PATIENT SAFETY MANUAL

SRI VENKATESWARA DENTAL COLLEGE AND HOSPITAL

Thalambur, Chennai

Certified

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PREFACE

PATIENT SAFETY:

"A discipline in the health-care sector that applies safety science methods towards the goal of achieving a trustworthy system of health-care delivery. Patient safety is also an attribute of health-care systems; it minimizes the incidence and impact of, and maximizes recovery from adverse events"

Why do dental students need to learn about patient safety?

The scientific discoveries of modern health care have led to markedly improved patient outcomes. However, studies conducted in many different countries have shown that significant risks to patient safety have accompanied these benefits.

A major consequence of this knowledge has been the development of patient safety as a specialized discipline.

Patient safety is not a traditional stand-alone discipline; rather, it is one that can and should be integrated into all areas of health care.

Students need to know about patient safety, including how systems impact on the quality and safety of health care and how poor communication can lead to adverse events

Students need to be ready to practise patient safety skills and behaviours as soon as they enter a hospital, clinic or patient's home.

Students also need the opportunity, whenever possible, to consider safety issues in a simulated environment prior to actual practice in the real world.

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MAIN GUIDELINES IN PATIENT SAFETY

- Develop relationships with patients
- Act ethically every day
- Practise evidence-based care
- Maintain continuity of care for patients
- Avoid blaming when an error occurs
- Be aware of the importance of self-care
- Recognize the role of patient safety in the delivery of safe health care

How to teach patient safety:

- Problem-based teaching (facilitated group learning)
- Simulation-based learning (role play and games)
- Lecture-based teaching (interactive/didactic)
- Mentoring and coaching (role models)

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PATIENT SAFETY ASPECTS IN DENTAL COLLEGE

Healthcare Systems to Prioritize Patient Safety

Patient safety in any branch of medicine has to start with the healthcare system as a whole. Medical practitioners should make the safety of patients a goal as they go about their business. They need to be keen on medical procedures so as to prevent any injuries. Members of a dental team should also make it their responsibility to report errors and accidents and discuss it amongst themselves when they hold staff meetings.

Dentists to Focus on Clinical Records

The clinical records should include assessing the patient's medical history before treatment. It is also important that clinical records showing allergies, pathologies and medication be updated regularly. All these measures aim at helping the dentist to treat the patient without making any unnecessary errors. Dentists can use touchless patient identification solutions to ensure that they are using the correct medical records – enhancing patient safety.

Avoid Reuse of Tools and Packaging Material Meant for Treatment Only

One of the main causes of errors in dentistry is the reuse of containers to package other materials. It brings about a lot of confusion as the dental care providers may end up giving the wrong treatment. If a particular material is to be disposed after use, dentists should ensure that it is done. If reused, these disposable materials may spread infections among patients. Containers should not be reused because they have fewer preservatives and could infect the areas where they kept.

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Be Cautious When Prescribing Medication

Giving the wrong prescription in dentistry is something that occurs often. Medical experts in this field, however, can take measures to ensure cases like this are eliminated. One way is letting the patient know about the prescription. Give the details: when to take, number of injections, duration and tell the patient the importance of following the doctor's advice.

The dentist should also look at the patient's medical history before making any prescriptions. Keenness on the doses given is also crucial. Talking to their patients and recording their reaction to medication is also equally vital.

Readiness for Emergencies

Emergency cases in dentistry are few but when they happen when the dental team is not prepared. It can be a painful experience for the patient. The goal here is for members of the dental team to be ready with treatment, and know their roles once they are informed that they need to attend to an emergency situation. During this situation, dentists should keep close to the patients and accompany them in the event that they are transferred to another medical facility.

Many of the adverse events happening in dental care are as a result of a few mistakes. These basic procedures will help significantly reduce their occurrence.

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Use of checklist in surgical procedures

- Although surgical procedures in dentistry are limited in terms of importance, it is clear that they pose risk exacerbation usually present in dental treatments.
- As currently done in surgical procedures at a hospital, the use of a checklist is a valuable tool to avoid most adverse events during oral surgery.
- A checklist helps prevent an erroneous intervention or an intervention being performed in the wrong area, among other risks
- Errors in treatment planning (sometimes associated with lack of adequate clinical records previous to treatment)
- Errors in the type of procedure performed (motivated by incorrect patient identification or inadequate clinical history)
- Errors in the area of intervention (Wrong-site surgery) that occur as a result of forgetfulness or the inappropriate interpretation of records by the professional
- Errors in pre-operative prophylaxis in medically compromised patients
- Errors in the monitoring and control of operated patients (no post-operative instruction sheet or lack of post-surgical control)Post-surgical infections (detected late or inadequately treated).

Limit the exposure of patients to ionizing radiation only to what is strictly necessary

- To reduce patient exposure to radiation the following may be done:
- Restrict patient exposure to ionizing radiation only to what is strictly necessary. Avoid the systematic use of radiographs without clinical suspicion of pathology. These restrictions should be tighter in the case of children.
- Protect from ionizing radiation anatomic areas that are not under study, using barriers. This is especially recommended in the cervical area.

