THE INTEGRATION OF QUALITY ASSURANCE, RISK MANAGEMENT, AND PATIENT SAFETY:

The Sharing of Information for Outcomes Improvement
Continuous Quality Improvement

“a system that seeks to improve the provision of services with an emphasis on future results. Like total quality management, CQI uses a set of statistical tools to understand subsystems and uncover problems, but its emphasis is on maintaining quality in the future, not just controlling a process.”

Risk Management

- “analysis of possible loss: the profession or technique of determining, minimizing, and preventing accidental loss in a business, e.g. by taking safety measures and buying insurance.”

- Encarta World English Dictionary 2009
Quality Assurance

Risk Management

Patient Safety
Getting Started

- Define Objectives
  - Decrease liability claims
    - Decrease the cost of professional liability insurance
  - Conform to accreditation standards
  - Analyze incident reports related to undesirable outcomes of care
  - Increase faculty involvement in assessment of incidents
  - Identify policies and procedures to reduce the risk of undesirable outcomes
Getting Started

- Define what are not objectives
  - Identify and eliminate poor performers
  - Produce perfect outcomes all the time
Quality Assurance Measurements

- Bloodborne exposure incidents
- Interim case reviews
- Final case reviews
- Redos
- Patient satisfaction surveys
- Infection Control Rounds
- Unusual occurrences
- Records review
Unusual Occurrence Report

UOR
- Identify unintended outcomes
- Define “sentinel events”

Data
- Collect data systematically (Access)
- Develop reports and queries

Review
- Identify desired change in trend

Measure
- Were desired outcomes achieved
Link UOR to AxiUm
Web-based Form Links to Database

Unusual Occurrence Report

* = Required Field

Your Role*  
- Faculty/Staff  
- DDS/DDS Student  
- Resident

Your Name*  
- Select faculty/staff

INCIDENTS*

Injury  
- First Name:  
- Last Name:  
- Patient  
- Chart #:  

Potential injury to patient  
Damage to patient property

Date of Incident

Location  
- Select Location

TREATMENT ISSUES

- Delayed or untimely treatment
- Missed, inaccurate, or untimely diagnosis
- Complication of procedure
- Adverse reaction to treatment or medication
- Wrong tooth treated

Failure to follow treatment plan
Infection control
Replant, remake or retreat. See ARED form.
Endodontic access perforation
Separated endo instrument

MEDICAL EMERGENCIES

- Medical emergency patient
- Medical emergency staff

Medical emergency student
Medical emergency another
Database is not Accessible to Users
Risk Management Activities
Define Responsibilities

- To whom are incidents reported
- Who is responsible for communicating with patients after an undesirable outcome
- Who is responsible for reporting incidents to risk management and/or insurance carrier
- Who will review data reports and make recommendations for changes/improvements
- Who will implement and monitor processes
Communication

- Giving patients realistic expectations
- Always explaining RBA’s
- Obtaining consent in writing
- Admitting errors and offering reasonable remediation
- Informing all care providers of the policies regarding incident reporting
- Maintaining a good relationship with risk management department and insurance carrier
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. -- Such events are called "sentinel" because they signal the need for immediate investigation and response.  JCAHO
Dental “Sentinel” Events

- Extraction or treatment of the wrong tooth
- Parasthesia
- Medical complications requiring hospitalization
- Wrong medication
- Failure to premedicate
- Aspiration of foreign object
- Burns or lacerations requiring sutures
- Medical emergency related to sedation/general anesthesia
- Hospitalization associated with dental treatment
Outcomes Review Committee

- Confidential
- Legally protected
- Impartial reviewers
- Provide recommendations on specific case and on general clinic policies and protocols
“To err is human, to cover up is unforgivable, and to fail to learn is inexcusable.”

-Sir Liam Donaldson
What is a Safety Culture?

- Leadership
- Responsibility
- Evaluation
- Solutions
- Correction
- Communication
- Avoiding blame
Assessment

- Root Cause Analysis
- Clinical microsystems
Clinical Microsystems

- Small organized groups of providers and staff caring for a defined population of patients. (Mohr 2002)
  - Failures at system level were responsible for 75% of adverse drug events in healthcare (Leape 1991)
Clinical Microsystems and Patient Safety

Microsystems must be:

- Preoccupied with safety
- Reluctant to simplify interpretations
- Sensitive to operations
- Committed to resilience
- Deferrent to expertise on the front line

