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Preventive Risk Management: Creating a Culture of Safety

CNA has long recommended a preventive risk control approach for dentists and their staff, supported by a "patient safety culture" that focuses the intentions and efforts of the entire dental team on serving and protecting patients. While definitions vary, safety culture is generally thought of as the collective product of individual and group values, attitudes, perceptions, competencies and behaviors relating to safety management and performance. At Johns Hopkins Hospital, the phrase refers to the presence of the following:

- Belief that harm is untenable.
- Ability to speak up and raise concerns.
- Obligation to listen when others have a concern.
- Recognition of personal and organizational hazards.
- Obligation to work as a team.
- Use of a systems approach to analyze safety issues.[1]

This issue of *Dental Expressions*® discusses basic safety culture principles and offers guidance for applying them to the dental setting, for the purpose of enhancing clinical outcomes and the risk posture of the practice. A variety of tools and resources are listed to help dental professionals evaluate and revise current processes and procedures, minimize errors, reduce liability exposure, and improve patient satisfaction and retention.

1 Paine, L.A. et al. "The Johns Hopkins Hospital: Identifying and Addressing Risks and Safety Issues." *Joint Commission Journal on Quality and Safety*, November 2004, volume 30:10, pages 543-550. Available at **http://www.researchgate.net/publication/8202793_The_Johns_Hopkins_Hospital_identifying_and_addressing_risks_and_safety_issues**.

THE NEED FOR A SAFETY CULTURE

The inherent risk in dentistry, and healthcare in general, makes patient safety a high priority for all practitioners. Moreover, a recent evidence-based review suggests that preventable adverse events in the hospital setting may be the third leading cause of death in the United States, after heart disease and cancer – a sobering thought.[2]

Dentistry continues to experience patient safety issues as well, although death is a rarity and injury statistics may not be as readily available or reported as they are in other healthcare disciplines. According to the 2008-2013 CNA dental claims database, the number-one cause of loss is "inadequate precautions to prevent injury." By adopting a culture of safety, dental practices can better integrate risk awareness into routine dental care delivery and decision-making, thus minimizing the likelihood of errors, patient injury and consequent claims.[3]

2 See MacDonald, I. "Hospital Medical Errors Now the Third Leading Cause of Death in the U.S." *FierceHealthcare*, September 20, 2013. Available at **http://www.fiercehealthcare.com/story/hospital-medical-errors-third-leading-cause-death-dispute-to-err-is-human-report/2013-09-20?utm_medium=nl&utm_source=internal** (last accessed 8/2/14).

3 See Ramoni, R.B. et al. "From Good to Better: Toward a Patient Safety Initiative in Dentistry." *Journal of the American Dental Association (JADA)*, September 2012, volume 143:9, pages 956-960. This guest editorial describes four elements of an effective dental patient safety initiative. Available at **http://jada.ada.org/content/143/9/956.full** (last accessed 11/21/14).

From a risk management perspective, patient safety extends well beyond the prevention of therapeutic errors, such as treating the wrong tooth or failing to diagnose a condition or disease. Other risk-prone clinical issues include:

- Scope of practice, including treatment, referral and consultation decisions.
- Compliance with pertinent regulations, such as HIPAA privacy requirements and OSHA's bloodborne pathogen rule.
- Dentist-staff-patient communication.
- Chart documentation.
- Patient education and informed consent.
- Technical proficiency and continuing staff education.

A comprehensive safety culture also applies to non-clinical concerns, ranging from hazardous chemicals, electric shock and falls, to such environmental hazards as severe weather, fire and floods.

The case for instituting a patient safety culture in dental practices is made by James Hupp, DMD, in a recent guest editorial in *JADA*.[4] In his essay, Dr. Hupp describes the beneficial impact that such an approach has had in various high-risk industries, such as automobile manufacture and commercial aviation. He also demonstrates how this philosophy, despite many challenges, is making a difference in hospital settings.[5] Finally, he discusses the importance of fostering a safety culture transformation in dentistry, given the many similarities between hospital and dental practice operations, in terms of such processes as patient histories and examinations, infection control and emergency management.

ADDRESSING HUMAN ERROR

Taking Dr. Hupp's comparison to the aviation industry one step further, a leading aerospace company describes a number of human error causes that directly align with the types of patient safety issues that may occur in a dental practice.[6] Some of the more commonplace lapses that may lead to injuries, conflicts and/or liability exposures are listed below, along with corresponding patient safety/risk management responses:

