Dental Patient Safety Consultant
DSN: 471-6428 CM: 210-221-6428

DENTAC Ft BRAGG Patient Safety Officer
American Board of Periodontology, Diplomate
DSN: 239-6190 CM: 910-432-6190
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
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

OSD oversight

ASD(HA)

DoD Patient Safety Executive Council

Patient Safety Planning and Coordination Committee

Patient Safety Division

Tricare Clinical Quality Forum

HA Functions:
- Policy
- Executive Oversight

TMA Functions:
- Joint Operations Management
- Support the Services’ PSP

Joint Operations

Navy DoD EA

Army DoD EA

USAF DoD EA

DoD Center for Education and Research in Patient Safety, (USU)
Education, Research and Development

DoD Patient Safety Center, (AFIP)
Management and Analysis of the Patient Safety Registry

Healthcare Team Coordination Program: Team Intervention, Education and COEs

Service Operations

Air Force

Army

Navy

Service Headquarters Functions:
- Manage PSP Service Operations
- Culture Change
- Collaboration/Integration
- Corporate Policy/Standardization
- Safe/Best Practice Adaptation/Promulgation
- Corporate Analysis/Lessons Learned

MTF/DTF Functions:
- Improve Patient Safety
- Culture Change
- Program Execution
- Data Collection
- Local Process Change/Action
What is Patient Safety?

- 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?

- **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

- 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
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

<table>
<thead>
<tr>
<th>MANDATE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create <strong>Culture</strong> to promote Patient Safety Initiatives</td>
<td>Promote a “Just Culture” throughout DENCOM</td>
</tr>
<tr>
<td>Implement Patient Safety <strong>Reporting</strong> System</td>
<td>Enter data into Dental Monthly Summary Report (DMSR)</td>
</tr>
<tr>
<td>Provide <strong>Training</strong> to encourage and promote safe, effective communication among team members</td>
<td>Implement and utilize TeamSTEPPS</td>
</tr>
<tr>
<td>Integrate <strong>Patient Safety</strong> into all aspects of <strong>Quality Management</strong> and Patient Care</td>
<td>Educate through SAV’s and at AMEDDC&amp;S</td>
</tr>
</tbody>
</table>
Characteristics of an Effective Culture of Safety
Characteristics of an Effective Culture of Safety

- **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*

- **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*
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

- **Non-punitive**
  - Reporters do not fear punishment as a result of reporting

- **Confidential**
  - Identities of reporter, patient, institution never revealed to 3rd 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)

- **Timely**
  - Reports analyzed promptly and recommendations disseminated rapidly

- **Systems-oriented**
  - Recommendations focus on systems not individuals

- **Responsive**
  - Those receiving reports capable of disseminating recommendations

PATIENT SAFETY
PROMOTING A
“JUST CULTURE”

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

Patient Safety and the “Just Culture”: A Primer for Health Care Executives, David Marx, JD, 2001
Charter/Glossary

Time to Dialogue and Discuss
Event Occurs-What next?

- Let’s take a look at the RCA Flow chart in your binder
What Happens Next
From Ms. Anne French

- DA Form 4106 reviewed by HSS
  - Additional documentation requested
    - Entered in the RM/PS Tracking Log

- RM and/or PS Officer Review
  - Briefed at CQM Committee Meeting
    - Score Applied/CQM Committee Discussion

- Reviewed by Commander
  - Entered on DENTAC Monthly PS Report

DENCOM MEDCOM OTSG DOD
Discussing Dental Monthly Summary Reports (DMSR)

AMEDD Patient Safety Program

DATA ENTRY PORTAL:
Main Menu

What is it and how do you use it?
DENTAL PATIENT SAFETY PRINCIPLES

TIME-OUT!!!

Adapted from
Universal Protocol: Procedure Verification Policy

MEDCOM Reg 40-54 (23FEB09)
Time-Out

- Procedure Verification Power Point for Provider/Staff Training
  - Explains new sticker and how to use it properly
  - Focus is on required behavior from your staff
  - 15 min or less to present
  - See DPS Toolkit
TAL - CONTINUATION

ANCE RECORD

16. SUBSEQUENT DISEASES AND ABNORMALITIES

MARKS

2010  2x1 #19
1105 - #3

12 DEC 08
PATIENT SAFETY LEARNING CONCEPTS

1. Emotional/subjective reaction to learning opportunity
2. Content of the learning opportunity
3. New learned behaviors performed on the job
4. Outcomes/ROI
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

Josh Bersin et al, 2008
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.
Implementing a Teamwork Initiative Into the Dental Community
What is TeamSTEPPSTM?

- 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
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

- 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

- 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
Cross walking DENCOM BSC and TeamSTEPPS

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

Wave-1

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? Realignments?
DENCOM TeamSTEPPS Spread
Strategy

Wave 2

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
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

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

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

- 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
RISK MANAGEMENT
PATIENT SAFETY

Newcomer’s Orientation

XXXXXXXX DENTAC

XXXXXXXXXXXXXXXX

DENTAC Patient Safety Officer

XXXXXXXX Dental Clinic
WHAT IS OUR DENTAC’S PATIENT SAFETY GOAL?

PATIENT SAFETY

PROVIDE THE RIGHT TREATMENT

FOR THE RIGHT PATIENT

AT THE RIGHT TIME
AMEDD
Dental Patient Safety Motto

A Full Time Commitment
Not a Part Time Practice
Valuable Patient Safety Websites

<table>
<thead>
<tr>
<th>Website</th>
<th>URL</th>
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<tbody>
<tr>
<td>Agency for Healthcare Research &amp; Quality (AHRQ)</td>
<td><a href="http://www.ahrq.gov/">http://www.ahrq.gov/</a></td>
</tr>
<tr>
<td>DOD Patient Safety Center (DOD PSC)</td>
<td><a href="https://patientsafety.satx.disa.mil/">https://patientsafety.satx.disa.mil/</a></td>
</tr>
<tr>
<td>Health Affairs</td>
<td><a href="http://www.ha.osd.mil/">http://www.ha.osd.mil/</a></td>
</tr>
<tr>
<td>Institute for Healthcare Improvement (IHI)</td>
<td><a href="http://www.ihi.org/">http://www.ihi.org/</a></td>
</tr>
<tr>
<td>Institute of Medicine (IOM)</td>
<td><a href="http://www.iom.edu/">http://www.iom.edu/</a></td>
</tr>
<tr>
<td>Institute for Safe Medication Practices (ISMP)</td>
<td><a href="http://www.ismp.org">http://www.ismp.org</a></td>
</tr>
<tr>
<td>Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</td>
<td><a href="http://www.jcaho.org/">http://www.jcaho.org/</a></td>
</tr>
<tr>
<td>National Patient Safety Foundation (NPSF)</td>
<td><a href="http://www.npsf.org">http://www.npsf.org</a></td>
</tr>
<tr>
<td>National Quality Forum</td>
<td><a href="http://www.qualityforum.org/">http://www.qualityforum.org/</a></td>
</tr>
<tr>
<td>Veterans Administration National Center for Patient Safety</td>
<td><a href="http://www.va.gov/ncps">http://www.va.gov/ncps</a></td>
</tr>
</tbody>
</table>
Regulatory References

- 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)