DEVELOPING A CULTURE OF SAFETY WITHIN THE ROYAL CANADIAN DENTAL CORPS

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WHO ARE WE?

Chief Quality and Patient Safety Officer
Directorate of Health Services Delivery
CF Health Services Group Headquarters
Department of National Defence
Government of Canada

Director Dental Services - Policy and Programs
Directorate of Dental Services
CF Health Services Group Headquarters
Department of National Defence
Government of Canada
OUR OBJECTIVES

• To share our approach and lessons learned while integrating quality improvement and patient safety into the Royal Canadian Dental Corps (RCDC)

• To share our strategies and ideas that have supported our ongoing efforts to improve care delivery and bring patient safety to the forefront within the Canadian Forces Dental Services

• To provide insight in how these activities which support a strong culture of patient safety awareness in dentistry is changing the way our dental professionals approach their clinical practices
Royal Canadian Dental Corps

- Dental services of the Canadian Forces Health Services (CFHS)
- 10 Dental Corps capabilities
- Corporatized model
- Regulated dental care delivery
A Few Facts...

• 26 dental clinics including six dental regional specialty centers

Our people

• general dentists
  & dental specialists
• hygienists
• assistants
• receptionists & financial admin staff
RCDC Patient Safety History

• CFHS had a patient safety program since 2005
• Dental was not engaged in the program at that time
• Majority of safety activities were focused on infection control practices
• If there was an incident and a patient was harmed, it was reported.... but not afforded the patient safety process
Our Approach

• Communicated intent
• People
  – Regional Quality and Patient Safety Advisors
  – Patient Safety Officers
• Policies, instructions, forms....
• Powerpoint slides, briefings, emails
• Education plan
CULTURE EATS STRATEGY FOR BREAKFAST

~Peter Drucker
“Shared values (what is important) and beliefs (how things work) that interact with an organization’s structures control systems to produce behavioural norms (the way things are done)”

B. Uttal “The corporate culture vultures” * Fortune 1983
**Why Safety Culture?**

**Chart 2-1**

Estimated Deaths Associated with Medical Mistakes Compared to the Leading Causes of Death in the U.S.

<table>
<thead>
<tr>
<th>Cause</th>
<th>Deaths in 1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart diseases</td>
<td>726,974</td>
</tr>
<tr>
<td>Cancers</td>
<td>539,577</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td>159,791</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>109,029</td>
</tr>
<tr>
<td>Medical mistakes (IOM high estimate)</td>
<td>98,000</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>95,644</td>
</tr>
<tr>
<td>Pneumonia and influenza</td>
<td>86,449</td>
</tr>
<tr>
<td>Diabetes</td>
<td>62,636</td>
</tr>
<tr>
<td>Medical mistakes (IOM low estimate)</td>
<td>44,000</td>
</tr>
<tr>
<td>Suicide</td>
<td>30,535</td>
</tr>
<tr>
<td>Nephritis and related</td>
<td>25,331</td>
</tr>
</tbody>
</table>

Sources: IOM 2000; Kranarow et al. 1999 (deaths).
Why Patient Safety?

• Old acceptance of error no longer tolerable

• Error not seen as inevitable – widespread and preventable

• National and international priority
Attitude towards Safety

Most airline pilots believe they make mistakes, so work and equipment are designed to lessen their effects. In healthcare, only 30% of providers believe they make mistakes.

IHI Online Learning Program Module, Q101, 2010
Importance of Culture in Healthcare

**Improvement in patient safety outcomes require a change in healthcare culture**

“The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm”

*Crossing the Quality Chasm 2001, p.79*
Patient Safety Culture

• We make, and will make errors
• Acknowledgment of the high-risk, error-prone nature of an organization’s activities
• We must know about errors and near misses if we are to correct them
• A “blame-free” environment where individuals are able to report errors or close calls without fear of punishment
• Safety is everyone’s concern from the practice owner to dental assistants to patients
• An expectation of collaboration across ranks to seek solutions to vulnerabilities
• Safety requires commitment and resources to improve
Key Features of a Positive Culture of Patient Safety

• Acknowledgment of the high-risk nature of activities and determination to achieve consistently safe operations;

• 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.”

