hector R., et al. "Chaos in the Clinic: Characteristics and Consequences of Practices Perceived as Chaotic" *Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality*, Vol. 39(1), 2017: 43-53[5]
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(l) DHA Ready Reliable Care website[7]
(m) DHA Ready Reliable Care Safety Communication Bundle Implementation Guide. DHA Patient Safety Program, September 25, 2021[8]

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[2] This reference can be found at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6978590/
[3] This reference may be accessed by emailing the Patient Safety Program at dha.ncr.j-3.dod.patient-safety-program@health.mil
[4] This reference can be found at: https://pubmed.ncbi.nlm.nih.gov/31940160/
[5] This reference can be found at: https://pubmed.ncbi.nlm.nih.gov/26566238/
[6] This reference can be found at: http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
[7] This reference can be found at: https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Ready-Reliable-Care
[8] This reference may be accessed by emailing the Patient Safety Program at DHA.PatientSafety@health.mil

(n) Scoville R., Little K., Rakover J., Luther K., Mate K. "Sustaining Improvement" Institute for Healthcare Improvement White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016[9]
(o) Smith, C. D., Balatbat C., Corbridge S., et al. "Implementing Optimal Team-Based Care to Reduce Clinician Burnout" *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, D.C. September 17, 2018[10]
(p) Agency for Healthcare Research and Quality, TeamSTEPPS® website[11]
(q) TeamSTEPPS® DoD Public website[12]
(r) TeamSTEPPS® DoD Secure website.[13]
(s) The Joint Commission Universal Protocol website[14]
(t) United States Code, Title 10, Section 1102
(u) Guidance for Dental Treatment Facilities, April 2022[15]
(v) DHA Administrative Instruction 6025.16, "Surgical and Procedural Patient Safety Practices," December 29, 2022.
(w) DHA Acting Director Health Care Administration Tasking Memo, Identification of RRC Champions, August 4, 2022[16]
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[13] This reference may be accessed by emailing the Patient Safety Program at DHA.PatientSafety@health.mil
[14] This reference can be found at: https://www.jointcommission.org/standards/universal-protocol/
[15] This reference may be accessed by emailing the Patient Safety Program at DHA.PatientSafety@health.mil
[16] This reference may be found by emailing: dha.ncr.j-3.mbx.dod-patient-safety-program@health.mil
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ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA, will:

a. Ensure the Defense Health Networks assign responsibilities to implement RRC SCB in all clinical and non-clinical areas, as applicable and as outlined in this DHA-AI.

b. Assign responsibility for tracking compliance with the standard processes and criteria as outlined in this DHA-AI to the DAD-MA.

2. ASSISTANT DIRECTOR, HEALTH CARE ADMINISTRATION. The Assistant Director, Health Care Administration, will:

a. Direct implementation of, and ensure compliance with, standards and procedures in this DHA-AI.

b. Support DAD-MA, the Defense Health Networks, and MTFs by identifying standard clinical, business, and administrative process changes or requirements, and assign resolution to the appropriate directorate within DHA.

3. DAD-MA. The DAD-MA will:

a. Ensure implementation of the requirements established by this DHA-AI within the MTFs.

b. Manage standardization of the data, measures, reporting, and analysis addressing compliance with the procedures in this DHA-AI.

4. DIRECTORS, DEFENSE HEALTH NETWORKS. The Directors, Defense Health Networks, will:

a. Ensure all MTF Directors are actively engaged in the implementation, measurement, and sustainment of RRC SCB.

b. Review quarterly data collection related to safety practices adherence and provide quarterly status updates to DAD-MA.

c. Address and monitor MTF progress in alleviating conditions contributing to workplace burnout.

d. Provide consultation and subject matter expertise support for implementation of this DHA-AI with the MTFs aligned to their Defense Health Networks.

e. Facilitate group coaching of leaders seeking assistance for establishing leadership engagement strategies into daily practice.

f. Appoint the Network Chief Medical Officer (CMO) to lead the RRC SCB initiative for the Network, including all related activities. The Network CMO leads Safety Forum presentation and discussion for their Network. If the Network CMO is unavailable to lead the discussion, the Chief Nursing Officer, or Chief Dental Officer, and or Network Patient Safety Lead will do so.

g. Appoint a Network RRC Champion.

h. Disseminate this DHA-AI and updates to all MTF Directors.

