

# *Dental Patient Safety Toolkit Overview*

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# Review of Dental PS Toolkit

## DENTAC PSO Initial Orientation/ Education

- What you need to do in order to have a robust PS program

## DENTAC Staff Learning & Education

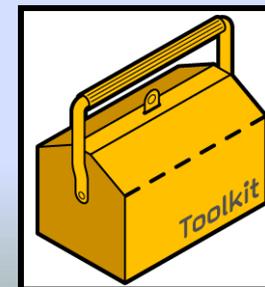
- How /what is needed to engage and educate the staff

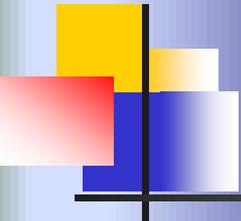
## DENTAC Senior Leadership

- Engaging and promoting leadership on Patient Safety

## Articles

- Selections of Several Articles to review





# Vision and Mission Statements

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## **VISION**

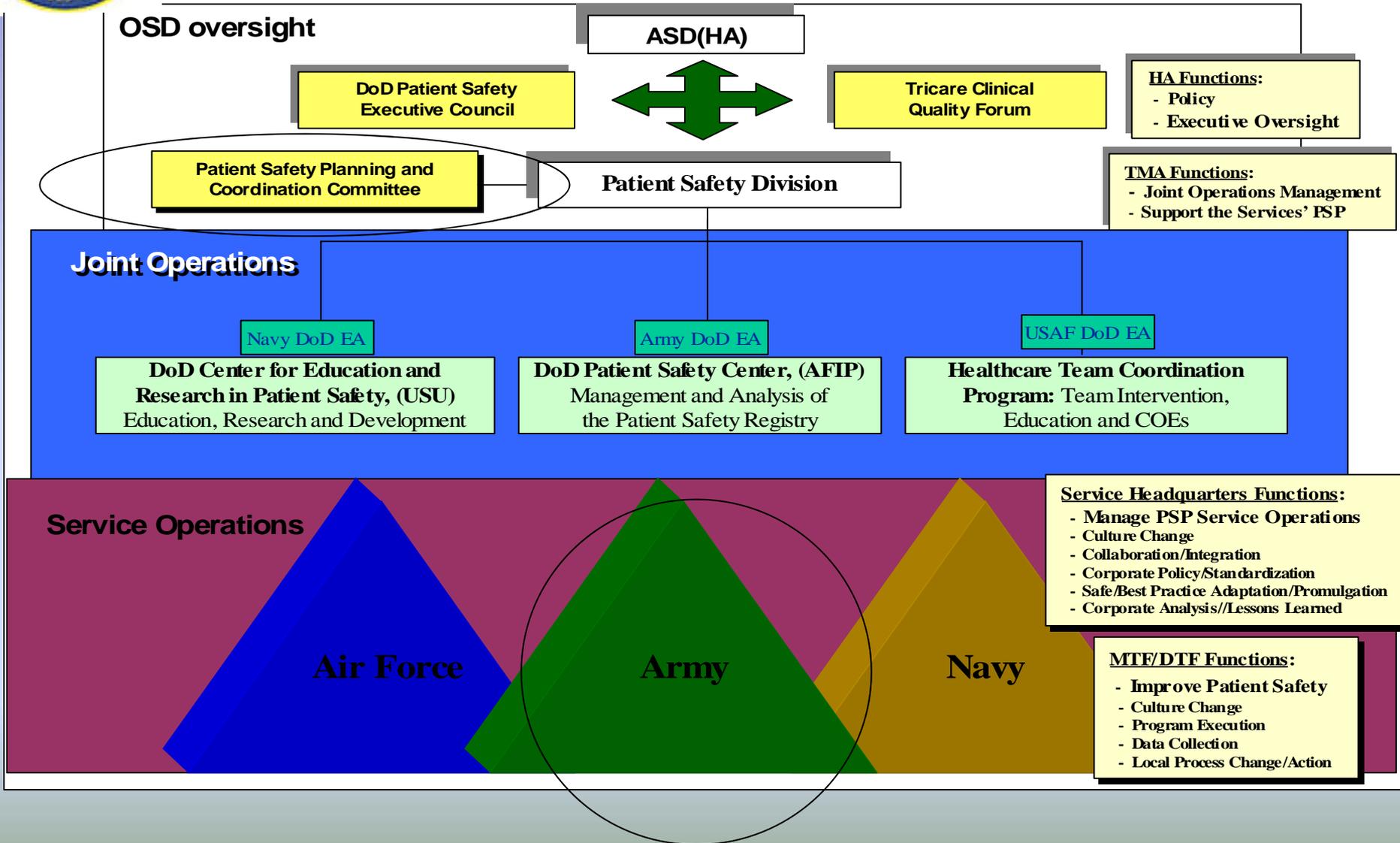
**An integrated, responsive and proactive healthcare system demonstrating the critical attributes of a patient safety culture**

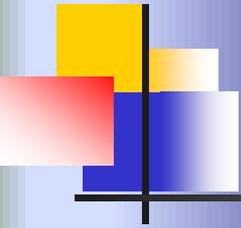
## **MISSION**

**Establish an environment of trust, transparency, teamwork, and communication to facilitate an interdisciplinary proactive approach to improving safety and preventing dental/medical errors**



# Organization Chart of the DoD PSP





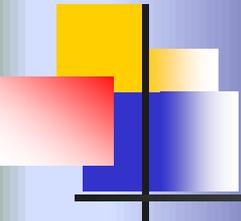
# What is Patient Safety?

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- **Actions undertaken by Providers and staff to protect patients from being harmed by the effects of health care services**
- **Preventing Harm**
- **Doing the right thing, at the right time for the right reason, using the right equipment**

***PATIENT CENTERED***

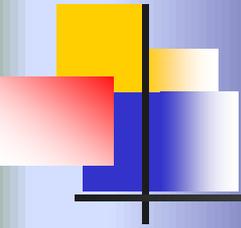
***PATIENT INVOLVED***



# Why Patient Safety?

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- **Right Thing to Do!**
  - Saves lives, saves money
- ***Response to the “Deadly Secret”***
  - IOM Report - To Err is Human**
    - 44,000-98,000 deaths due to medical error
    - National Cost: \$17-29 Billion/year
    - 10-35% suffer from preventable adverse drug events cost hospitals \$2 Billion/year
- **Federal Mandate & Regulatory Requirement**
  - Presidential Directive, NDAA, DoD
  - Mandated from DENCOM to report
  - JC requirements for MTFs

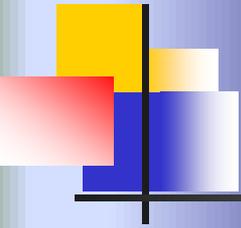


# Dental Claims within DoD

## 1985-2005

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- **775 Closed Claims with 43.3% paid out**
- **Total Payments Amount: \$ *11,595,330***
  - **Average settlement: \$34,510**
  - **Median: \$15,000**
  - **Largest Payout: \$1,000,000**

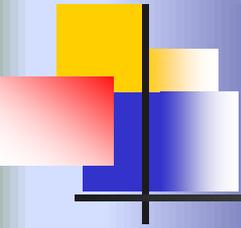


# AMEDD

## Patient Safety Program Goals

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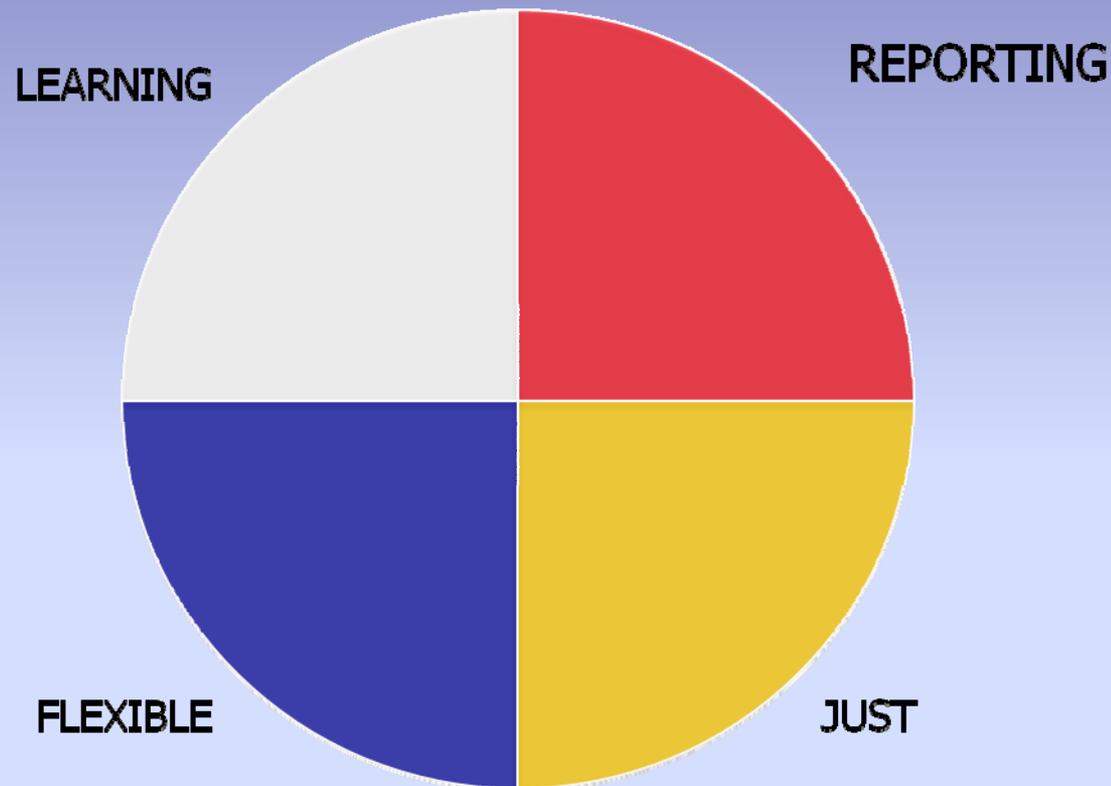
- **Create non-punitive culture where potential and actual errors are identified and processes put in place to promote patient safety**
- **Reduce risk of treatment-related injury to patients**
- **Remove or minimize hazards which increase risk of healthcare associated injury to patients**

