



## VA National Center for Patient Safety Topics in Patient Safety®

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## The Daily Plan®: How Things Have Changed

Wendy Morrish, MSN, R.N., CNL, The Daily Plan® lead, VA National Center for Patient Safety



There have been many changes to The Daily Plan® (TDP) since it was initially developed in 2007; yet, TDP continues to enhance patient safety by engaging the patient and/or their family in the health care and decision-making process.

### Introduction

TDP is an extracted health summary report that is printed and given to the patient and/or their family member(s) during a hospital stay or at the time of a scheduled outpatient appointment. It is intended to enhance safety and communication by helping the patient to:

**KNOW** what to expect on that particular day of care. TDP can include such items as medications, diet, allergies, x-rays and more.

**ASK** questions if something on TDP appears unexpected or unplanned.

**PARTICIPATE** by promoting patient and family involvement. This helps us to consistently do the right thing, at the right time, for the right person.

### Goals of TDP

1. Provide patients and families with a document delineating what to expect during that day for their inpatient or outpatient visit.
2. Enhance patient safety by encouraging the patient to ask questions about their health care, especially if something seems different than planned.
3. Draw upon information already in the electronic medical record, making the process more efficient.
4. Strengthen the communication process between patient, family

and those involved in his/her health care.

### What has changed?

Originally intended for use by nurse and patient in the medical-surgical area, use has expanded to acute mental health, intensive care, emergency department, community living center and primary care.

TDP was piloted by five sites and is now used in 37 Veterans Health Administration (VHA) facilities on 91 units; another 22 VHA facilities are in various stages of implementation.

TDP maintains the strong nurse and patient relationship. We encourage use of TDP by providers, dietitians, clinical pharmacists and other members of the health care team.

All products associated with TDP have been recently revised and are 508 compliant.

Of note, TDP continues to represent *current* patient activity and is *not* a full list of everything that takes place during the patient's inpatient or outpatient visit.

### Articles of interest

Two articles have been published about TDP:

King, B., Young-Xu, Y., Lee, W., Van Aalst, R., Shiner, B., Mills, P., Eickhoff, L., Neily, J., (2017). [Impact of The Daily Plan on length of stay and readmission](#). *Journal of Nursing Quality*. 00(00), 1-5. DOI: 10.1097/NCQ.0000000000000271

King, B., Mills, P., Fore, A., Mitchell, C., (2012). [The Daily Plan: Including patient's for safety's sake](#). *Nursing Management*. 43(3), 15-18. DOI-10.1097/01.NUMA.0000412229.53136.3e

### To learn more

Please visit the NCPS SharePoint site (<https://vaww.cmopnational.va.gov/CR/ncpsoit/TDP/default.aspx>) for more information about TDP. You will find recently revised booklets, brochures and instruction for patients and staff. There are also articles, poster presentations, podcasts and an array of PowerPoints from TDP national monthly calls.

TDP national monthly calls occur on the fourth Tuesday of the month at 2 p.m. EST.

For questions or more information, please contact [Wendy.Morrish@va.gov](mailto:Wendy.Morrish@va.gov).

## Simulation Training Impacts Veteran Care at Truman VA

Megan M. Dercher, R.N., high reliability specialist, Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri

In January 2015, the Harry S. Truman Memorial Veterans' Hospital (Truman VA) partnered with the VA National Center for Patient Safety (NCPS) to participate in the Hospital of the Future project. One of our many goals is to provide Clinical Team Training (CTT) to 80 percent of our clinical staff. CTT takes the fundamental concepts used in high-reliability industries and applies them to health care. CTT focuses on teamwork, standard operating procedures and being preoccupied with failure.

For personnel to become proficient with the tools provided in CTT, it is necessary to practice in life-like situations. This is where simulation training comes into play. Simulation exercises provide a controlled, safe environment for employees to practice. During recurrent training sessions, employees get hands on experience with CTT tools and

witness the benefits that come from appropriate utilization.