5. DIRECTOR, MTF. The Director, MTF, is responsible for the care and safe care practices provided at the MTF and will:

a. Lead RRC Safety Communication Bundle efforts within the facility directed towards improving communication and teamwork.

b. Hold leaders, health care providers, supervisors, and staff accountable for implementation, measurement, and sustainment of the safety practices as outlined in this DHA-AI.

c. Submit a quarterly data collection report to the Director, Defense Health Network within 45-calendar days of the end of the quarter.

d. Upon request, lead Safety Forum presentation and discussion for their organization. If the Director is unavailable to lead the discussion, the CMO, the Chief Nursing Officer, or Chief Dental Officer will do so.

e. Identify, correct, and monitor opportunities that address workplace stressors contributing to burnout.

f. Disseminate this DHA-AI and all updates to all MTF health care providers and health care personnel.

g. Appoint a RRC Champion.

6. MTF LICENSED STAFF MEMBER. MTF licensed staff members will comply with procedures detailed in this DHA-AI.

ENCLOSURE 3

PROCEDURES

1. RRC SCB: OVERVIEW

a. DHA is committed to the delivery of safe, high-quality care to all beneficiaries. As the DHA aims to become a high reliability organization, it is essential to learn from errors made in the past and create conditions for the delivery of the safest care in the future, and to implement processes to facilitate early recognition, communication, and mitigation of risk to move toward zero preventable harm.

b. RRC is a strategic cross-functional initiative that is instrumental in getting everything else right. It builds on the existing work and best practices of the Military Medical Departments and the DHA. RRC works across clinical and non-clinical settings to drive better outcomes for patients, staff, and the enterprise, with the aim of zero preventable harm. DHA leaders and staff contribute to high reliability by embodying seven RRC Guiding Principles in their daily work. These Guiding Principles serve as the foundation for four Domains of Change, the organizational changes necessary to progress toward high reliability. The RRC SCB operationalizes the Domains of Change and exemplifies the Guiding Principles. More information on RRC may be found on Reference (l). NOTE: Reference in this DHA AI to "health care" or "medical care" includes "dental care".

c. The RRC SCB Practices were adapted from several sources. TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety), as defined by References (p), (q), (r), was developed by DoD in partnership with the Agency for Healthcare Research and Quality and is an evidence-based system aimed at optimizing patient outcomes by improving communication and other teamwork skills and is foundational to the Safety Practices. The Leadership Engagement Toolkit as defined by Reference (h) is also a key source. It was adapted from a similar resource developed by the Institute for Healthcare Improvement, the Joint Commission Resources, and the Health Research Education and Trust of the American Hospital Association.

d. The RRC SCB consists of six Practices: (1) Leader Daily Safety Brief (LDSB), (2) Safety Leadership Rounds (SLR), (3) Unit-Based Huddles (UBH), (4) Illness Severity-Patient Summary-Action List-Situational Awareness Contingency Planning-Synthesis by Receiver (I-PASS), (5) Surgical Brief/Debrief, and (6) Universal Protocol (UP). These are foundational to a supportive organizational culture, focusing on trust and respect to promote early identification and reporting of safety concerns which will create a healthy work atmosphere free of culture-related stressors contributing to staff burnout. Leaders at all levels must foster an atmosphere of mutual trust and respect that empowers all to speak up when safety concerns are identified and, when appropriate, take actions to mitigate risk and resolve preventable workplace stressors leading to workforce burnout and enhancing well-being. All leaders, health care providers, and staff must understand their roles in supporting a work environment that promotes team and individual well-being and resilience and identify, mitigate, and monitor opportunities that

address workplace conditions contributing to burnout. These Practices may be integrated into training exercises, to include simulation, as much as possible.

e. The Practices are designed to apply to clinical and non-clinical areas and apply to medical and dental facilities, as appropriate. Some departments and units may use all the Practices, and some may not, depending upon the services provided in the facility, as follows:

(1) LDSB: Director Suite senior leaders, Patient Safety and Quality Officers participate; and, MTF Department and Unit Leaders participate, as appropriate and per MTF Director guidance.

