Patient safety Stateside

Major Tim Fildes* shares his experience of the patient safety initiatives used with great success among US dental teams.

Adverse occurrences

Most of our patients feel a little vulnerable when we ask them to lie back and open wide. Is it from fear of the unexpected or is it from a more educated fear, fuelled by information found on the Internet? As dental professionals we are highly skilled people and the vast majority of the procedures that we carry out pass without any adverse occurrence, whatever the anxieties of the patient in the chair. But like any medical procedure, things can go wrong and sadly sometimes do. Allegations of professional negligence are very embarrassing and can cause serious damage to reputations, businesses and livelihoods. Such incidents are thought to occur due to a syndrome of causes such as individual error, poor equipment design, unclear labelling, lack of training and sub-optimal working practices.

It is for these reasons that the patient safety movement began as an initiative within healthcare to emphasise the reporting, analysis and prevention of medical errors and adverse healthcare events.

For the last two years I have been working in the USA as the British Army Dental Exchange Officer to the United States Army Dental Command. The command is based in Texas and is currently the world's largest corporate dental body. Part of my job is to be involved with their Dental Patient Safety programme which is showcased at conferences with a promotional booth using the slogan 'A Full Time Commitment, Not A Part Time Practice'.

Error prevention as a team

The overall aim of any dental patient safety programme should be the prevention of the full spectrum of dental errors, from the treatment of the wrong tooth to serious adverse events such as death. This ultimately

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resides with the dental professional who provides the treatment; however, prevention is also the shared responsibility of the entire dental team. One of the most interesting aspects of the programme here is how to use the whole dental team to decrease the number of dental patient safety errors. Our main focus is on the various aspects and practice of robust teamwork because it has been found that 60% of dental errors occur due to a lack of communication within the team.

How the team is managed by its leader, how the team members interact with each other and the amount of support they receive is also a vital component to the successful prevention of dental errors.

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'No blame' culture

Despite an increasing emphasis on evidence-based dentistry in the UK and the United States, data on the true number of adverse outcomes can still be hard to come by as some studies only collate anecdotal events. To overcome this problem our programme promotes a culture of 'No Blame' which encourages all personnel to report full details of all errors anonymously. This way we can collate live, accurate data on events and, where appropriate, act upon these lessons learnt by taking action on the system rather than the individual so as to prevent recurrences of a similar nature in other locations. The problem with reporting systems is that they are cumbersome and take too much time out of our busy days to use and this is seen as the main block to gathering data on events. For ease of use we have designed an online reporting system that allows providers to anonymously submit error reports on a wide range of events, as and when they occur. These data are then tracked and analysed to monitor any trends within the entire command.

Of course no patient safety programme is complete without its promotional campaigns. We have tried to be responsible and proactive in our initiatives whilst being sensitive to the needs and requirements of the dental team. Firstly we encourage the blanket use of a 'time out' procedure which has had a major effect in preventing wrong site treatments by simply encouraging teams to take the time out to check the patient's full name and date of birth when they arrive at the clinic and again as they are seated in the dental chair. This simple procedure has been most effective in reducing the number of wrong patients and teeth treated and, due to its ease of use, is ideal for practices that have a high turnover of patients throughout the day. We highlight the use of this initiative by displaying 'time out' posters throughout the centres and this also has the added benefits of bringing the patient into the team and emphasising the requirement for good communication.