Over the past 18 months, CTT has proven to be useful in many aspects at our facility. The program introduces tools within the framework of the [effective followership algorithm](#), which allows all employees to speak a common language, helping to break down communication barriers and improve patient care. Our employees are working together to meet common goals, consistently seeking opportunities for improvement and striving to provide safe, excellent care to our Veterans. To date, more than 550 employees have attended CTT.

To sustain the program, we have identified CTT master trainers across Truman VA to facilitate CTT (initial and recurrent sessions). Our master trainer team is made up of a wide variety of staff with clinical and

## CLINICAL TEAM TRAINING

*Building High Reliability in Patient Care*

non-clinical backgrounds: respiratory therapists, nurses, managers, physicians and administrative staff members. Each trainer has attended multiple CTT classes and has met various requirements to facilitate CTT.

One such requirement was to take a deep dive into the world of simulation, thus "Sim Boot Camp" was initiated at Truman VA in January 2016. During this two-day training, master trainers were coached on everything from the importance of simulation to the "[sic] how to's" of creating and facilitating scenarios.

At the end of the boot camp, each master trainer had a working scenario – centered on real-life situations, that has presented numerous learning opportunities. In fact, one scenario stemmed directly from a Root Cause Analysis (RCA) conducted at Truman VA. By replaying the RCA scenario during simulation training,



the lessons learned will be spread widely, leading to a lower frequency of similar occurrences in the future.

Additionally, all the scenarios created during Sim Boot Camp are compiled into an electronic simulation library that will be readily available for any master trainer to use in future simulation-based training. The skills learned in Sim Boot Camp will also allow master trainers to adapt scenarios to various departments and patient care acuity levels.

Sim Boot Camp participants have discovered opportunities for improvement in several of our current clinical processes. By walking through real life scenarios, recreated by way of simulation in a controlled environment, our team identified weak points in certain practices. We have found opportunities to improve upon them, preventing potentially adverse events from recurring. For example, while the team was walking through an acute care scenario, it was noted that debriefs were not occurring after code blue events. By simply bringing this discovery to key players, a systems redesign team took it upon themselves to complete a green belt project targeting post-code debriefs, connecting the dots between CTT and systems redesign.

Truman VA looks forward to continuing the simulation program and welcomes the many benefits it brings to staff members and to the care of Veterans. Because CTT has been widespread at Truman VA, a new common language has been adopted. Now, no matter where individuals venture in the facility, when they hear the phrases “What I see ... What I’m concerned about ... What I want ...” a red flag goes up. People stop, listen and act. Patients’ needs are being met more efficiently every day. Huddles are taking place all over the facility and issues are being elevated in a timely manner by confident employees. Daily briefings have helped workgroups come together, striving

to meet common goals. Debriefs have served to help identify and address opportunities for improvement.

Additionally, playing fields have been leveled to some degree by utilizing the effective followership algorithm, helping to harbor strong

working relationships among employees. Bridges are being built between physicians and nurses, front-line staff and administration. Silos are breaking down between services. Transparency is on the rise. The pulse at Truman VA is changing!

## NCPS Chief Risk Officer Receives National Ethics Award

David Sine, DrBE, M.A., CSP, ARM, CPHRM, is the recipient of the 2017 William A. Nelson Award for Excellence in Health Care Ethics from the [VA National Center for Ethics in Health Care](#).

Since 2008, Dr. Sine has served as chief risk officer in the Office of Quality, Safety and Value at the [VA National Center for Patient Safety](#) in Ann Arbor, Michigan. He is recognized nationally as a consultant, scholar and leader in patient safety and quality.

[The Nelson Award](#) honors the career-long legacy of William A. Nelson, Ph.D., former chief of the Ethics Education Service in the National Center for Ethics in Health Care, who retired after 30 years of service to VHA in November 2003.

Each year, the award recognizes an individual who has demonstrated a long-term commitment to promoting ethical health care practice in VHA, through excellence, dedication and accomplishment in the field of health care ethics (including clinical, organizational and research ethics).