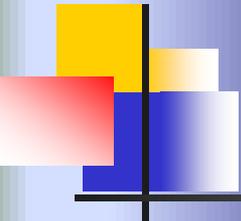


# Dental Patient Safety Mandates

| <b>MANDATE</b>  | <b>STATUS</b>   |
|---|---|
| <b>Create <u>Culture</u> to promote Patient Safety Initiatives</b><br>(National Defense Authorization Act 2001) | <b>Promote a “Just Culture” throughout DENCOTM</b>          |
| <b>Implement Patient Safety <u>Reporting</u> System</b>   | <b>Enter data into Dental Monthly Summary Report (DMSR)</b> |
| <b>Provide <u>Training</u> to encourage and promote safe, effective communication among team members</b>        | <b>Implement and utilize TeamSTEPPS</b>                     |
| <b>Integrate <u>Patient Safety</u> into all aspects of <u>Quality Management</u> and Patient Care</b>           | <b>Educate through SAV’s and at AMEDDC&amp;S</b>            |

# Characteristics of an Effective Culture of Safety





# Characteristics of an Effective Culture of Safety

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- ***Reporting* Culture**

- Individuals report their errors/near-misses

- ***Just* Culture**

- Individuals encouraged/rewarded for providing essential information
- Also know difference between acceptable and unacceptable behavior

- ***Flexible* Culture**

- Control is situational, not only hierarchical

- ***Learning* Culture**

- Organization able to self-analyze and make changes as needed

# Foundation of a Culture of Safety Reporting

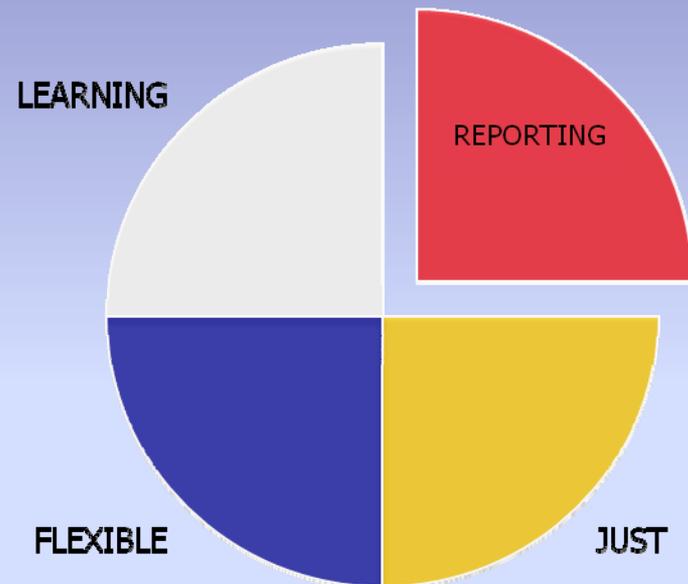
- Any *accurate* safety information system depends critically on:

- Willing participation of the workforce to report

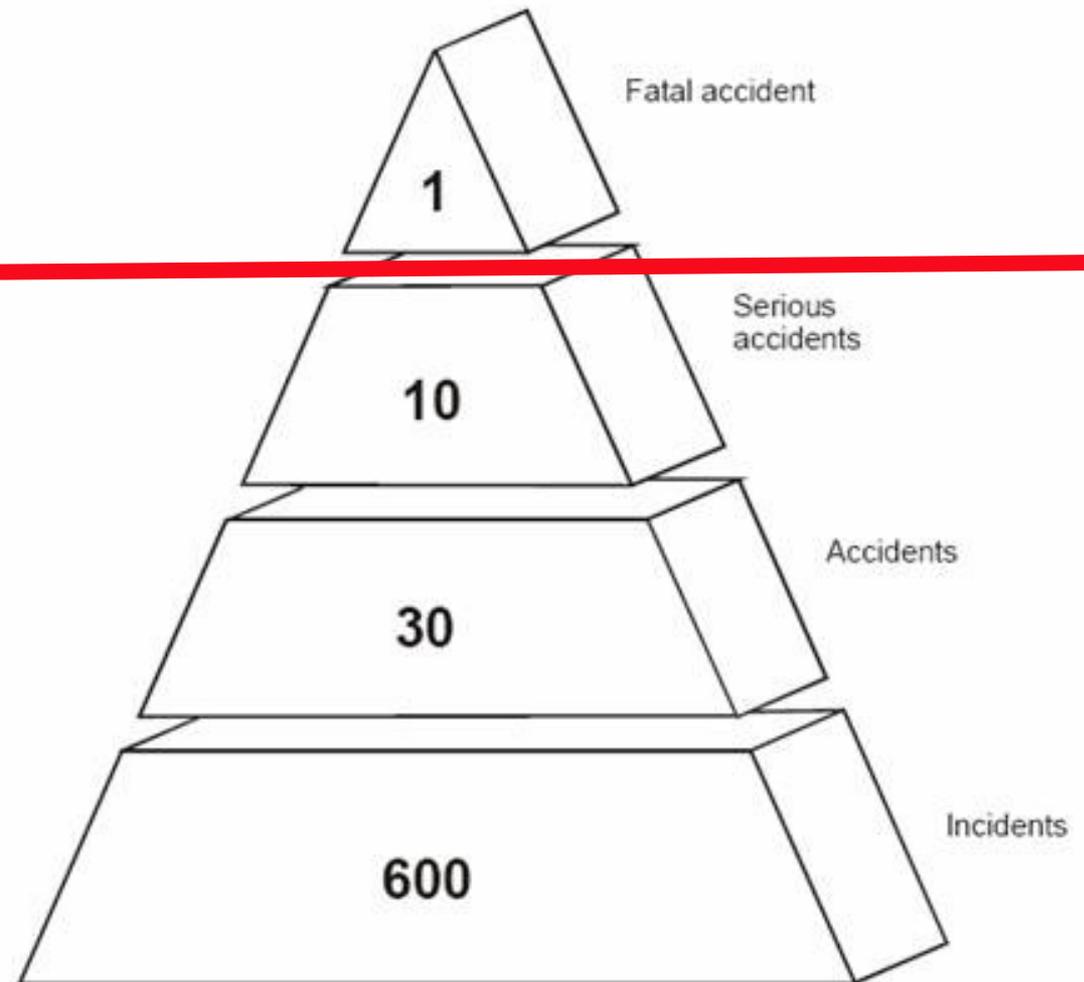
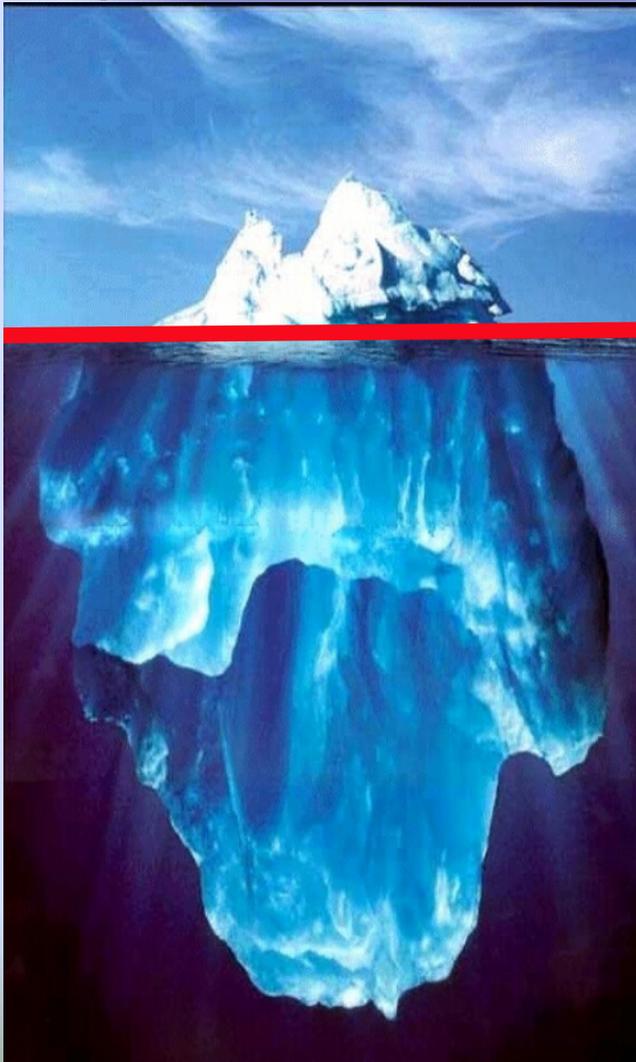
- Engineering a Reporting Culture