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- Always be aware of a possible pregnancy among patients or staff potentially exposed to ionizing radiation.
- Prevent accidental exposure of patients or caregivers to ionizing radiation. Use visual alerts such as posters or lights that indicate the performance of radiographic tests,etc.
- Choose diagnostic systems that emit a minimal amount of ionizing radiation.

Protect the patient's body and eyes during dental procedures:

- Patients can be protected using appropriate aprons and other materials during the procedure
- Patient's ocular protection with goggles, similar to those we use, is one of the easiest and most effective patient safety measures.

Establish barriers to prevent ingestion or inhalation of materials or small instruments

- Ingestion or inhalation of materials or small dental instruments is a “classic” accident during dental care performed without the use of appropriate barriers, rubber dams, or “threads,” ensuring that small tools (such as implant screwdrivers) are not ingested or inhaled.
- The vast majority of ingestion or inhalation accidents usually have no clinical effect, but swallowed sharp instruments may need to be removed by gastroscopy.
- Few inhalation cases may require performing a bronchoscopy.

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Monitor the onset and progression of infection in the oral cavity:

Although most infectious diseases in the oral cavity are usually self-limiting, in exceptional cases (and especially in medically compromised patients), they may endanger the patient's life.

Accidents

• The patient falls (due to poorly organized furniture, architectural barriers, slippery floors, etc.)

• Heavy or sharp instruments or apparatus fall on the patient

• The patient suffers accidental cuts and burns

• The patient ingests/inhales small dental material

• The patient suffers eye damage

PROPOSED FUTURE DIRECTIONS

MULTI LAYERED SYSTEM TO ENSURE PATIENT SAFETY

There should be a multi layered system to ensure that errors in patient management are promptly diagnosed and prevented from causing harm to the patient. This is also known as the Swiss Cheese Model. A series of barriers are placed in the system to identify and prevent patient hazards. Our institution is currently developing such a model system.

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GLOSSARY

The WHO Conceptual Framework for the International Classification for Patient Safety (v.1.1).

Final Technical Report 2009

1. Adverse reaction: unexpected harm resulting from a justified action where the correct process was followed for the context in which the event occurred.

2. Agent: a substance, object or system which acts to produce change.

3. Attributes: qualities, properties or features of someone or something.

4. Circumstance: a situation or factor that may influence an event, agent or person(s).

5. Class: a group or set of like things.

6. Classification: an arrangement of concepts into classes and their subdivisions, linked so as to express the semantic relationships between them.

7. Concept: a bearer or embodiment of meaning.

8. Contributing factor: a circumstance, action or influence that is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.

9. Degree of harm: the severity and duration of harm, and any treatment implications, that result from an incident.

10. Detection: an action or circumstance that results in the discovery of an incident.

11. Disability: any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with past or present harm.

12. Disease: a physiological or psychological dysfunction.

13. Error: failure to carry out a planned action as intended or application of an incorrect plan.

14. Event: something that happens to or involves a patient.

15. Harm: impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes disease, injury, suffering, disability and death.

16. Harmful incident (adverse event): an incident that resulted in harm to a patient.

17. Hazard: a circumstance, agent or action with the potential to cause harm.

18. Health: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

19. Health care: services received by individuals or communities to promote, maintain, monitor or restore health.

20. Health care-associated harm: harm arising from or associated with plans or actions taken during the provision of health care, rather than an underlying disease or injury.

21. Incident characteristics: selected attributes of an incident.

22. Incident type: a descriptive term for a category made up of incidents of a common nature, grouped because of shared, agreed features.

23. Injury: damage to tissues caused by an agent or event.

24. Mitigating factor: an action or circumstance that prevents or moderates the progression of an incident towards harming a patient.

25. Near miss: an incident that did not reach the patient.

26. No harm incident: an incident that reached a patient, but no discernable harm resulted.

27. Patient: a person who is a recipient of health care.

28. Patient characteristics: selected attributes of a patient.

29. Patient outcome: the impact upon a patient that is wholly or partially attributable to an incident.

30. Patient safety: the reduction of risk of unnecessary harm associated with health care to an acceptable minimum.

31. Patient safety incident: an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient.

32. Preventable: accepted by the community as avoidable in the particular set of circumstances.

33. Reportable circumstance: a situation in which there was significant potential for harm, but no incident occurred.

34. Risk: the probability that an incident will occur.

35. Safety: the reduction of risk of unnecessary harm to an acceptable minimum.

36. Semantic relationship: the way in which things (such as classes or concepts) are associated with each other on the basis of their meaning.

37. Side-effect: a known effect, other than that primarily intended, related to the pharmacological properties of a medication.

38. Suffering: the experience of anything subjectively unpleasant.

39. Violation: deliberate deviation from an operating procedure, standard or rule.

Source: WHO conceptual framework for the international classification for patient safety. Geneva, World Health Organization, 2009 (http://www.who.int/patientsafety/en/; accessed 11 March 2011).

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