(2) SLR: Director Suite senior leaders facilitate; all clinical and non-clinical units/departments participate.

(3) UBH: All clinical and non-clinical units/departments conduct at least daily and more frequently as needed.

(4) I-PASS: Highly encouraged for all clinical areas during transitions of care; must be conducted in all inpatient units and Emergency Departments.

(5) Brief/Debrief: Brief conducted by Operating Room (OR) teams and Procedural Areas; debriefs using OR Debrief Issue Tracker are conducted by OR teams.

(6) UP: Conducted by OR teams and Procedural Areas.

f. Though leaders are committed to and are involved in all the Practices, Practices 1 through 3 directly involve leaders daily. Practice 1, LDSB, is led by director- suite senior leaders, but it is critical for leaders at all levels to identify and discuss issues that have occurred or are likely to occur. Practice 2, SLR, is led by the Director Suite senior leaders. Clinical and non-clinical units, departments, and work areas participate. Information from Practice 3, UBH, may be a source of information for discussion during the LDSB. Information from Practices 1 and 3, LDSB and UBH respectively, may guide discussion during Practice 2, SLR. See Reference (l, m) for more information.

2. SUMMARY: RRC SCB PRACTICES

a. Practice 1: LDSB

(1) Purpose: A brief meeting of the Director Suite senior leaders, Patient Safety and Quality Officers participate; and, MTF Department and Unit Leaders participate, as appropriate, per MTF Director guidance, to provide updates on events from the past 24 hours and projections of concerns for the next 24 hours. The focus is on patient and staff safety and quality care for a shared situational awareness, promoting early identification and resolution of problems to include factors related to workplace stressors and well-being. Detailed guidelines for conducting the LDSB are in Reference (m).

(2) Who: Led by the Director, MTF or Senior Leader.

(3) When: A 15-minute brief that occurs daily at the start of the day.

(4) What: The topic order for each reporting participant:

(a) Look Back at significant safety or quality concerns and issues in the past 24 hours:

1. Any reported Joint Patient Safety Reporting system events including those related to staffing, equipment, or patient safety in the past 24 hours.

2. Any DHA Patient Safety Alerts, Advisories, and HEART Messages; and other critical communications.

3. Any issues elevated from the SLR or UBH.

(b) Look ahead at anticipated safety or quality concerns and issues in the next 24 hours:

1. Mitigation efforts to prevent future occurrence.

2. Team preparation to prevent occurrence.

3. Error-prevention staff behaviors to prevent occurrence.

4. Patient and family involvement to prevent occurrence.

5. Communication plan for mitigation of potential occurrence.

(c) Follow-Up:

1. Provide status report on concerns and issues previously identified.

2. Provide status updates on process improvement projects.

3. Maintain record or database of concerns and issues discussed and mitigated, to include dates, department, or unit addressing the issue.

b. Practice 2: SLR

(1) Purpose: A routine, planned event for MTF senior leaders to visit clinical and non-clinical areas and speak to staff about quality, safety, areas of potential risk, and policy compliance to improve the reliability of care and promote a culture of safety and workforce well-being. Detailed guidelines for conducting the SLR are in Reference (m).

(2) Who: Led by the Director, MTF and other MTF Director Suite senior leaders. This may not be delegated below the MTF Director Suite senior leaders.

(3) When: Weekly, for 15–20 minutes for each unit or department visited.

(4) What: The format for SLRs is as follows:

(a) Develop a set of planned or recommended questions to ask staff based on current safety concerns identified in Patient Safety reports, the LDSB, or Culture Survey.

(b) Assign roles to members of the Leadership Team doing the rounds.