- Creating an organization in which people are prepared to report their errors and near-misses

- **Difficult to do!**

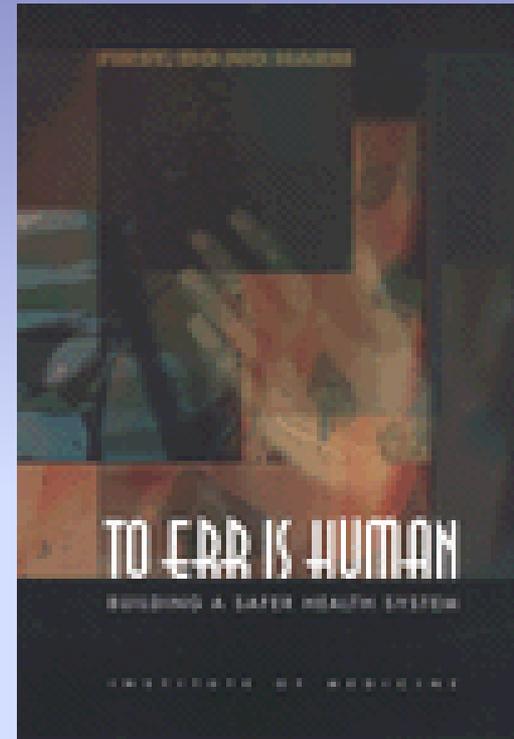


# Heinrich's Ratio (Bird's modification)

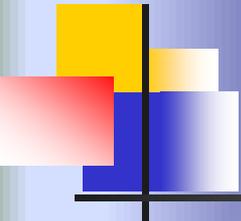


# What is the Problem? Why so Difficult to Do?

- “The problem is *not bad people...* the problem is that the *system* needs to be made safer...”
- *Voluntary* reporting systems
  - Important part of overall program
  - Play very important role in understanding factors which contribute to errors



*To Err is Human:  
Building a Safer Health System*

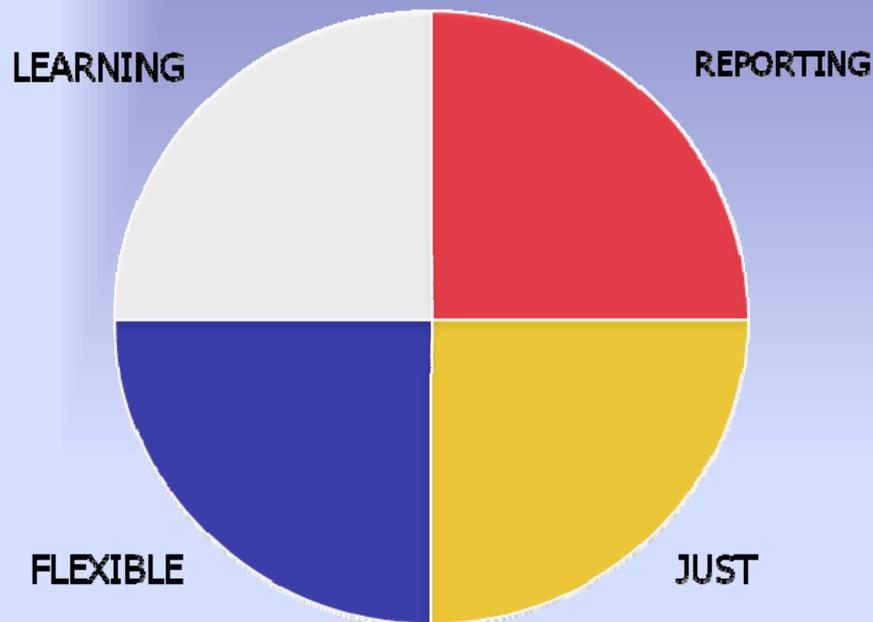


# Reporting Supported by *Just, Flexible, and Learning Cultures*

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- **Individual willingness to report requires beliefs:**
  - Leadership/Management will support and reward reporting
  - Discipline occurs based on a worker's risk-taking, not just honest human error (the more risk taken, the more discipline delivered)
  - Clear line between acceptable and unacceptable worker behavior
  - Organization practices a *Just Culture*
  
- **Individual willingness to report requires belief:**
  - Authority patterns relax when safety information is exchanged because managers respect front-line workers for their knowledge
  - Organization practices a *Flexible Culture*

# Reporting Supported by *Just, Flexible, and Learning* Cultures (Cont'd)

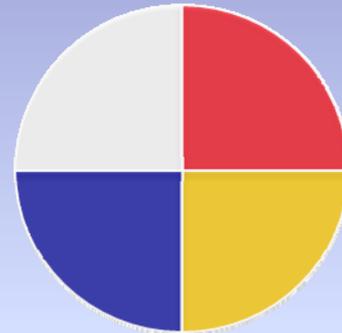


- **Individual willingness to report requires beliefs:**
  - Leadership/Management will analyze what I report
  - They will make changes if and when appropriate
  - Organization practices a *Learning Culture*

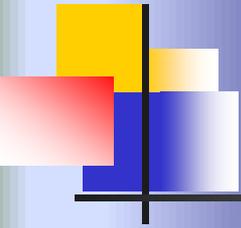
# Reporting Supported by *Just, Flexible, and Learning* Cultures

- Combining practices which support *Reporting, Just, Flexible, and Learning* cultures produces an organization which is:

- Safe
- Informed
- Highly reliable



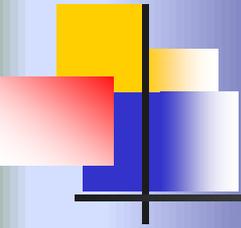
- Individual beliefs, organizational practices, and workforce perceptions are measured and described by the Patient Safety Culture Survey (AHRQ HSOPSC)



# Characteristics of Successful Reporting Systems

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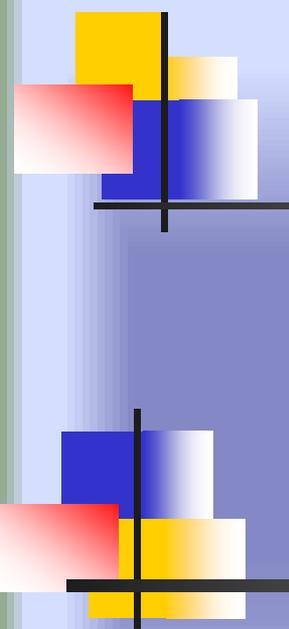
- **Non-punitive**
  - Reporters do not fear punishment as a result of reporting
- **Confidential**
  - Identities of reporter, patient, institution never revealed to 3<sup>rd</sup> parties
- **Independent**
  - Reporting is independent of any authority with power to discipline the reporter
- **Expert analysis**
  - Reports analyzed by those with knowledge to recognize underlying system causes of error



# Characteristics of Successful Reporting Systems (Cont'd)

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- **Timely**
  - Reports analyzed promptly and recommendations disseminated rapidly
- **Systems-oriented**
  - Recommendations focus on systems not individuals
- **Responsive**
  - Those receiving reports capable of disseminating recommendations



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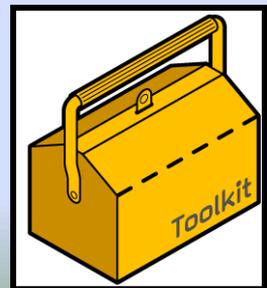
***PATIENT SAFETY  
PROMOTING A  
"JUST CULTURE"***

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*AMEDD Patient Safety Conference*

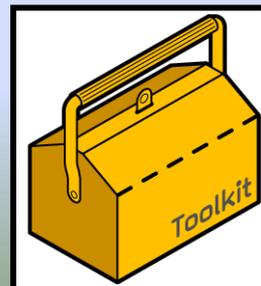
*San Antonio, TX*

*25-27 AUG 09*



# "Just Culture" Topics

- **What is a Just Culture?**
- **Why is a Just Culture needed?**
- **Why can't we just eliminate all errors?**
- **4 basic human behaviors related to errors**
- **Culpability Gradient**
- **How does Leadership fit into a Just Culture?**
- **How is our culture right now?**
- **What are the benefits of changing our culture?**
- **What can happen if we change our culture?**
- **Where do we start?**