- **Forgetfulness.** Dentists or staff members may forget essential procedural steps or details, such as informing the patient of certain risks, documenting informed consent discussions, checking new bite-wing radiographs or imparting important post-operative instructions. *(Effective preventive measures include consistently utilizing written informed consent documents, establishing a formal office procedure for reviewing charts/radiographs, and drafting safety checklists for specific procedures and patient management processes.)*
- **Dentist-patient misunderstanding.** Communication breakdowns are prevalent, judging by the number of telephone calls on this subject received by the CNA dental risk management support line (312-822-5541). Dentist-patient communication issues often involve differing interpretations of health or dental history, payment policies or informed consent discussions. *(Minimizing these exposures requires practicing active listening, using the "tell-show-do" technique when describing procedures, asking patients to repeat key messages, providing visual or written resources to reinforce care instructions, and offering patients information about practice policies in written form.)*
- **Improper identification.** Wrong-site or wrong-side surgery is an example of this type of error. Misidentification remains far too common in both medical and dental practice, despite promulgation of The Joint Commission's Universal Protocol, which was designed to prevent such lapses in hospitals and outpatient surgery facilities. *(By adopting the Protocol and involving the patient and the entire dental team in the site/tooth verification process, dentists can significantly minimize the risk of wrong-tooth errors.[7] The fact that many wrong-tooth calls to the dental risk management support line involve referral errors and miscommunication between practitioners underscores the importance of ensuring that all referral letters and related documents are reviewed by another individual before being sent out.)*
- **Employee turnover.** Dentists used to working with committed, longtime staff members often experience a loss of rapport when a new member joins the team, potentially leading to a decline in safety awareness and efficiency. *(Clinical training/mentoring programs, compliance education, and regular review and revision of written policies and procedures are all vital methods of orienting and managing new employees. In addition, ongoing efforts to recognize staff accomplishments and promote two-way communication can help strengthen staff loyalty and enthusiasm, thus reducing turnover.)*
- **Ill-advised shortcuts.** This error frequently involves newly acquired equipment. *(As CNA dental claims data attest, it is imperative to always read and follow manufacturers' instructions.)*
- **Clinical inexperience.** Lack of experience in diagnosing, treating or managing a specific condition or situation can lead to inadvertent error, patient injury and allegations of failure to refer. *(Reducing these exposures involves a commitment to continuing education/mentoring, adherence to clinical guidelines, and honest self-assessment of skills and competency.)*

4 Hupp, J.R. "Creating a Culture of Safety." *JADA*, April 2014, volume 145:4, pages 321-326. Available at **http://jada.ada.org/content/145/4/321.full** (last accessed 11/21/14).

5 See also "Does Improving Safety Culture Affect Patient Outcomes?" London: The Health Foundation, November 2011. Available at **www.health.org.uk/public/cms/75/76/313/3078/Doespercent20improving percent20safetypercent-20culturepercent20affectpercent20outcomes.pdf?realName=fsu8Va.pdf** (last accessed 11/21/14).

6 See the descriptions and examples of aviation-related error types posted by Kidde Aerospace and Defense, at **http://utcaerospacesystems.com/sites/kiddeaerospace/Documents/ItoU_HumanErrors.pdf** (last accessed 11/21/14).

7 See the online Safety Net Dental Clinic Manual at **http://www.dentalclinicmanual.com/chapt4/1_6.html** for guidance in applying the Universal Protocol concept of team time-outs to dentistry (last accessed 11/21/14).

- **Noncompliance.** Standards abound in dentistry and healthcare generally, in the form of regulations, clinical guidelines and state dental practice acts, as well as dental professional association recommendations. Unfortunately, dental claim scenarios and risk management phone support calls often reveal an incomplete knowledge of and/or adherence to these standards on the part of dentists and staff. *(The key to enhancing compliance is regular review of and annual training on applicable laws/regulations [e.g., HIPAA and OSHA requirements], as well as statutes governing delegation and scope of practice. In addition, regular review and updating of clinical guidelines and office protocols can help improve awareness and implementation of rules and standards.)*
- **Technical glitches.** The aerospace industry and other high-tech fields are vulnerable to equipment malfunctions or suboptimal system performance. This type of risk is highly relevant to dentistry, especially as the profession continues to evolve in the direction of greater technological sophistication. *(Minimizing equipment and system lapses requires a commitment to regular, documented maintenance, as well as proper training, reliable data backup capability and expert technical support.)*

TOWARD A 'JUST CULTURE'

"Just culture" is another key to successful development and implementation of a safety-centered practice.[8] The concept, which became popular in the medical world following publication of a 2001 report,[9] refers to the cultivation of positive, humane values that support an open, fair and learning-oriented workplace, where individuals are encouraged to question substandard practices and ask for assistance when in doubt. Achieving a just culture requires the fostering of accountability on the part of both the institutions that implement systems and processes, and the individuals who make choices within those systems.

A just culture recognizes that while human beings are fallible, they are also capable of learning from experience, making better choices and rectifying bad habits, if they are not prevented by fear of condemnation and punishment from engaging in objective self-examination. When individuals feel comfortable disclosing and discussing their own lapses and those of others, it becomes possible to correct problems via systems analysis, process improvements, education and behavior coaching.

However, a just culture does not condone reckless behavior, gross misconduct, or decisions that reflect a disregard for patient safety or ethical standards. Examples of such indefensible behavior would be working while impaired or falsifying clinical records.