(c) Prepare opening and closing statements as well as potential topic questions.

1. Opening statement: Promotes transparent, blame-free conversation.

2. Open-ended topic questions: Centered on pre-specified areas of potential risk (operational processes, potential safety concerns, and actionable workplace stressors).

3. Closing statement: Promote understanding, sharing, and co-creating the method to ensure effective feedback.

(5) Post-rounds debrief provides the opportunity to synchronize and:

(a) Develop Action Plan from list of findings.

(b) Maintain record or database of SLR.

(c) Monitor progress of items identified, actions taken, or date resolved.

(d) Share findings and/or actions with facility leadership and unit within 30 days of discovery.

c. Practice 3: UBH

(1) Purpose: The UBH establishes and maintains a shared mental model on the plan for the day, shift, or event of care. It is a method to communicate, collaborate, and coordinate with core team members on the medical or operational plan. The multi-disciplinary team provides the collective wisdom of all team members focused simultaneously on the needs of the patient.

(2) What: A planned event conducted by all MTF departments, units, and work centers.

(3) Who: The UBH is used in clinical and non-clinical areas. Core team members; those essential to safely progressing medical plans of care and operations; includes physicians, dentists, nurses, technicians, social workers, pharmacists, etc. The huddle team may invite and

engage the patient to participate in their care. In non-clinical areas, the team may consist of the team leader and team members.

(4) When: Daily, at start of day, shift, or whole team change—up to 20 minutes. Should any team member lose situational awareness of the plan or operations, they must call a quick team huddle with team members to restore their situational awareness related to planning, problem solving, and staying in safe forward action. Should issues be identified that are outside the scope of the UBH, teams work together using a structured improvement approach designed to solve more complex problems.

(5) Additionally:

(a) The UBH refers to a team planning session. In TeamSTEPPS®, it is called the team "Brief", as defined by References (p), (q), and (r). A checklist for conducting the UBH may be accessed in Reference (m).

(b) The multi-disciplinary UBH is not the same as the patient handoff of care across the continuum. That is Practice 4; I-PASS is the tool for handing over the patient and their information from one care team member to another.

d. Practice 4: I-PASS

(1) Purpose: I-PASS is a verbal mnemonic to communicate information during a transition in care; for example, during change of shift from one nurse or provider to another, or during an inter-unit or inter-facility transfer of care. I-PASS is an evidence-based bundle of interventions shown to significantly decrease communication errors during patient care handoffs. It is centered around a verbal mnemonic:

(a) I = Illness Severity (e.g., Stable, "Watcher", Unstable);

(b) P = Patient Summary (e.g., summary statement, events leading up to admission, hospital course, ongoing assessment/plan);

(c) A = Action List (to do list, timeline, and ownership);

(d) S = Situational Awareness and Contingency Planning (know what's going on; plan for what might happen; e.g., "if this happens, do this…");

(e) S = Synthesis by Receiver (receiver summarizes what was heard; asks questions; restates key action/to do items).

(2) A handoff document that is organized in I-PASS format should accompany the verbal handoff but should not serve as a substitute for verbal communication. MTFs must optimize MHS GENESIS automated tools whenever possible. Printed versions should be used only as a last resort, for example, MHS GENESIS downtime. A detailed example of an I-PASS verbal handoff and an I-PASS printable version can be accessed through Reference (l, m).

(3) Who: Highly encouraged for all clinical areas during transitions of care; must be conducted in all inpatient units and Emergency Departments.

(4) NOTE: I-PASS and Situation-Background-Assessment-Recommendation/Request (SBAR) are not interchangeable. If a patient's condition has changed but there is not a transition in care, the tool of choice remains SBAR. SBAR ensures communication of critical information requiring immediate attention and action concerning a patient's condition.

e. Practice 5: Surgical Brief/Debrief

(1) Purpose: A surgical debrief must be conducted for all procedures conducted in the OR. Every surgical case will be debriefed by the team involved in the case. The debrief occurs at the end of the case before any team member or the patient leaves the room. The Surgical Debrief is a peer review and information exchange session, protected pursuant to Reference (t), required after all procedures conducted in the OR with the surgical team. It is currently documented in the Carepoint site, using the Operating Room Debrief Issues Tracker system. Recommended timing of the debrief is during skin closure or at the end of the case. As the team lead, it is the responsibility of the operating provider to ensure the debrief occurs; however, anyone can initiate the debrief.