The Evolution of Safety Cultures

OUR JOURNEY...
Assessing the Culture of Safety

• Raise staff awareness about patient safety
• Diagnose and assess the current status of patient safety culture
• Identify strengths and areas for patient safety culture improvement
• Examine trends in patient safety culture change over time
• Evaluate the cultural impact of patient safety initiatives and interventions
• Conduct internal and external comparisons
Patient Safety Culture Tool

- Accreditation Canada – Canadian Healthcare Accrediting body
  - Administered on a regular basis as part of the accreditation process

- Efficient way of measuring perceptual indicators of the organization’s culture

- Benchmarking and comparison
The Patient Safety Culture Tool

- Administered in Fall 2012

- 387 responses from all staff (military, civilian, contractors) within the dental services (>70%)
  - Dentists
  - Hygienists
  - Assistants
  - Administration
Patient Safety Culture Survey Questions (Hand Out)

Overall perceptions of patient safety
- Please give your unit an overall grade on patient safety.
- Please give your organization an overall grade on patient safety.

Senior leadership support for safety
- Senior management has a clear picture of the risk associated with patient care.
- Good communication flow exists up the chain of command regarding patient safety issues.
- Patient safety decisions are made at the proper level by the most qualified people.
- Senior management provides a climate that promotes patient safety.
- Senior management considers patient safety when program changes are discussed.
- My organization effectively balances the need for patient safety and the need for productivity.
- I work in an environment where patient safety is a high priority.

Learning Culture
- On this unit, when a serious error occurs, we think about it carefully.
- On this unit, when people make a serious error, they ask others about how they could have prevented it.
- On this unit, after a serious error has occurred, we think about how it came about and how to prevent the same mistake in the future.
- On this unit, when a serious error occurs, we analyze it thoroughly.
- On this unit, it is difficult to discuss errors.
- On this unit, after a serious error has occurred, we think long and hard about how to correct it.

Supervisory leadership for safety
- I am rewarded for taking quick action to identify a serious error.
- My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
- My supervisor/manager seriously considers staff suggestions for improving patient safety.
- Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.
- My supervisor/manager overlooks patient safety problems that happen over and over.

Talking about errors / Communication barriers
- If I make a serious error I worry that I will face disciplinary action from the college.
- When an incident is reported, it seems like the person is being written up, not the problem.
- I would feel ashamed if I made a serious error and my co-workers heard about it.
- There is no point in talking about a patient safety problem because nothing usually gets done about it.
- My co-workers will think I am incompetent if they know I’ve made a serious error.
- If I make a serious error my manager will think I am incompetent.
- On my unit, staff who report a co-worker’s error are labelled as ‘not being a team player’.
- My co-workers would support me if they learned of a serious error I made.
- On this unit it is difficult to speak up if you feel there is a problem related to patient safety.
- My co-workers will lose respect for me if they know I’ve made a serious error.
- If I report a patient safety incident, someone usually follows up to get more information from me.
- Making a serious error may cause a staff member to lose his/her job.
- On this unit it is difficult to question the decisions or actions of those with more authority.
- If I point out a potentially serious patient safety incident, management will look into it.
- Others make you feel like a bit of a failure when you make an error.
- Staff are usually given feedback about changes put into place based on incident reports.
- If I make a serious error I worry that I will face disciplinary action from management.
- Making a serious error would limit my career opportunities around here.
- If I made a serious error my manager would be supportive.
- Individuals involved in patient safety incidents have a quick and easy way to report what happened.
The Results...

Patient Safety Culture Tool Results - Percentages of responses by themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>% of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall perception of patient safety</td>
<td>Positive Response: 90%</td>
</tr>
<tr>
<td>Senior leadership support for safety</td>
<td>Positive Response: 80%</td>
</tr>
<tr>
<td>Learning culture</td>
<td>Positive Response: 60%</td>
</tr>
<tr>
<td>Supervisory leadership for safety</td>
<td>Positive Response: 80%</td>
</tr>
<tr>
<td>Talking about errors</td>
<td>Positive Response: 70%</td>
</tr>
</tbody>
</table>

Themes: Positive Response, Neutral Response, Negative Response
What did the survey tell us?