# REPORTING INCREASES

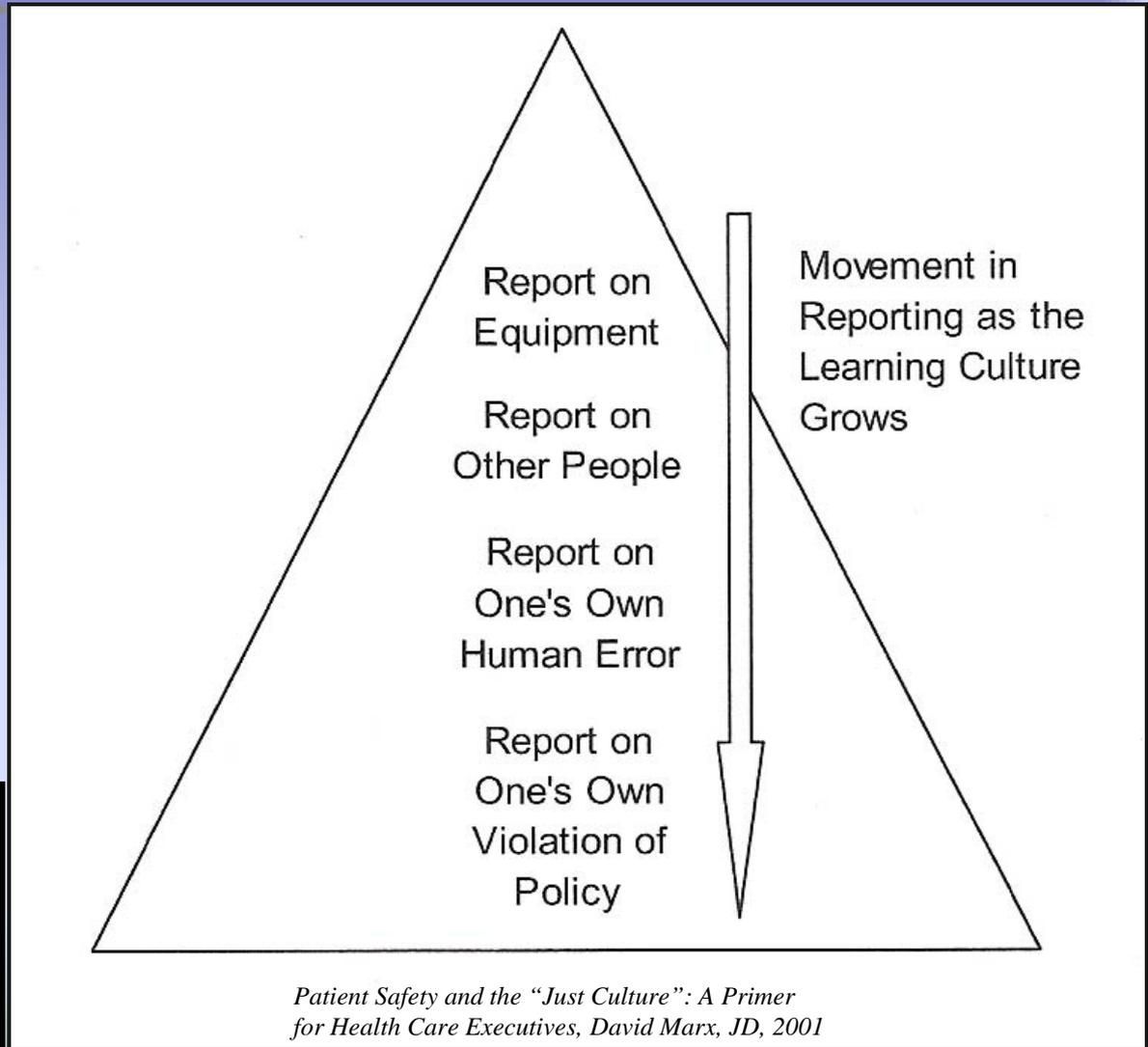
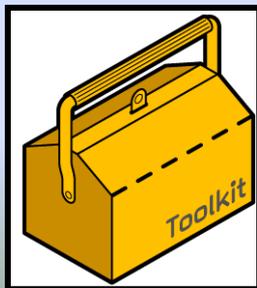
## 1: Equipment

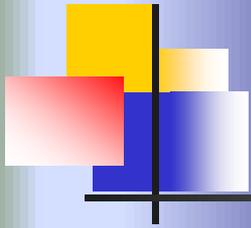
(People fear no retribution against broken equipment)

## 2: On other people's actions

## 3: One's own human error

## 4: One's own violation of policy

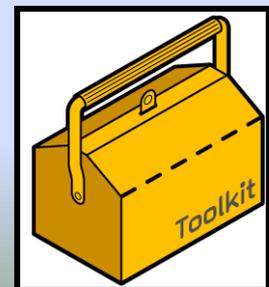




# Charter/Glossary

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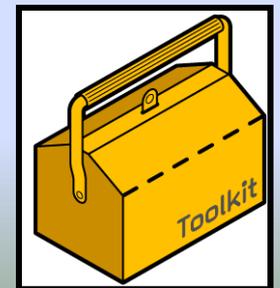
**Time to Dialogue and Discuss**



# Event Occurs-What next?

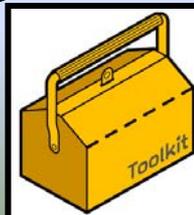
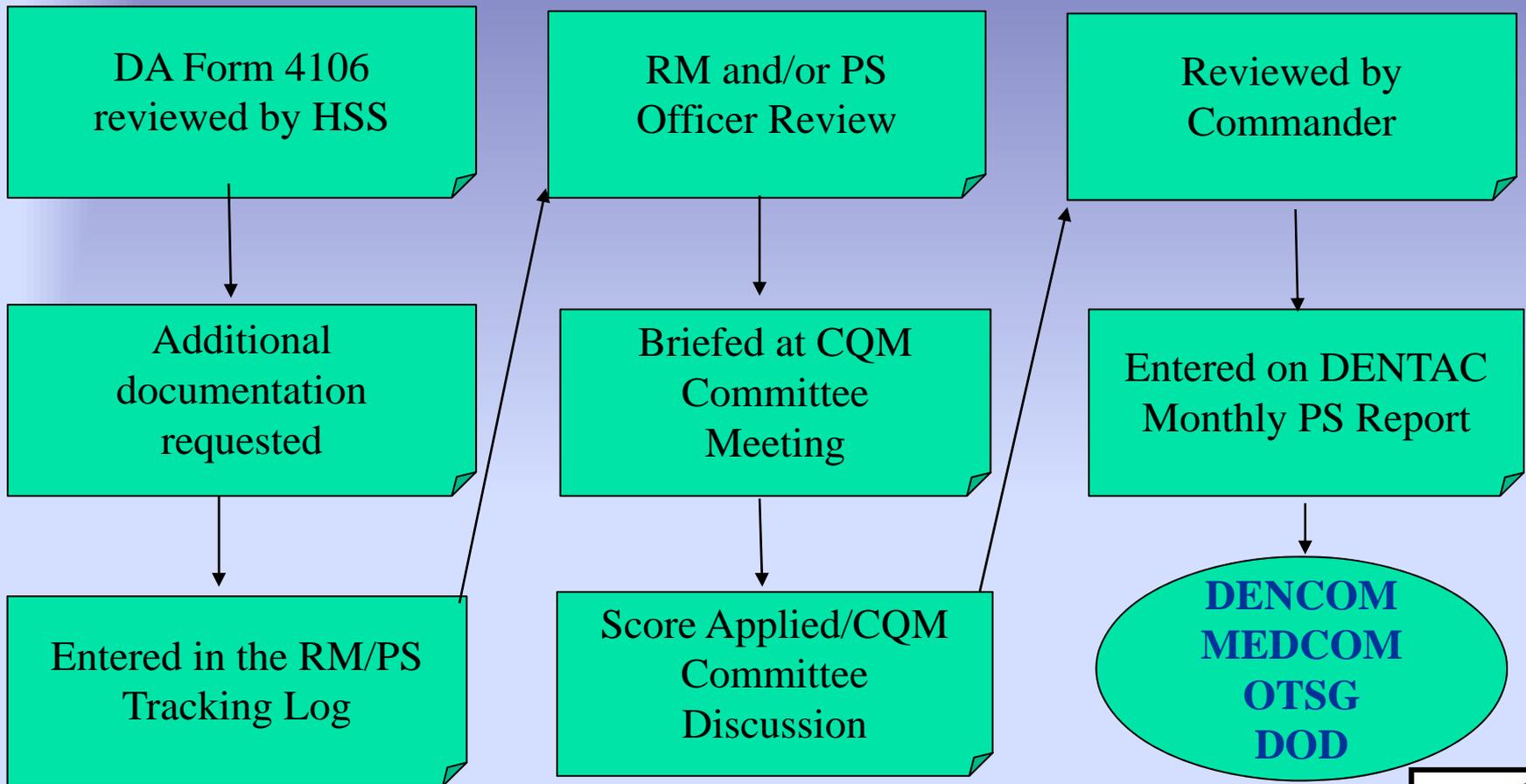
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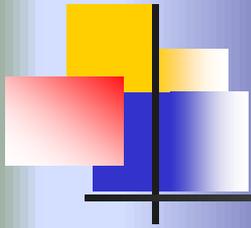
- Let's take a look at the RCA Flow chart in your binder



# What Happens Next

From Ms. Anne French





# Discussing Dental Monthly Summary Reports (DMSR)

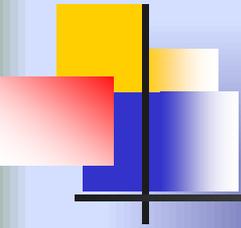
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## **AMEDD Patient Safety Program**

### **DATA ENTRY PORTAL:**

#### **Main Menu**

**What is it and how do you  
use it?**



# *DENTAL PATIENT SAFETY PRINCIPLES*

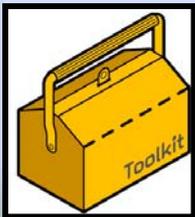
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***TIME-OUT!!!***

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*Adapted from  
Universal Protocol: Procedure Verification Policy*