(2) Who: Entire surgical team to include staff surgeon, resident, intern, staff anesthesia, circulating nurse, surgical technician, students, etc.

(3) When:

(a) The Surgical Brief occurs prior to the start of an invasive procedure (in the OR and other procedural areas), prior to opening instruments, and prior to the patient arriving.

(b) The Surgical Debrief occurs at the end of a case in the OR after final counts are confirmed and before any team member leaves the room; recommended timing is during skin closure.

(4) What: The RRC SCB Brief and Debrief specifically focuses on surgical cases done in the OR. Debrief verification requirements are in Reference (v). (Please note as an aside, the TeamSTEPPS® Brief and Debrief should be used in all clinical and non-clinical areas to share the plan and review team performance. Debriefs are particularly important following a patient safety event or a procedure in a procedural area).

f. Practice 6: UP

(1) Purpose: Provides standardized strategies to optimize patient safety and prevent wrong site surgery. These procedures are based on the major components of The Joint Commission (TJC) UP (Reference (s)): A pre-operative/pre-procedure verification process that includes a Pre-Anesthesia Pause, marking the operative/procedural site, and a time-out immediately before starting an invasive procedure.

(2) What: Implementation of these UP procedures is required for all operative and other invasive procedures that expose the patient to the risk of harm. They apply to invasive procedures, as defined by TJC, that occur in the following settings: ORs, procedural areas, inpatient settings, and outpatient settings. This guidance applies to all surgical procedures involving incisions, drilling, removal of implanted devices, or insertions that are invasive and require written informed consent (e.g., hernia surgery, vasectomy, bone marrow biopsy). For detailed guidance on UP strategies, refer to Reference (v).

(3) How:

(a) Pre-procedure verification process: The pre-procedure verification is an interdisciplinary collaborative process to ensure the correct patient receives the intended procedure at the intended site with all necessary equipment or supplies available. It is purposefully designed with multiple redundancies in place to decrease the risk of preventable harm events. Every member of the surgical team is expected to actively engage in this process. Minimum requirements are identified in Reference (v).

(b) Marking of the operative/procedural site: Site marking is done in the pre-procedural area to prevent errors of wrong site surgery. Minimum requirements are identified in Reference (v).

(c) Pre-Anesthesia Pause: The Pre-Anesthesia Pause serves as the official anesthesia UP procedural time-out and will take place before any invasive procedure requiring all types of anesthesia that are administered in the main OR setting. The Pre-Anesthesia Pause can be used as a time-out for a regional anesthetic that is being performed in the OR. More guidance can be found in Reference (v).

(d) Time-out: A time-out is required for all invasive procedures. Refer to Reference (x) and Glossary, Part II of this document, for TJC definition of invasive procedure. The time-out is a pause immediately before the outpatient invasive procedure or surgery that begins during which the team verbally agrees the correct patient, site, and invasive procedure are identified. In some cases, a procedure may require multiple time-outs (e.g., surgical procedures done under spinal anesthesia require two time-outs: one for anesthesia and the second for the actual surgical procedure). More guidance can be found in Reference (v).

(e) Special verifications: Guidance on special verifications can be found in Reference (v).

(f) Documentation: The DHA UP checklists must be used for all invasive medical and dental procedures, regardless of where they are performed. Invasive procedures conducted in the Main OR or Labor and Delivery must be documented on a physical or electronic version of DHA Form 228. Invasive procedures conducted in non-OR procedural areas must be documented on a physical or electronic version of DHA Form 229. Invasive procedures performed in a DTF must be documented on DHA Form 205. Documentation of pre-procedural

verifications, time-outs, surgical debriefs, and site marking will be recorded on the appropriate checklist or using the workflow in the EHR.