## NCPS Acting Director Receives National Simulation Award



VA National Center for Patient Safety Acting Director Douglas E. Paull, M.D., M.S., FACS, FCCP, CHSE, is one of five VHA leaders who have been singled out for their expertise in leadership and mentoring in the field of clinical simulation training to earn the 2016 VA Under Secretary for Health's Award for Excellence in Clinical Simulation Training, Education and Research. This award program recognizes VHA clinical and executive leaders who have supported and advanced VHA's strategic plan for simulation.

The annual awards were established as a means of promoting and advancing system-wide progress of VHA goals, objectives and strategies for the deployment of clinical simulation to improve the quality of health care that Veterans receive.

“Since the inception of the USH Simulation Awards in 2010, we have identified and recognized VHA staff members who are national and international leaders in health care simulation,” said Dr. Haru Okuda, [SimLEARN](#) national medical director. “The quality of the recipients from this year continues to ensure VA maintains its innovativeness and advantage in progressing simulation-based health care training for the clinical providers in order to improve Veteran care and contribute to the field of health care simulation.”

## The Joint Commission Releases Environment of Care Recommendations With NCPS Input

Derek D. Atkinson, public affairs officer, VA National Center for Patient Safety

Twenty Veterans die by suicide each and every day. The risk for suicide amongst Veterans is 21 percent higher than those who have not served. The Department of Veterans Affairs' top clinical priority is getting to zero Veteran deaths by suicide. VA has taken significant steps to build the necessary infrastructure to accomplish this mission.

Recent changes to interpretations of The Centers for Medicare & Medicaid Services (CMS) and The Joint Commission standards regarding anti-ligature requirements in behavioral health occupancies are an important issue regarding patient safety and suicide prevention.

This summer, The Joint Commission convened an expert panel which included world-renowned experts in suicide prevention and the design of behavioral health facilities. The panel, which included VA National Center for Patient Safety (NCPS) staff, contributed significantly to The Joint Commission's recently published [Special Report on Suicide Prevention in Health Care Settings](#). The report suggests 13 recommendations

to create a safer environment for individuals on inpatient behavioral health units, many of which the VA has already championed through the Mental Health Environment of Care Checklist (MHEOCC).

"The balance between providing a healing environment and the required safety precautions on inpatient behavioral health units is a delicate one," said Dr. Douglas E. Paull, acting director of the VA National Center for Patient Safety. "VA is a national leader in this area and we applaud The Joint Commission for their shared interest in suicide prevention."

The MHEOCC is a mandatory, semi annual tool used to evaluate the safety of the environment of care in VA inpatient behavioral health units. Since its implementation in 2007, there has been an 82 percent decrease in completed suicides on VA inpatient behavioral health units – from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions. If hazards are found, NCPS ensures that abatement plans are created, monitored and shared throughout the VA enterprise.



The Patient Safety Huddle presented by the VA National Center for Patient Safety features discussions about patient safety topics from around the country.

The Podcast is available for download at: <https://www.patientsafety.va.gov/podcasts.asp>

To subscribe to The Patient Safety Huddle Podcast RSS feed: <https://www.patientsafety.va.gov/rss/podcasts.xml>

The Patient Safety Huddle Podcast is also available on iTunes: <https://itunes.apple.com/us/podcast/the-patient-safety-huddle-podcast/id1250098105>

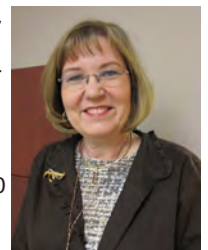


## Putting a Face to a Name: Your Patient Safety Team

**Mary Kathleen Wilcox, MSN, RN, CPPS**  
Patient Safety Manager

VA Health Care System of the Ozarks

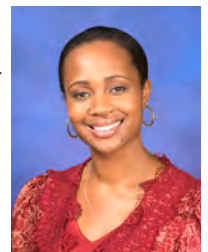
13 years with VA and 10 years in patient safety



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**SAVE THE DATE** #WEAREALLPATIENTS

2018

PATIENT SAFETY  
AWARENESS WEEK

March 11-17