BY ORDER OF THE COMMANDER
73D MEDICAL WING

73 MDW OPERATING INSTRUCTION 44-102

15 JANUARY 2026

Medical Operations

PATIENT SAFETY AND CLINICAL QUALITY MANAGEMENT

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This Operating Instruction implements Department of the Air Force Instruction (DAFI) 44-119, Medical Quality Operations, and establishes procedures for the 73d Medical Wing Patient Safety and Clinical Quality Management Program. This instruction applies to all personnel assigned, attached, or under contract to the 73d Medical Wing and its subordinate units. Ensure all records generated as a result of processes prescribed in this publication adhere to Air Force Instruction 33-322, Records Management and Information Governance Program. Refer recommended changes and questions about this publication to the Office of Primary Responsibility using DAF Form 847, Recommendation for Change of Publication.

SUMMARY OF CHANGES

This revision incorporates significant updates to patient safety event reporting timelines (reduced from 72 hours to 24 hours for serious events), adds new requirements for Artificial Intelligence assisted diagnostic tool validation, updates medication reconciliation procedures, and adds

CHAPTER 5 ADDRESSING CYBERSECURITY REQUIREMENTS FOR MEDICAL DEVICES. ALL PERSONNEL MUST REVIEW

this document in its entirety.

CHAPTER 1

PROGRAM OVERVIEW

1.1. Purpose. This instruction establishes the framework for patient safety and clinical quality management within the 73d Medical Wing. It defines roles, responsibilities, and procedures for identifying, reporting, analyzing, and mitigating risks to patient safety.

1.2. Scope. This instruction applies to:

1.2.1. All clinical and administrative personnel assigned to 73 MDW facilities.

1.2.2. Contract healthcare providers and support staff.

1.2.3. Students, residents, and fellows training within 73 MDW facilities.

1.2.4. Volunteers working in patient care areas.

1.3. Program Goals.

1.3.1. Maintain a culture of safety where all personnel feel empowered to report concerns.

1.3.2. Achieve zero preventable patient harm.

1.3.3. Meet or exceed all Defense Health Agency (DHA) quality metrics.

1.3.4. Continuously improve clinical processes through data-driven decision making.

1.4. Governing Directives.

1.4.1. DAFI 44-119, Medical Quality Operations

1.4.2. DHA Procedural Instruction 6025.13, Clinical Quality Management

1.4.3. The Joint Commission Hospital Accreditation Standards

1.4.4. DoD 6025.18-R, DoD Health Information Privacy Regulation

CHAPTER 2

ROLES AND RESPONSIBILITIES

2.1. 73d Medical Wing Commander (73 MDW/CC).