1. The completed DHA Form 228 or 229 checklist must be included in the patient's electronic medical record. If there is an outage or the EHR is not accessible, a physical version of these forms must be completed and scanned into the EHR.

2. For dental procedures, lack of a digital solution and the volume of dental procedures precludes uploading the completed DHA Form 205 checklists into the EHR. Until a fully digital UP workflow is developed, the completed DHA Form 205 will be appropriately disposed of. Compliance with the process will be assessed using Joint Commission tracer methodology. To document completion of the checklist in the EHR, providers will include one of the following statements in their dental clinical note:

a. "The dental team ([state names and roles)] completed extraoral and intraoral pre-procedure verification, utilized the [specific technique] to mark the procedure site and performed a time out at [time] prior to initiating [specific teeth AND/OR site AND procedure]. Re-verification was continuous throughout the procedure."

b. "The dental team [(state names and roles]) completed extraoral and intraoral pre-procedure verification, site marking was not accomplished due to [state reason; e.g., procedure involved the entire mouth] and performed a time out at [time] prior to initiating [specific teeth AND/OR site AND procedure].

ENCLOSURE 4

INFORMATION COLLECTION

1. MEASUREMENT AND REPORTING OVERVIEW

a. RRC means consistent excellence in quality and safety across all services maintained over long periods of time. As the DHA advances in maturity (from beginning, to developing, to advancing, to approaching) toward high reliability, leadership commits to achieve zero preventable harm, instills a culture of safety, and marries it to a continuous process improvement system. The result is a learning organization that learns and improves from its successes and failures and celebrates transparency and contributions from every individual regardless of their position.

b. Measuring and reporting of the RRC SCB Practices will be required on a quarterly basis, through the appropriate Defense Health Networks and MTFs RRC SCB Champions. Targeted performance improvement measures will focus on implementing, sustaining, and enhancing the Practices.

c. When implementing and evaluating the impact of the RRC SCB Practices, individual facilities may track changes in staff burnout levels and/or reducing workplace stressors. These assessments are currently optional and for local use; reporting of results is not required by this policy.

2. MEASUREMENT AND REPORTING PROCESS

a. When:

(1) MTFs will report quarterly, within 45-calendar days of the end of each quarter, through the appropriate Defense Health Networks and MTFs RRC SCB Champions.

(2) MTF measurement data will be reported at the child level, then aggregated to the Network-level for reporting, on a quarterly basis.

b. Who:

(1) The Director, MTF is responsible for ensuring reporting requirements are accurate and consistently monitored and maintained.

(2) MTFs may identify staff members to support data collection and reporting.

(3) Defense Health Network Patient Safety Managers will support the collection and reporting of the data for their facilities.

(4) Final quarterly reports will be signed and owned by one individual at the MTF, the RRC Champion or equivalent.

c. How: RRC SCB data will be reported through several channels:

(1) OR Debrief Issue Tracker: Records debrief for OR cases only.

(2) Tracers with Accreditation Manager Plus®: A software tool to help evaluate how safety practices are conducted across the enterprise, as well as a tool to collect data on safety practices.

(3) DHA Data Collection Site: Provides a template for Network and/or MTFs to use as they collect data necessary to measure the performance of the RRC SCB Practices; automatically totals the data for ease of reporting in SharePoint at the end of the quarter.

(4) Patient Safety Information Distribution (Closed-Loop Communication) Process: A closed-loop communication capability that ensures critical patient safety program communications are received by targeted audiences and that DHA receives acknowledgement and verification of follow up action when required. Recipients will be responsible for completing acknowledgement of message receipt, confirmation of completed required actions, and attestation to the distribution of the message in the Closed-Loop Communication Process.

d. What: A list of Targeted Performance Improvement Measures with detailed descriptions can be accessed through Reference (m).