*MEDCOM Reg 40-54 (23FEB09 )*

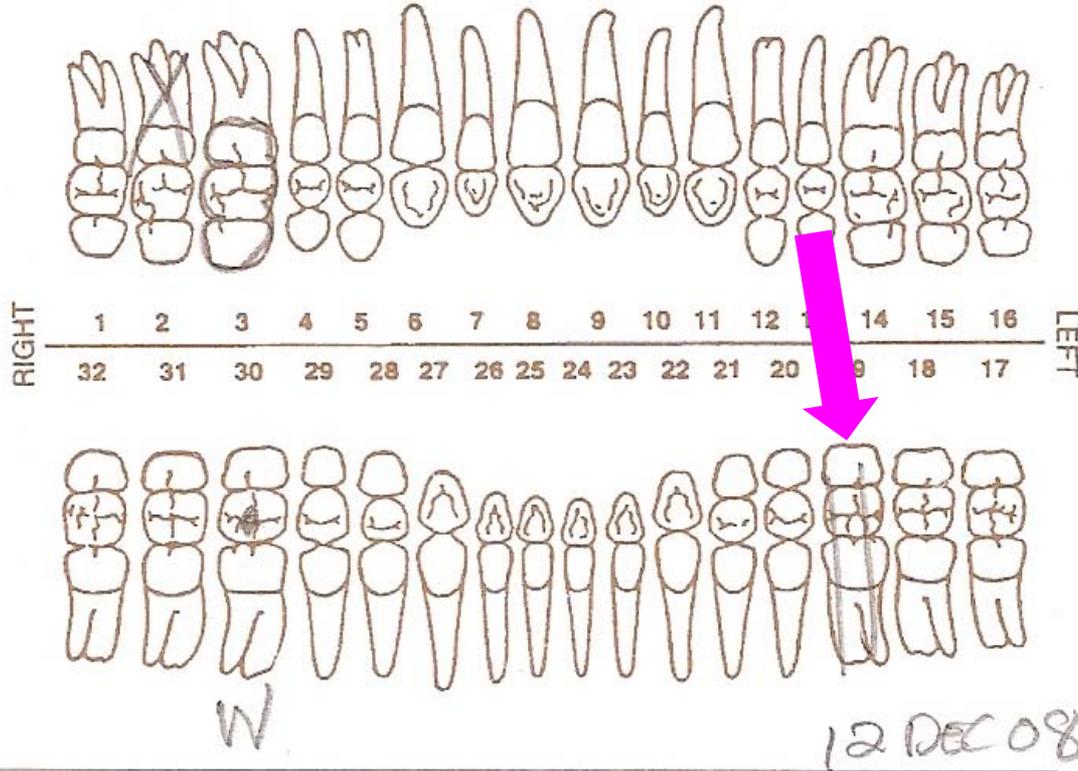




# TAL - CONTINUATION

## ANCE RECORD

### 16. SUBSEQUENT DISEASES AND ABNORMALITIES

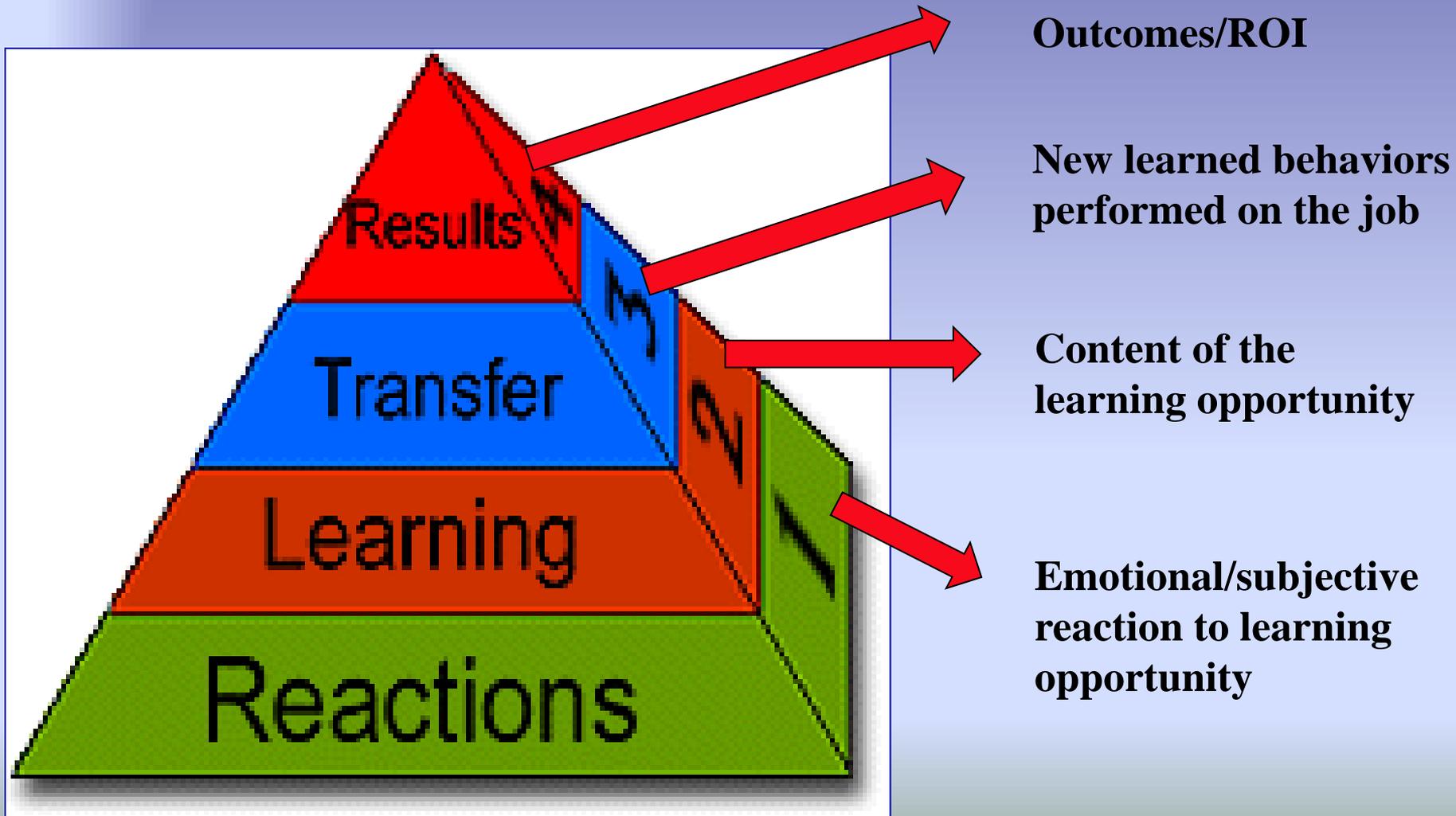


## MARKS

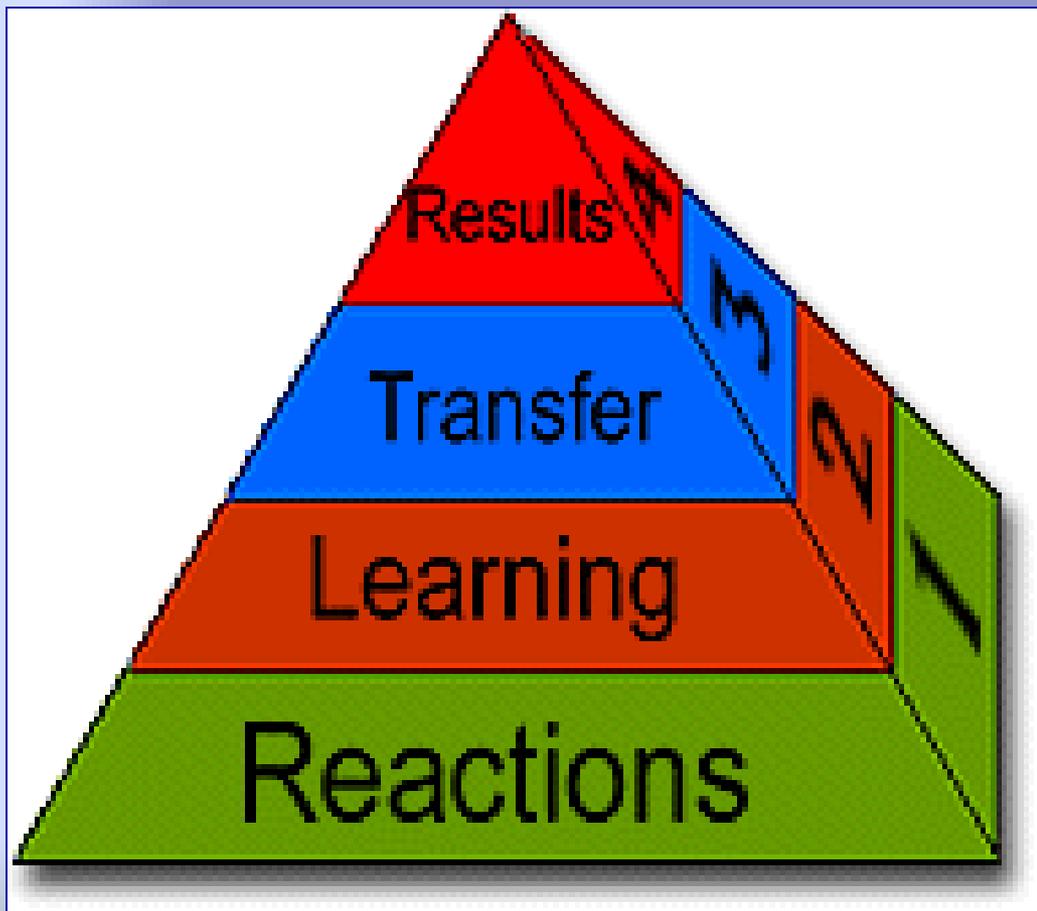
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pus - #3;



