We’re moving!
Occupancy July 1, 2014
As of October, 2013
Objectives

- overview of the current state of patient safety systems
- describe what constitutes a patient safety system
- present critical steps in establishing a dental patient safety system
- review example efforts underway in dentistry
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FIRST, DO NO HARM

TO ERR IS HUMAN
BUILDING A SAFER HEALTH SYSTEM

CROSSING THE QUALITY CHASM
A New Health System for the 21st Century
What is patient safety?

- Patient safety was defined by the IOM as "the prevention of harm to patients."
  
  . . . . the system of care delivery that
  (1) prevents errors;
  (2) learns from the errors that do occur; and
  (3) is built on a culture of safety that involves health care professionals, organizations, and patients.
Is there really a safety problem?

- **Wrong site surgery** – btw 1995 and 2010, 956 WSS were reported to the Joint Commission

- **Medication errors** – harm ~1.5 million Americans each year resulting in more than $3.5 billion in extra medical costs

- **Health care-acquired infection** – 1 out of 20 hospitalized patients contract HAI
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Essential elements of a patient safety system

Patient safety vocabulary

**Safety**: freedom from accidental injury

**Adverse event**: an injury resulting from a medical intervention (i.e., not due to the underlying clinical condition of the patient)

**Preventable adverse event**: an adverse event that was attributable to a clinical error.

**Error**: the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim; not all errors result in injury. Errors can include problems in practice, products, procedures, and systems.

*Institute of Medicine*
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Steps to patient safety

• Build a safety culture
• Lead and support the practice team
• Integrate risk management activity
• Promote reporting
• Involve and communicate with patients and public
• Learn and share safety lessons
• Implement solutions to prevent harm

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management.

Key features of a positive patient safety culture

- acknowledgment of the high-risk nature of activities and determination to achieve consistently safe operations;
- a blame free environment in which individuals report errors or near misses without fear of repercussion or punishment;
- encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems.”
Teamwork

• Plays an important role in causation and prevention of AEs
• Staff perceptions of teamwork are related to quality and safety
• Effective teams have high levels of communication, coordination, and leadership

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Survey of patient safety culture

Attitudes toward Patient Safety Standards
US Dental Schools: UCSF

• AHRQ survey instrument administered to dental faculty, students and support staff and to hospital staff
• Dental ratings higher than hospital in overall perceptions of safety, management support for safety, and teamwork.
• Dental below hospital in frequency of adverse events reports, and organizational learning/CI
Evaluation of a Clinical Outcomes Assessment Tool in a US Dental School.
University of Louisville

An Initiative to Prepare Adult Nurse Practitioners and Family Nurse Practitioners (ANP/FNP) and Dental Students for Deliberative Interprofessional Collaborative Practice

Theresa G. Mayfield, D.M.D. Associate Dean for Clinical Affairs University of Louisville School of Dentistry

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Editorial

From good to better: Toward a patient safety initiative in dentistry
Rachel B. Ramoni, Muhammad F. Walji, Joel White, Denice Stewart, Ram Vaderhobli, Debora Simmons and Elsbeth Kalenderian
JADA 2012;143(9):956-960
Developing a Patient Safety System for Dentistry

R01, 5-Year NIH/NIDCR Grant
Dental Schools of University of Texas Houston, Harvard University, University of California San Francisco, Oregon Health & Science University

1. Develop the tools to document dental AEs
2. Generate a classification scheme and repository to organize AEs
3. Enable five dental organizations to systematically collect and analyze AEs
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Questions, comments?