Team training

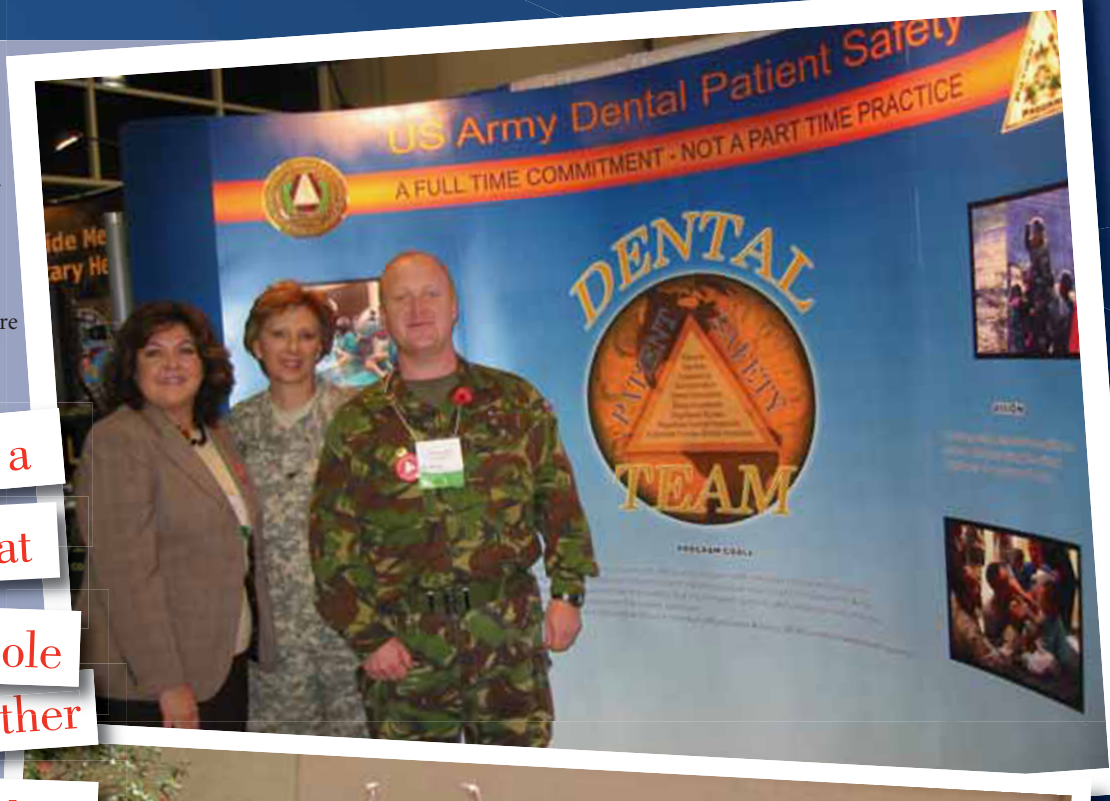
Secondly we have addressed the importance of the role of the entire dental team in the prevention of errors by providing training in an evidence-based teamwork training system called TeamSTEPPS™ (Team Strategies and Tools to Enhance Performance and Patient Safety). We are currently having a lot of success with this teamwork system which is aimed at optimising patient outcomes by improving communication and other teamwork skills amongst dental professionals. It has been very popular with the dental practices that we have trained as it is based on inherent and easily integrated teamwork principles such as communication, leadership, mutual support and situation monitoring which are quick and easy to use and don't impact on patient treatment. The training is systematic and is spread over three phases: 1) Assessment; 2) Planning, Training and Implementation; and 3) Sustainment. The assessment phase is designed to be a two-way process and initially requires the practice themselves to recognise that there is a need; then they are visited to assess their suitability for this training. At this stage the practice is reminded that TeamSTEPPS™ optimises outcomes, improves communication and teamwork skills but does not solve internal HR issues.

Action plan

The second phase recommends that two important selections are made: a practice champion who will act as a team motivator plus a 'change team'. This phase is dependent on the size of the practice and whether or not the practice is part of a chain or group system. If the practice is small and so only has a few staff then the entire team is trained; if it is large or part of a group system then training is given to the change team, which should represent as broad a cross-section of the personnel as possible.

'Sixty per cent of dental errors occur due to a lack of communication within the team.'

With the aid of a small team of master trainers this change team then receives training, which ideally takes place over one and a half days, and is responsible for developing a detailed action plan. This action plan is taken back to the practice and then followed to ensure the full implementation of the systems methods and principles.



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We have found that some of the most popular methods to use have been the team huddle and the 2-challenge rule. Team huddle is a simple method that encourages the whole team to come together at the start of the day to discuss what lies ahead and if there are any potential pitfalls to be aware of. The 2-challenge rule is designed to empower the chairside assistant, especially the inexperienced or newly qualified, to speak out in a structured and non-confrontational manner if they feel that a patient safety error is about to happen. Lastly the sustainment phase is there to ensure that these new teamwork tools and behaviours have been implanted into daily practice and also monitors the ongoing effectiveness of the training to identify opportunities for continued improvement.

Top: Army patient safety booth to promote patient safety

Above: Tim and his team

Left: Timeout poster displayed in all US army dental centres

A shared goal to achieve excellence

Of course there is no panacea for patient safety as it is impossible to remove all the risks associated with the practice of dentistry, especially unpredictable ones. At best reporting and other initiatives can only act as an adjunct to the prevention of dental errors and cannot substitute good leadership, the acceptance of personal responsibility and a shared goal to achieve excellence each and every day.