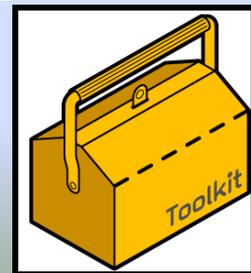
# PATIENT SAFETY LEARNING CONCEPTS



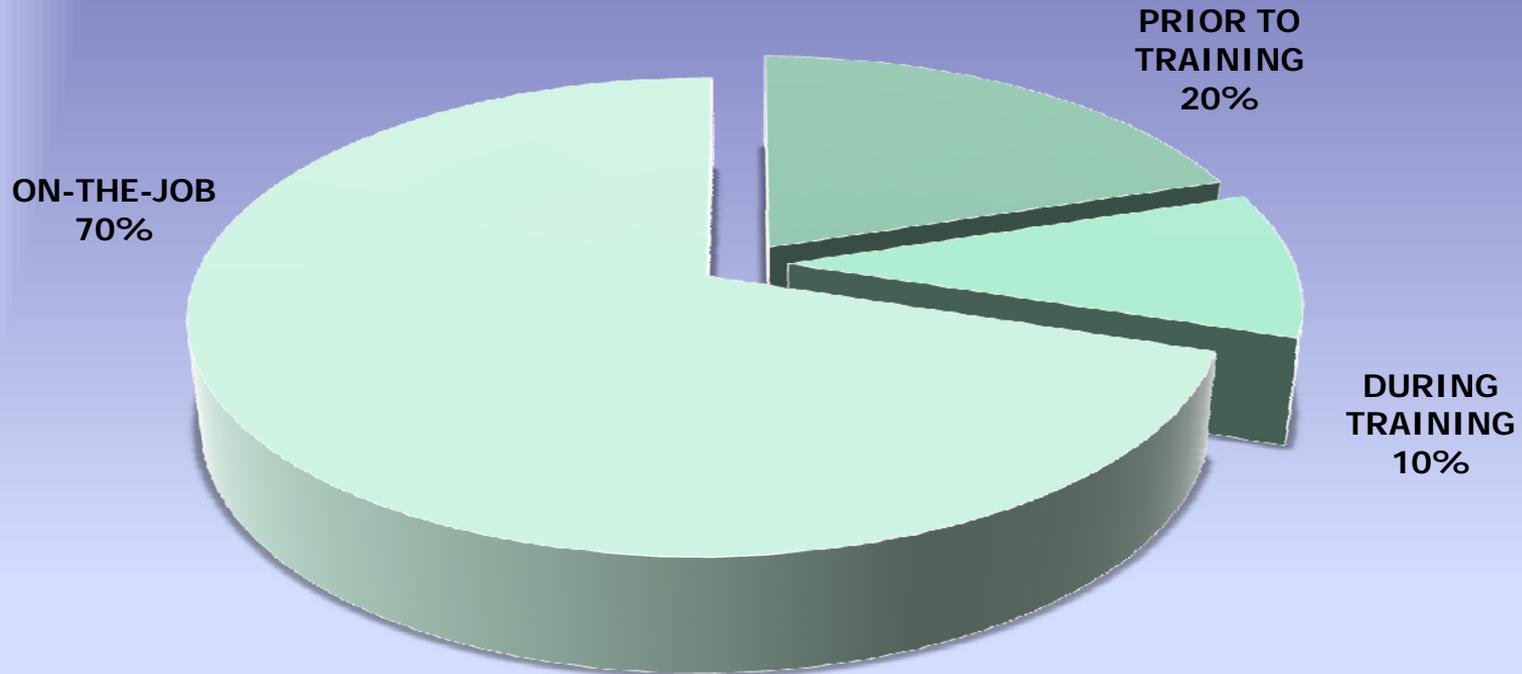
# PATIENT SAFETY LEARNING CONCEPTS



- **Measurement Tools**
- **Create measurement tools to evaluate Levels 1, 2, 3**
- **2 examples in your packet**



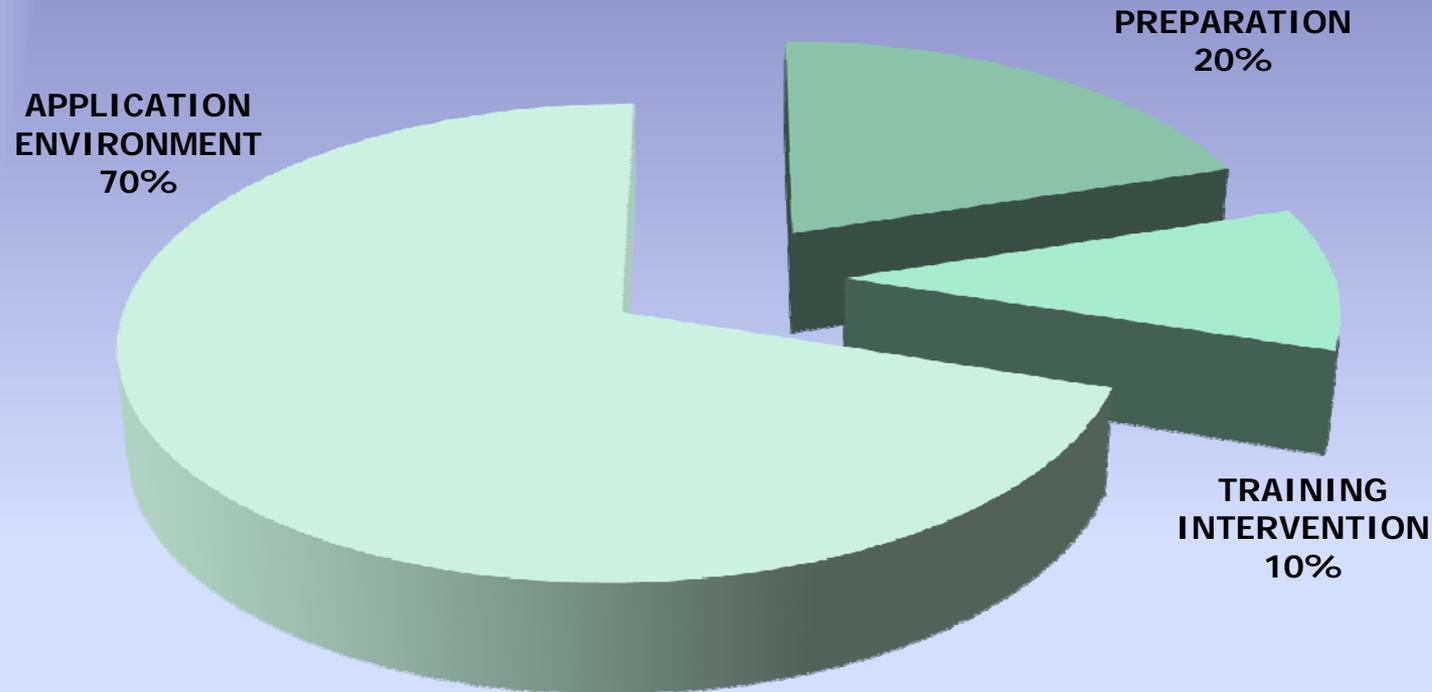
# WHERE LEARNING TAKES PLACE



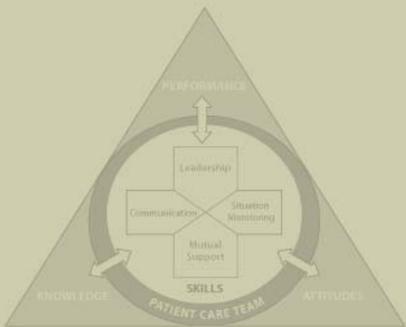
- **Prior to Training** = Learning before the formal training experience
- **During Training** = Actual course, training, hands-on experience, etc.
- **On-the-Job** = Work environment where formal learning is applied after the training

# CAUSES OF TRAINING FAILURE

American Society for Training and Development study, 2006



- **Preparation** = Readiness leading up to the training experience
- **Training Intervention** = Actual course, training, hands-on experience, etc.
- **Application Environment** =  
Work environment where the learning is applied, i.e. Leadership, infrastructure, mentoring, evaluation, structure, accountability, etc.