Mohr, 2002
Characteristics of Effective Microsystems

- Integration of information
- Measurement
- Interdependence of the core team
- Supportiveness of the larger system
- Constancy of purpose
- Connection to the community
- Investment in improvement
- Alignment of role and training
Response and Evaluation

- “seven pillars” approach (UIMCC)
  - Grounded in transparency
  - Disclosure of errors
  - Systems-induced errors vs. reckless disregard
Seven Pillars

1. Reporting – professionals and patients
2. Investigation
3. Communication and disclosure
4. Apology and remediation
5. System improvement
6. Data tracking and performance evaluation
7. Education and training

McDonald TB, Helmchen LA, Smith KM, et al. Responding to patient safety incidents; the “seven pillars”
Guiding Principles (UIMCC)

1. We will seek to provide effective and honest communication to patients and families following patient safety incidents involving patient harm.

2. We will apologize and provide rapid compensation when inappropriate or unreasonable medical care causes patient harm and defend rigorously care that we believe was appropriate.

McDonald TB, Helmchen LA, Smith KM, et al. Responding to patient safety incidents; the “seven pillars”
3. We will learn from our mistakes.

4. Reckless behavior will be subject to corrective action.

5. We will provide support services for providers involved in patient safety incidents.
Adverse Events

- Not all adverse events are errors
- Not all errors result in adverse events
Adverse Events--Dental

- Paresthesia, dysesthesia
- Wrong tooth/site treated
- Separation of endo instrument
- Reaction to medication
- Swallowed or aspirated foreign object
Outcomes at Pacific

Financial
- Premiums for professional liability reduced by 50% over 8 years
- Deductible reduced by $40,000 per incident

Non-financial
- Improved relationship with insurance carrier
- Increased open discussion of adverse events and prevention
- Incorporation of patient safety into institutional culture and educational program
OUTCOMES REVIEW
Purpose

- Discover root cause of incident
- Provide recommendations to prevent future occurrence
- Calibrate clinic leadership
- Advice to insurance carrier
- Advice to risk management
- Advice to legal counsel
Development

- Established 2001
- Recommendation of University risk management
- Part of larger process
- Calibration by University attorney
- Panels called only as needed
- Administrative committee with numerous members
Faculty identifies unusual occurrence

Student completes UOR

UOR provided to GPA

GPA sends UOR to DEHS

DEHS identifies potential case for review

Panel is called and recommendations provided

TOUCH seminar topic

Retraining as needed
Calibration

- University attorney
- Required committee attendance
- Certified to sit on panel
- Committee membership
  - Clinical dept chairpersons
  - Group practice administrators
  - Clinic directors
  - Selected clinic faculty
Panel

- Panel activities
- Panel membership: dept chairperson, GPA, faculty member, facilitator, ADCS, DEHS
- Facilitator
  - Directs meeting
- ADCS
  - Recommendations for clinic operations
- DEHS
  - Recommendations for risk management
Panel meeting

- Review case beforehand
- Confidentiality statement
- Discuss findings of review
- Provide clear recommendations
- Note taking prohibited
  - Exception: recommendations
  - Notes: no names attached
Confidentiality

- Panel meeting: freedom to speak freely
  - Non-discoverable
  - Reviewed at beginning and end of each meeting
- Outside of panel meeting: no freedom to speak with anyone about the case
- Breach
  - Everything becomes discoverable
Calibrate leadership

- Reminders
- Discoveries
- System gaps
- Redundancies
- Educational opportunities
  - Students
  - Faculty
  - Staff
Example

- Resident supervision
- CBCT utilization
- Case selection based on practitioner experience level
- Difficult case management
- Re-implantation
Example

- Supervisory group meeting
- Faculty point person
- Gap management
- Student transfer
- GPA support
- Timing
Example

- All cases require surgical template
- Prosthodontist approves all surgical changes
- Case presentation before surgery
- Checklist
- Patient expectations management
- Student education modifications
Example

- Record entry legibility
- Record entry accuracy
- Signatures
- Minimize length of time between screening and first treatment planning appt
- All patients receive ODTP
- Patient needs supersede student needs
Process Outcomes

- Change clinic operations
  - Policy and protocol
- Advise legal/insurance
- Modify student education
- Inform decision making
  - AxiUm conversion
  - Building structure
  - Cross training
Faculty orientations
TOUCH seminars
Strategic planning
Committee work
  Curriculum
  CQA
  Clinic Advisory
  Department
Challenges

- Change
- Buy-in
- Information distribution
- Calibration
- Reporting unusual occurrences
Questions