2.1.1. Has overall responsibility for the Patient Safety and Clinical Quality Program.

2.1.2. Chairs the Executive Committee of the Medical Staff (ECOMS) quarterly.

2.1.3. Approves all quality improvement strategic plans and major policy changes.

2.1.4. Reviews serious patient safety events within 48 hours of notification.

2.2. Chief Medical Officer (73 MDW/SGP).

2.2.1. Serves as the senior clinical advisor on all quality matters.

2.2.2. Oversees credentialing and privileging processes.

2.2.3. Leads peer review activities for physician and advanced practice provider cases.

2.2.4. Reports quality metrics to the Wing Commander monthly.

2.3. Chief Nursing Officer (73 MDW/SGN).

2.3.1. Oversees nursing quality indicators and practice standards.

2.3.2. Leads nursing peer review activities.

2.3.3. Ensures compliance with nursing-sensitive quality measures.

2.3.4. Coordinates patient experience improvement initiatives.

2.4. Quality Management Division (73 MDW/SGQ).

2.4.1. Administers the day-to-day operations of the quality program.

2.4.2. Manages the patient safety event reporting system.

2.4.3. Conducts root cause analyses and failure mode effects analyses.

2.4.4. Prepares quality reports for leadership and external agencies.

2.4.5. Coordinates accreditation readiness activities.

2.4.6. Maintains the Quality Management SharePoint site with current policies.

2.5. Patient Safety Manager (73 MDW/SGQ).

2.5.1. Serves as the primary point of contact for patient safety concerns.

2.5.2. Reviews all patient safety event reports within 24 hours of submission.

2.5.3. Classifies events using the DHA Patient Safety Event Taxonomy.

2.5.4. Coordinates immediate response to serious safety events.

2.5.5. Provides patient safety education and training to all personnel.

2.6. Unit Quality Representatives.

2.6.1. Each squadron and clinic will designate a primary and alternate Quality Representative.

2.6.2. Quality Representatives will:

2.6.2.1. Attend monthly Quality Representative meetings.

2.6.2.2. Disseminate quality information to unit personnel.

2.6.2.3. Assist with data collection for quality metrics.

2.6.2.4. Promote a culture of safety within their unit.

2.6.2.5. Serve as the first point of contact for quality concerns in their area.

2.7. All Personnel.

2.7.1. Are responsible for providing safe, high-quality patient care.

2.7.2. Must report patient safety events within 24 hours of discovery.

2.7.3. Must complete annual patient safety training requirements.

2.7.4. Must participate in quality improvement activities as directed.

CHAPTER 3

PATIENT SAFETY EVENT REPORTING

3.1. Reporting Philosophy. The 73d Medical Wing maintains a non-punitive reporting culture. The goal of event reporting is system improvement, not individual punishment. Personnel who report events in good faith are protected from retaliation.

3.2. What to Report. The following events must be reported:

3.2.1. Patient Safety Events. Any event, incident, or condition that could have resulted or did result in harm to a patient. This includes:

3.2.1.1. Adverse events (harm reached the patient)

3.2.1.2. No-harm events (reached patient but no harm occurred)

3.2.1.3. Near misses (caught before reaching patient)

3.2.1.4. Unsafe conditions (hazards identified before an event occurs)

3.2.2. Medication Events. Including but not limited to:

3.2.2.1. Wrong medication administered

3.2.2.2. Wrong dose administered

3.2.2.3. Wrong route administered

3.2.2.4. Wrong patient

3.2.2.5. Omitted medication (when clinically significant)

3.2.2.6. Adverse drug reactions

3.2.3. Falls. All patient falls, regardless of injury.

3.2.4. Surgical/Procedural Events.

3.2.4.1. Wrong site, wrong procedure, wrong patient events

3.2.4.2. Retained surgical items

3.2.4.3. Unplanned return to operating room

3.2.4.4. Surgical site infections

3.2.5. Healthcare-Associated Infections. As defined by CDC/NHSN criteria.

3.2.6. Diagnostic Events.

3.2.6.1. Delayed diagnosis

3.2.6.2. Missed diagnosis

3.2.6.3. Wrong diagnosis

3.2.6.4. Laboratory or imaging errors

3.2.7. Equipment/Device Events.

3.2.7.1. Device malfunction affecting patient care

3.2.7.2. Equipment-related injuries

3.2.7.3. CYBERSECURITY INCIDENTS AFFECTING MEDICAL DEVICES (SEE CHAPTER 5)

3.3. Reporting Timelines.

3.3.1. Serious Events. Events resulting in death, permanent harm, severe temporary harm, or intervention required to sustain life must be reported within 24 hours of discovery. (Changed from 72 hours per this revision)

3.3.2. Moderate Events. Events resulting in temporary harm requiring intervention must be reported within 48 hours of discovery.

3.3.3. Minor Events and Near Misses. Must be reported within 72 hours of discovery.

3.3.4. Unsafe Conditions. Should be reported as soon as practical but no later than 7 days after identification.

3.4. How to Report.

3.4.1. Electronic Reporting. The preferred method is through the Patient Safety Reporting System (PSRS) accessible via the 73 MDW SharePoint or directly at https://psrs.health.mil.

3.4.2. Telephone Reporting. For urgent events, call the Patient Safety Hotline at DSN 554-SAFE (7233) or commercial (210) 292-SAFE (7233). Available 24/7.

3.4.3. Anonymous Reporting. Anonymous reports may be submitted through PSRS or via the Patient Safety drop boxes located in each clinic waiting area.

3.5. Event Classification. The Patient Safety Manager will classify events using the following severity categories:

3.5.1. Category A: Circumstances with capacity to cause error (unsafe condition)

3.5.2. Category B: Error occurred but did not reach patient

3.5.3. Category C: Error reached patient, no harm

3.5.4. Category D: Error reached patient, monitoring or intervention to confirm no harm

3.5.5. Category E: Temporary harm requiring intervention

3.5.6. Category F: Temporary harm requiring initial or prolonged hospitalization

3.5.7. Category G: Permanent patient harm

3.5.8. Category H: Intervention required to sustain life

3.5.9. Category I: Patient death

3.6. Immediate Response to Serious Events.

3.6.1. Upon notification of a serious event (Categories F-I), the Patient Safety Manager will:

3.6.1.1. Notify the Wing Commander and Chief Medical Officer within 2 hours.

3.6.1.2. Activate the Serious Event Response Team if warranted.

3.6.1.3. Ensure the patient and family are informed per disclosure policy.

3.6.1.4. Preserve relevant medical devices and equipment.

3.6.1.5. Secure relevant medical records.

3.6.1.6. Report to DHA Patient Safety within 24 hours via the Joint Patient Safety Reporting System (JPSRS).

3.7. Root Cause Analysis (RCA).

3.7.1. An RCA will be conducted for all Category E-I events within 45 days.

3.7.2. The RCA team will include subject matter experts, frontline staff involved in the event, and quality management personnel.