# TeamSTEPPS

*Team Strategies & Tools to Enhance Performance & Patient Safety*



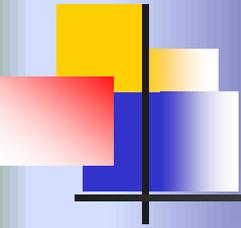
## Implementing a Teamwork Initiative Into the Dental Community



Agency for Healthcare Research and Quality  
Advancing Excellence in Health Care • [www.ahrq.gov](http://www.ahrq.gov)

PATIENT SAFETY

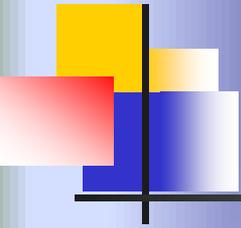




# What is TeamSTEPPS™?

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- An evidence-based teamwork system
- Designed to improve:
  - Quality
  - Safety
  - Efficiency of health care
- Practical and adaptable
- Provides ready-to-use materials for training and ongoing teamwork



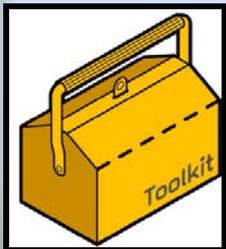
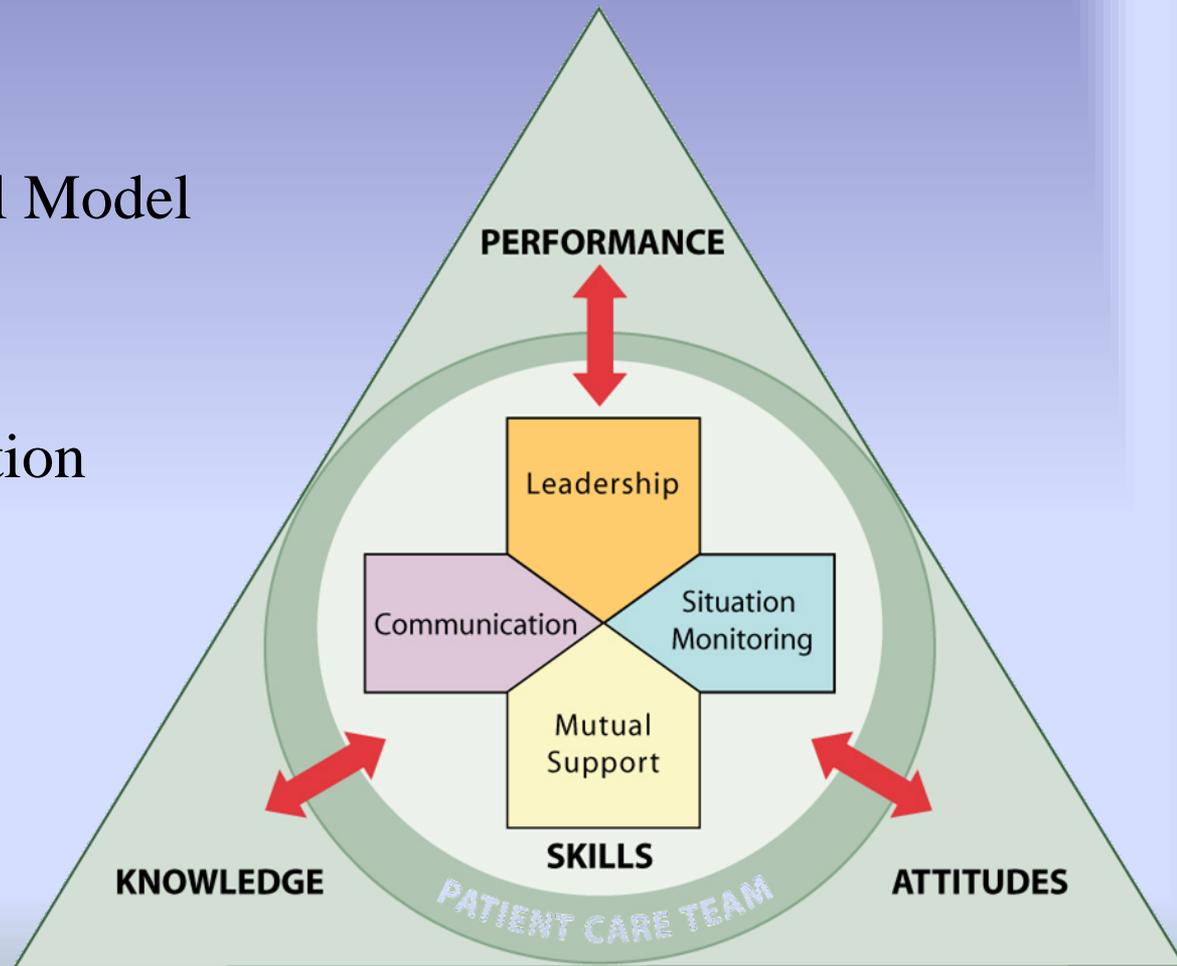
# Why Use TeamSTEPPS?

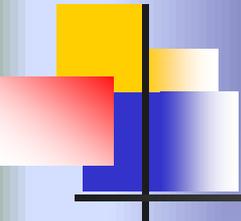
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- **Goal:** Produce highly effective Dental teams that **optimize** the use of **information, people and resources** to achieve the best clinical outcomes
- Teams of individuals who **communicate effectively and back each other** up dramatically reduce the consequences of human error
- **Team skills** are not innate; they must be trained

# Outcomes of Team Performance

- **Knowledge**
  - Shared Mental Model
- **Attitudes**
  - Mutual Trust
  - Team Orientation
- **Performance**
  - Adaptability
  - Accuracy
  - Productivity
  - Efficiency
  - Safety

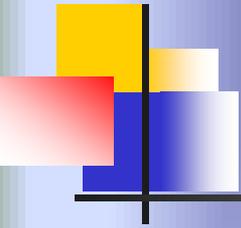




# Importance of Communication

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- Communication failure has been identified as the leading root cause of sentinel events over the past 10 years (JC)
- Communication failure is a primary contributing factor in almost 80% of more than 6000 root cause analyses of adverse events and close calls (VA Center for Patient Safety)



# Patient Safety Culture Survey

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- Response Rate
- Response rates—after data cleaning
- Overall DENTAC response rate (excluding MTFs\*)
  - $3,219/3,997 = 81\%$
- Average DENTAC Region response rate = 79%
  - Range (lowest to highest): 63% to 93%
- Average Parent DENTAC response rate = 80%
  - Range (lowest to highest): 39% to 100%

\*Army MTF response rate =  $23,338/47,159 = 49\%$

Pre-training

2-3 months later  
training sessions

Ongoing coaching, monitor,  
reassess, spreads

**PHASE I**

Assessment

**PHASE II**

Planning, Training  
& Implementation

**PHASE III**

Sustainment

**Pre-Training Assessment**

SITE  
ASSESSMENT

CULTURE  
SURVEY

DATA/  
MEASURES

Ready?

YES

NO

ACTION  
PLAN

T  
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G

Intervention

Test

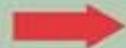
**Culture Change**

COACH &  
INTEGRATE

MONITOR  
THE PLAN

CONTINUOUS  
IMPROVEMENT

**Climate Improvement**



Set the Stage



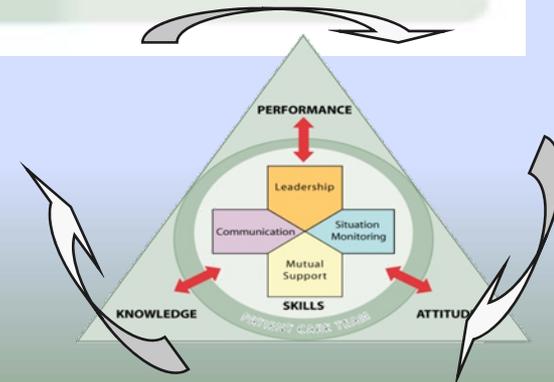
Decide What to Do

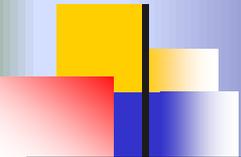


Make it Happen



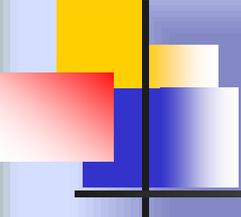
Make it Stick





# Cross walking DENCOM BSC and TeamSTEPPS

| DENCOM BSC   | DoD PSP TeamSTEPPS   |
|--|--|
| CS 5.0 Improved Patient and Customer Satisfaction                    | Patient centered care is the emphasis of the TeamSTEPPS Program educating on the importance of including patients in their care  |
| CS 6.0 Maximized Trust in Army Dentistry                             | Fostering a culture of safety within the DENCOM will cultivate and develop a high reliability organization that can develop Trust, Transparency, and Team among it's members and promote open communication to ensure the mission is met |
| IP 8.0 Improve Quality, Pt Safety, Outcome-Focused care and Services | Teamwork provides a concrete yet dynamic operations infrastructure from which to anticipate, contain and manage or mitigate the impact of human error  |
| IP 14.0 Improve Internal Communication                               | TeamSTEPPS is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among healthcare professionals.  |
| LG 18.0 Improve Professional training and Development                | Core training refreshed, renewed, updated and modified with lessons learned and provide CE's for providers and staff   |



# DENCOM Team STEPPS Spread Strategy

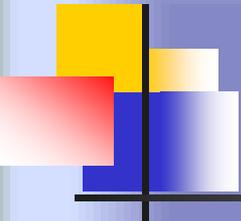
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## *Wave-1*

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### **Train “New” Regions: ERDC, WRDC, SERDC**

- Dates:        Sep 09                                - ERDC \*
- Nov 30-Dec 2 09        - WRDC
- Jan 2010                                - SERDC
  
- Resources- TMA, MEDCOM PSC, and DENCOM
- Impact- Any Deployments? Realignment?