Changing the culture of an organization is a significant challenge that requires dedicated leadership, tenacity and understanding. It involves acknowledging that no practice is perfect, and that adverse events must be recognized, tracked and analyzed as a precondition for learning and improvement. As Dr. Michael Glick, editor of *JADA*, rightly observes, the pursuit of truth begins with the realization that all knowledge is incomplete.[10] Developing a patient safety culture requires a willingness to consider the possible limits of one's own awareness and to examine not just the patient, but also office policies, practices and systems. In this way, dentists can meet the challenge of serving their patients in a safe and supportive environment, thus maximizing the benefits of dental care while minimizing the attendant risks.

RESOURCES

The following publications and tools offer additional direction and assistance for dentists seeking to foster a proactive culture of safe dentistry. These resources address a variety of healthcare settings, but all can be adapted to the dental practice environment:

- AHRQ Patient Safety Network (PSNet), at **http://www.psnet.ahrq.gov/about.aspx** (last accessed 11/21/14). (AHRQ PSNet is a national web-based resource devoted to minimizing healthcare errors.)
- American Academy of Pediatric Dentistry (AAPD) Council on Clinical Affairs. "Policy on Patient Safety," revised 2013. Available at **http://www.aapd.org/media/Policies_Guidelines/P_PatientSafety.pdf** (last accessed 11/21/14).
- American Dental Association (ADA) PatientSmart service, at **http://www.ada.org/en/publications/ada-catalog/patient-smart** (last accessed 11/21/14). (This library of ADA dental patient education content in English and Spanish is designed to enhance practice websites. It is available for a monthly fee.)
- HealthIT.gov's SAFER Guides, at **http://www.healthit.gov/safer/** (last accessed 11/21/14). (SAFER Guides, from the Office of the National Coordinator for Health Information Technology, address electronic health record safety issues. The self-assessment tools can be reviewed online or downloaded.)
- The Joint Commission Patient Safety site, at **http://www.jointcommission.org/topics/patient_safety.aspx** (last accessed 11/21/14). (The site includes information on a number of safety-focused initiatives. Although primarily geared to the medical environment, the site includes resources and tools applicable to dentists, such as the "Do Not Use" list of medical abbreviations at **http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf**, and *Improving Patient and Worker Safety*, a comprehensive study available at **http://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf**.)

8 A brief, informative video from the Agency for Healthcare Research and Quality (AHRQ), titled "Apply CUSP: Understand Just Culture," is available at **http://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/videos/07a_just_culture/index.html** (last accessed 11/21/14).

9 Marx, D. "Patient Safety and the 'Just Culture': A Primer for Health Care Executives." April 2001. Available at **http://www.safer.healthcare.ucla.edu/safer/archive/ahrq/FinalPrimerDoc.pdf** (last accessed 11/21/14).

10 Dr. Glick's essay, "An Affirmation of Fallibility," is in *JADA*, volume 136, October 2005, page 1356. The essay is free to ADA members and available to non-members for a fee at **http://jada.ada.org/content/136/10/1356.full** (last accessed 11/21/14).

- Kalenderian, E. et al. "An Adverse Event Trigger Tool in Dentistry: A New Methodology for Measuring Harm in the Dental Office." *JADA*, July 2013, volume 144:7, pages 808-814. The article is free to ADA members and available to non-members for a fee at **http://jada.ada.org/content/144/7/808** (last accessed 11/21/14). (The article describes the design and use of a "trigger tool" to help dental practices effectively and proactively monitor safety issues and adverse events.)
- Stewart, D. "Patient Safety: Where Are We and Where Do We Want to Go?" This slide presentation from Oregon Health and Science University is available at **http://www.adea.org/uploadedFiles/ADEA/Content_Conversion/events/past_events/BFACA/2013_BFACA/2013_BFACA_STEWART.pdf** (last accessed 11/21/14).
- Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®), at **http://www.teamsteppsportal.org/** or **http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html** (last accessed 11/21/14). (This program provides evidence-based tools designed to strengthen communication and teamwork in any healthcare setting. The TeamSTEPPS dental module videos are available at **http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/dental/index.html**.)

LOOKING FOR ADDITIONAL RISK MANAGEMENT INFORMATION?

Visit the Professional Protector Plan® for Dentists program website at **www.protectorplan.com** for additional resources. The site's Risk Management tab contains links to information about both our in-person CE seminars and our online self-study CE course.

Dental Risk Management Seminars

Dentists can obtain risk management information by attending any of the risk management seminars listed below, or by completing the CNA online self-study CE course (see above). For more information about our in-person seminars, please contact the nearest Professional Protector Plan state administrator agent.

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- **May 1, 2015** Boise, ID
- **May 1, 2015** Phoenix, AZ
- **May 2, 2015** Phoenix, AZ
- **May 8, 2015** Las Vegas, NV
- **May 15, 2015** Sioux Falls, SD
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