Quality Improvement: Fostering a Culture of Safety

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Disclosure

Neither I nor members of my immediate family have any financial relationships with commercial entities that may be relevant to this presentation.

Objectives

1. Define culture of safety
2. Discuss six key components of a culture of safety
3. Define Root Cause Analysis
4. Demonstrate the application of RCA in dental practice to improve infection control compliance
5.

Definition: Culture of Safety

Definition (CDC)
- The shared commitment of management and employees to ensure the safety of the work environment

Focus is on systems being improved (not individuals)

Characteristics of culture of safety

- Global village concept: It is everyone’s responsibility
- Safe to report an incident
- Safety needs to be a priority

An oral healthcare instrument that is VALIDATED

- Instrument for assessing the quality of safety in the dental setting
- At https://oralhealthquality.wordpress.com/

Key Components of a Culture of Safety

1. Assess the Culture
2. Teamwork
3. Patient Involvement
4. Systems
5. Openness/Transparency
6. Accountability

Root Cause Analysis: Definition
Root cause analysis (RCA) is a class of problem solving methods aimed at identifying the root causes of problems or events.

The primary aim of RCA is to identify the root cause(s) of a problem in order to create effective corrective actions that will prevent that problem from ever recurring.

**Root Cause Analysis**
- What happened?
- Why did it happen?
- What to do to prevent it from happening again?

**Process to Action**

**Root Cause Analysis: Techniques**
- Causal factor tree analysis
- Change analysis
- Fault tree analysis
- Fishbone diagram
- Pareto analysis
- Scatter diagram

**Develop the question**
- Question: How can the University of Manitoba Dental School improve compliance with disinfection of laboratory cases?

**Plot the major components**

**Define specific areas to assess**

**Collaboration?**
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**Prioritize resources?**
- Dedicated lab support
  - Inspection of incoming lab cases for decontamination
  - Students by-passing protocol

**Teamwork**
- Cross-training
  1. Inspections
- Communications
Cross-training

- Defined role for each team member
- Clear job descriptions
- All team members know each other's role and back each other up
- Team members understand processes and protocols; identify gaps
- Communication protocols established

Inspections

- Instructors
- Lab support
- Who is responsible?

Communication

- Regular Department meetings
- Central Administration meetings
- Reporting of Breaches
- Sanctions
- What is the Organizational map?

Organizational chart

Administration of IPC

Summary for Teamwork

- Everyone involved?
  - System is developed?
  - Evidence of Training?

Protocols

- Curriculum support?
Adequate instructions in Student Manuals?

Adequate instructions in the Faculty IPC Manual?

Check-lists/questions that this has been done from Clinical Instructors

24 Accountability
   Individual
   ➢ Every member of the team is responsible for maintaining safety
   ➢ Is there evaluation of safety performance in annual reviews?

   Organization
   ➢ Process organizational self-evaluation
   ➢ Key indicators are developed, evaluated, and communicated within the organization
   ➢ Established orientation for new faculty, students and staff
   ➢ Patient safety is part of the annual evaluation, process
   ➢ Is there established retraining protocols?

25 Openness or transparency
   ➢ Is there a method for reporting problems?
   ➢ Is the reporting protocol widely known?
   ➢ Is there documentation of adverse events or breaches in compliance?
   ➢ Fairness: Are Remediation/Sanctions fair and equitable?

26 Where are the gaps?
27 STRATEGIES to improve gap:
   ✓ Curriculum updates: role model disinfection of lab cases in pre-clinical labs
   ✓ Lab manual updates: instructions
   ✓ Consistent checking of clinical cases involving laboratory procedures
   ✓ Resources: Ensure that disinfectant is available in all labs
   ✓ Develop a protocol check-list
✓ Administrative support for lack of compliance
✓ Professionalism document
✓ Annual organizational evaluation of patient safety

Key take-aways

Definition of a “Culture of Safety”

Assessment tool for dental practices

Applied a Root cause analysis (RCA) tool to discover causes and strategies for weakness in compliance with ONE issue of Infection prevention and control

THANK YOU for allowing us to share this with you!