3. SAFETY FORUMS. Safety Forums are held on a quarterly basis and are directly linked to the data submissions by the MTFs.

a. What: The Safety Forums provide an opportunity to review:

(1) Data collection participation,

(2) High-level measures overview by Safety Practice,

(3) Data collection by, MTF and the Defense Health Network level.

(4) MTF-specific implementation related to:

(a) Performance/Significant Events at the Facility,

(b) RRC-SCB Goals/Objectives,

(c) RRC-SCB Challenges/Issues, and

(d) Lessons learned.

b. Who:

(1) DHA Roles:

(a) DAD-MA: Host/Facilitator

(b) Deputy CMO: Hosts/facilitates if DAD-MA is unavailable

(c) Chief, Clinical Quality Management: Integrates Lessons Learned and leading practices within CQM Programs and relevant CQM-led initiatives.

(2) Target audience: Network CMOs, Network Chief Nursing Officers, Network Chief Dental Officers, Network RRC Champions, Network Patient Safety Professionals, MTF Director, MTF Chief Medical Officers, MTF Chief Nursing Officers, MTF Chief Dental Officers, MTF RRC Champions, and MTF Patient Safety Professionals.

(3) Leaders: The Network CMO leads Safety Forum presentation and discussion for their Network. If the Network CMO is unavailable to lead the discussion, the Chief Nursing Officer, or Chief Dental Officer, and or Network Patient Safety Lead will do so.

(4) Presentations: DAD-MA will direct format, frequency, and briefers.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AI	Administrative Instruction
CMO	Chief Medical Officer
CQM	Clinical Quality Management
DAD	Deputy Assistant Director
DHA	Defense Health Agency
EHR	Electronic Health Record
I-PASS	Illness Severity-Patient Summary-Action List-Situational Awareness and Contingency Planning-Synthesis by Receiver
LDSB	Leader Daily Safety Brief
MA	Medical Affairs
MTF	Military Medical Treatment Facility (inclusive of Dental Treatment Facilities)
OR	Operating Room
RRC	Ready Reliable Care
SBAR	Situation-Background-Assessment-Recommendation/Request
SCB	Safety Communication Bundle
SLR	Safety Leadership Rounds
TeamSTEPPS®	Team Strategies and Tools to Enhance Performance and Patient Safety
TJC	The Joint Commission
UBH	Unit-Based Huddle
UP	Universal Protocol

PART II. DEFINITIONS

Compliance. The ongoing process of meeting the legal, ethical, and professional standards applicable to a particular health care organization or provider; conformity in fulfilling official requirements.

Invasive Procedure. A procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or foreign material is inserted into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, biopsies and excisions, and all percutaneous procedures (for example, cardiac, electrophysiology, interventional radiology). Exclusions include venipuncture, which is defined as a collection of blood from a vein. Note: This exclusion is still considered a patient safety event and should be reviewed by the appropriate local quality and safety teams.

Licensed Staff Member. An MTF staff member with a professional health care license.

Operating Provider. As used in this DHA-AI, includes the individual performing the invasive procedure, regardless of the setting. Examples of operating providers include, but are not limited to, internists, pediatricians, anesthesiologists, nurse anesthetists, surgeons, dentists, pulmonologists, radiologists, advanced practice nurses, and physician assistants.

Procedural Area. An OR, cardiac catheterization or interventional suite, radiation or nuclear medicine area, treatment or procedure room, patient room, emergency room, clinic room, or any other location where surgical or invasive procedures occur.

Process. A goal-directed, interrelated series of actions, events, mechanisms, or steps. Processes should always be designed with flexibility in mind and the ability to periodically introduce controlled, measurable changes.

Ready Reliable Care. The DHA approach to increasing high reliability across the DHA.

Ready Reliable Care Safety Communication Bundle. Addresses patient safety; a set of six Practices designed to improve leadership engagement, teamwork with a goal of zero patient harm.

Verification. A process that involves checking for consistency among patient identification, information contained on the procedural consent form, any diagnostic study reports, the pre-operative checklist, and the marked anatomical site; all confirmed with the response of the patient or legally authorized representative.