3.7.3. The RCA will identify system factors contributing to the event and develop corrective actions.

3.7.4. The Wing Commander will approve all RCA reports and corrective action plans.

CHAPTER 4

CLINICAL QUALITY MEASURES

4.1. Quality Metrics Program. The 73d Medical Wing monitors quality metrics across multiple domains to ensure consistent, high-quality patient care.

4.2. Core Metrics. The following metrics are reported monthly:

4.2.1. Patient Safety Indicators.

4.2.1.1. Patient Safety Event reporting rate (target: ≥15 reports per 1,000 patient days)

4.2.1.2. Serious Safety Event rate (target: zero)

4.2.1.3. Falls with injury rate (target: <0.5 per 1,000 patient days)

4.2.1.4. Hospital-acquired pressure injury rate (target: <2.5%)

4.2.2. Clinical Effectiveness Indicators.

4.2.2.1. Surgical site infection rate

4.2.2.2. Central line-associated bloodstream infection rate

4.2.2.3. Catheter-associated urinary tract infection rate

4.2.2.4. 30-day readmission rate

4.2.2.5. Mortality rate (observed vs expected)

4.2.3. Access Indicators.

4.2.3.1. Primary care appointment availability within 7 days

4.2.3.2. Specialty care appointment availability within 28 days

4.2.3.3. Emergency Department wait time to provider

4.2.3.4. Urgent care same-day access rate

4.2.4. Patient Experience Indicators.

4.2.4.1. Overall satisfaction score (JC CAHPS)

4.2.4.2. Provider communication score

4.2.4.3. Care coordination score

4.2.4.4. Likelihood to recommend

4.3. Metric Review and Action.

4.3.1. Quality metrics are reviewed monthly at the Quality Council meeting.

4.3.2. Metrics falling below threshold for two consecutive months require a Performance Improvement Plan within 30 days.

4.3.3. Sustained performance below threshold for 90 days may result in focused review by the ECOMS.

4.4. Peer Review.

4.4.1. Peer review is conducted to evaluate the quality of clinical care provided by individual practitioners.

4.4.2. Cases are selected for peer review based on:

4.4.2.1. Random sampling (minimum 5% of cases per provider per quarter)

4.4.2.2. Triggered review criteria (e.g., unplanned return to OR, mortality)

4.4.2.3. Referral from risk management or patient complaints

4.4.3. Peer review findings are protected under 10 U.S.C. § 1102 and are not discoverable.

4.5. Artificial Intelligence and Clinical Decision Support.

4.5.1. AI-assisted diagnostic tools require validation before clinical use.

4.5.2. All AI tools must be approved by the Medical Executive Committee.

4.5.3. Clinicians retain ultimate responsibility for clinical decisions; AI tools are advisory.

4.5.4. AI tool performance must be monitored quarterly with results reported to Quality Council.

4.5.5. Any AI-related patient safety event must be reported through PSRS with specific notation of the AI tool involved.

CHAPTER 5

MEDICAL DEVICE CYBERSECURITY (NEW)

5.1. PURPOSE. THIS CHAPTER ESTABLISHES REQUIREMENTS FOR CYBERSECURITY MANAGEMENT OF NETWORK-

connected medical devices to protect patient safety and data integrity.

5.2. APPLICABILITY. THIS CHAPTER APPLIES TO ALL MEDICAL DEVICES THAT:

5.2.1. Connect to the 73 MDW network infrastructure

5.2.2. Transmit or store protected health information (PHI)

5.2.3. Have wireless connectivity capabilities

5.2.4. Interface with electronic health records

5.3. Medical Device Inventory.

5.3.1. Biomedical Engineering will maintain a comprehensive inventory of all network-connected medical devices.

5.3.2. The inventory will include device type, manufacturer, model, software version, network address, and physical location.