# DENCOM Team STEPPS Spread Strategy

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## *Wave 2*

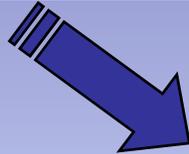
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### **Complete Regions w/Partial Training- GPRDC, PRDC, NARDC**

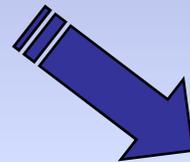
- Dates: Spring 2010 - GPRDC\*\*  
Spring 2010 - PRDC  
Spring 2010 - NARDC
- Resources: TMA, MEDCOM PSC, and DENCOM
- Impact- Any Deployments? Continue Sustainment of DENTAC training

# Dissemination

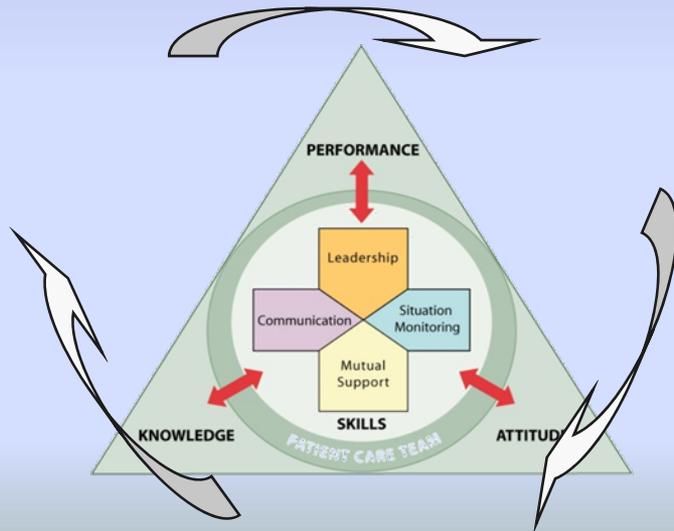
*Regional Master Trainers (Guiding Coalition)*



**Train DENTAC Change Teams and  
Instructors**



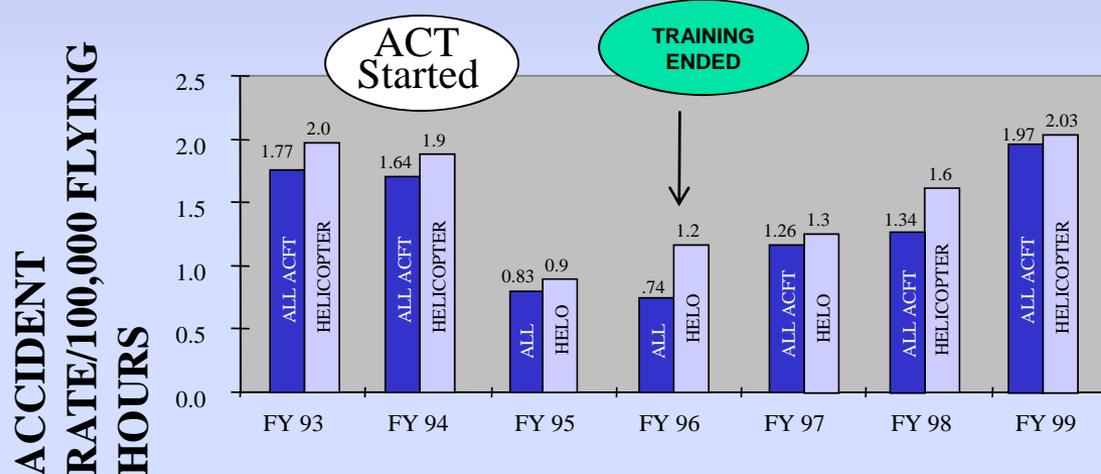
**Change team and Instructors  
Train & Coach Staff Members**



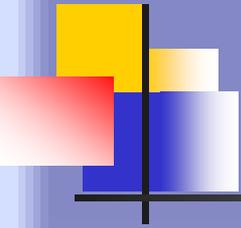
# Refresher Training is Necessary to Sustain

## Impact on Army Aviation Accident Rate

Immediate positive impact  
50 percent reduction in  
Class A accidents



When Aircrew Coordination Training  
was no longer emphasized,  
Class A accident rate increased

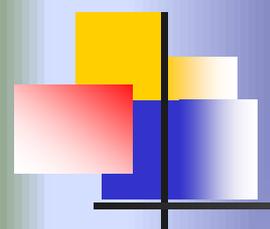


# DENCOM OIP Inspectable Area

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## Commander's Guide

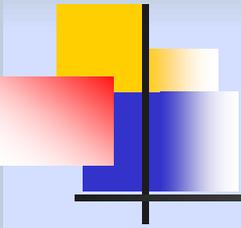
- TeamSTEPPS specific checklist will be written for inclusion in the Patient Safety section of the Guide
- These items will be inspected for compliance during OIP visits from DENCOM personnel
- Feedback to be provided to DENTAC and RDC Commanders to facilitate improvement and focused local or online Sustainment Training



# SUSTAINMENT

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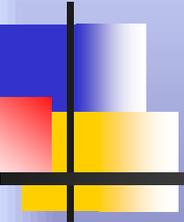
- **Passing the Baton to the next PSO/Manager/Advocate/Champion**
  - Give them this notebook
  - Encourage to attend BPSM Course
  - Select and have “New PSO” Shadow
- **Continuing to re-educate the Front-line staff**
  - Review material Yearly, Quarterly, Newcomer’s



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# ***RISK MANAGEMENT PATIENT SAFETY***

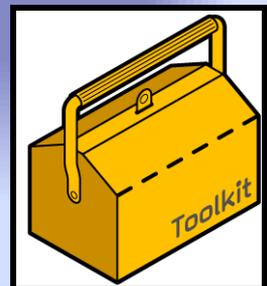
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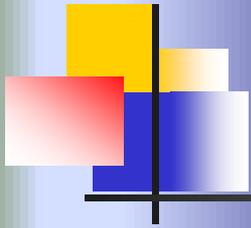


Newcomer's Orientation  
XXXXX DENTAC

XXXXXXXXXXXXXXXXXXXX  
DENTAC Patient Safety Officer

XXXXXX Dental Clinic





# WHAT IS OUR DENTAC'S PATIENT SAFETY GOAL?

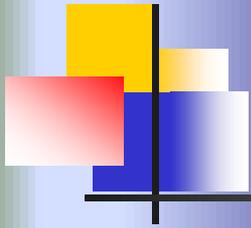
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*PATIENT  
SAFETY*

*PROVIDE THE RIGHT TREATMENT*

*FOR THE RIGHT PATIENT*

*AT THE RIGHT TIME*



AMEDD

Dental Patient Safety Motto

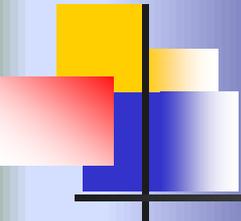
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*A Full Time*

*Commitment*

*Not a Part Time*

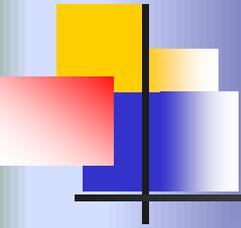
*Practice*



# Valuable Patient Safety Websites

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|   |   |
|---|---|
| MEDCOM Patient Safety Web Page  | <a href="http://www.qmo.amedd.army.mil/ptsafety/pts.htm">http://www.qmo.amedd.army.mil/ptsafety/pts.htm</a> |
| Agency for Healthcare Research & Quality (AHRQ)                       | <a href="http://www.ahrq.gov/">http://www.ahrq.gov/</a>   |
| DOD Patient Safety Center (DOD PSC)                                   | <a href="https://patientsafety.satx.disa.mil/">https://patientsafety.satx.disa.mil/</a>                     |
| Health Affairs  | <a href="http://www.ha.osd.mil/">http://www.ha.osd.mil/</a>   |
| Institute for Healthcare Improvement (IHI)                            | <a href="http://www.ihl.org/">http://www.ihl.org/</a>   |
| Institute of Medicine (IOM)   | <a href="http://www.iom.edu/">http://www.iom.edu/</a>   |
| Institute for Safe Medication Practices (ISMP)                        | <a href="http://www.ismp.org">http://www.ismp.org</a>   |
| Joint Commission on Accreditation of Healthcare Organizations (JCAHO) | <a href="http://www.jcaho.org/">http://www.jcaho.org/</a>   |
| National Patient Safety Foundation (NPSF)                             | <a href="http://www.npsf.org">http://www.npsf.org</a>   |
| National Quality Forum  | <a href="http://www.qualityforum.org/">http://www.qualityforum.org/</a>                                     |
| Veterans Administration National Center for Patient Safety            | <a href="http://www.va.gov/ncps">http://www.va.gov/ncps</a>   |



# Regulatory References

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- National Defense Authorization Act (NDAA), 2001
- DoDD 6025.13, Medical Quality Assurance in the MHS
- DoD 6025.13-R MHS Clinical Quality Assurance Program
- AR 40-68, Clinical Quality Management (22MAY09)
- MEDCOM Reg 40-41, The Patient Safety Program (14JAN02)
- DENCOM Policy 09-46, Correct Site Surgery (06MAY09)
- Patient Safety and Quality Improvement Act (2005)

# Questions?