5.3.3. The inventory will be updated within 5 business days of device acquisition, relocation, or disposal.

5.4. Security Requirements.

5.4.1. All medical devices must undergo security assessment prior to network connection.

5.4.2. Default passwords must be changed before clinical use.

5.4.3. Security patches must be applied within 30 days of release unless clinical impact assessment requires delay.

5.4.4. Devices unable to receive patches must be network-isolated or removed from service.

5.5. Incident Reporting.

5.5.1. Suspected cybersecurity incidents involving medical devices must be reported immediately to:

5.5.1.1. Biomedical Engineering: DSN 554-2636

5.5.1.2. Communications Squadron Cybersecurity: DSN 554-CYBER (2923)

5.5.1.3. Patient Safety (if patient impact): DSN 554-SAFE (7233)

5.5.2. Do not attempt to power cycle, disconnect, or troubleshoot the device without guidance from Biomedical Engineering.

5.5.3. Document device identifiers, time of incident, and any observed abnormal behavior.

5.6. Training Requirements.

5.6.1. All personnel using network-connected medical devices must complete annual cybersecurity awareness training specific to medical devices.

5.6.2. Training records are maintained by the Education and Training office.

CHAPTER 6

MEDICATION SAFETY

6.1. Medication Reconciliation.

6.1.1. Medication reconciliation must be completed at every care transition:

6.1.1.1. Admission to inpatient care

6.1.1.2. Transfer between units or levels of care

6.1.1.3. Discharge from inpatient care

6.1.1.4. Outpatient visits where medication changes occur

6.1.2. Reconciliation must compare current medications against the medication administration record within 24 hours of admission. (Changed from 48 hours per this revision)

6.1.3. Discrepancies must be resolved with the prescribing provider before administration.

6.2. High-Alert Medications.

6.2.1. The following medication classes require independent double-verification:

6.2.1.1. Anticoagulants (heparin, warfarin, direct oral anticoagulants)

6.2.1.2. Insulin

6.2.1.3. Opioids (IV and PCA)

6.2.1.4. Neuromuscular blocking agents

6.2.1.5. Chemotherapy

6.2.1.6. Concentrated electrolytes (potassium chloride, hypertonic saline)

6.2.2. Both verifying parties must document verification in the medication administration record before administration.

6.3. Look-Alike, Sound-Alike (LASA) Medications.

6.3.1. LASA medications are identified using tall-man lettering in all ordering systems.

6.3.2. LASA pairs are stored separately in medication storage areas.

6.3.3. The current LASA list is maintained on the Pharmacy SharePoint site.

6.4. Controlled Substance Management.

6.4.1. Controlled substances are managed per AFI 44-102, Medical Care Management.

6.4.2. Discrepancies in controlled substance counts must be reported to Pharmacy and the Patient Safety Manager within 2 hours of discovery.

CHAPTER 7

TRAINING REQUIREMENTS

7.1. Annual Training. All personnel must complete the following training annually:

7.1.1. Patient Safety Fundamentals (2 hours)

7.1.2. Medical Device Cybersecurity Awareness (1 hour) (New requirement)

7.1.3. Infection Prevention and Control (1 hour)

7.1.4. Emergency Response and Code Team Training (for clinical staff)

7.2. New Personnel Training. Within 30 days of arrival:

7.2.1. Unit-specific patient safety orientation

7.2.2. Electronic health record safety features training

7.2.3. Patient Safety Event Reporting System training

7.3. Just Culture Training. All supervisors and quality personnel must complete Just Culture training within 90 days of appointment to a supervisory position.

7.4. Training Documentation. All training is documented in the Learning Management System. Unit Quality Representatives will monitor compliance and report monthly.

CHAPTER 8

ACCREDITATION AND REGULATORY COMPLIANCE

8.1. The Joint Commission Accreditation.

8.1.1. The 73d Medical Wing maintains accreditation through The Joint Commission.

8.1.2. Quality Management coordinates continuous survey readiness activities.

8.1.3. All personnel must be prepared to discuss their role in patient safety during surveys.

8.2. Regulatory Reporting.

8.2.1. Quality Management reports to external agencies as required:

8.2.1.1. DHA Patient Safety (JPSRS) - serious events within 24 hours

8.2.1.2. FDA MedWatch - device and medication adverse events

8.2.2.3. CDC NHSN - healthcare-associated infections monthly

8.2.2.4. State health department - as required by Texas law

8.3. Document Control. This instruction will be reviewed annually and updated as needed. The next scheduled review is January 2027.

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Attachment 1: Glossary of Terms

Attachment 2: Patient Safety Event Report Form

Attachment 3: Root Cause Analysis Template

Attachment 4: Quality Representative Checklist