• The overall intent and vision for patient safety was well communicated by the leadership and understood
• But... this strategy was not enough

Three key areas:
• Supervisors do not always create an environment that is conducive to supporting patient safety
• Staff feel they cannot report or discuss patient safety incidents without reprisal
• The organization needs to take the opportunity to learn from these events
What can you do?

• Administering a survey may not be practical for you and your dental team

• Ask your team questions about their perception of the work environment
  – Use questions from surveys as discussion points
Following the Assessment...

• You will not be able to change the culture of your workplace overnight

• Culture change takes leadership, commitment, and time

• It is a complex change that needs to be managed; it will likely not be easy
Managing Complex Change

Case for Change → Vision → Skills → Incentives → Resources → Action Plan → Change Success

Vision → Skills → Incentives → Resources → Action Plan → Status Quo

Case for Change → Vision → Incentives → Resources → Action Plan → Confusion

Case for Change → Vision → Skills → Incentives → Resources → Action Plan → Anxiety

Case for Change → Vision → Skills → Incentives → Action Plan → Gradual Change

Case for Change → Vision → Skills → Incentives → Action Plan → Frustration

Case for Change → Vision → Skills → Incentives → Resources → False Starts
To Effect Change

• Case for change
• Vision
• Skills
• Incentives
• Resources
• Action Plan
Action Plan

• Implement the Patient Safety Program within the Dental Services

• Create the Patient Safety Officer (PSO) role

• Patient safety education and training to the clinics & PSOs

• Share lessons learned

• Participate in Canadian Patient Safety Week
  – 26-30 October 2015
Lead by Example

- Senior leadership encouraged management to openly discuss errors and mistakes with a view to preventing harm to patients

- Discouraged the natural reaction to find fault in someone
As the patient safety program develops we are experiencing successes that are very encouraging for us all but, along with those often come growing pains.

We recently encountered a situation where we experienced those growing pains and we wanted to be open with you, our stakeholders, and acknowledge this. A Patient Safety Incident was reported and, as part of the intended process, a meeting was set up to discuss the way forward with communicating the incident to the patient. Unfortunately, due to a series of miscommunications the conversation took an unintended direction, and we did not have the safe and open dialogue that we had hoped for. Although this did not have a significant impact on any parties involved, it likely set back the important progress that we are making towards systems improvement and developing a strong patient safety culture. We immediately were aware that we were not on the right track, and appreciated the feedback from those involved. As a result, we re-evaluated that step in the process to ensure the best possible outcomes in all future analyses and associated processes. This situation gave us the opportunity to look at the problem and develop an improved plan to move forward. We are committed to developing the roles and responsibilities within our patient safety program, exploring when it is best to involve others in the process, and striving for continuous improvement.

We are learning and we have plenty more work to do but will not fully succeed without your involvement. Your feedback and participation is important. Please contact us at any time. [insert contact]

“To Err is Human”, so let us all learn from our mistakes to make patient care safer.
Every day...

- People do unsafe things
  - Distracted, in a hurry

- Patterns of error that occur in healthcare are no different from those occurring in any other setting
Systems Thinking

• Most errors cannot be linked to the performance of an individual
• Recognize that most patient harm is caused by bad systems...not bad people
• People never make errors intentionally

Need to design systems that intercept errors before they can cause harm to the patient
NASA Example
Normalizing Deviance

• Little problems that crop up in daily routine become so familiar that staff start assuming they are normal
• When we see things go wrong – we ignore them
• When accidents do not occur, the belief is safety has not been compromised
• Small problems are not just obstacles to overcome, but are actually weak signals that the system is not working as it should
• Identify and discuss these small problems, before harm reaches the patient
Ratios of Harm


One death / injury

Ten errors that had potential to cause serious harm

100 errors with little potential to cause harm
Increase Awareness

• Education and training
  – Patient Safety Education Program: Full curriculum on patient safety
  – Focus on developing attitudes, knowledge, skills, behaviours, outcomes, and then norms

• Provide key messages that are meaningful and relevant to your staff and that do not take them away from providing patient care
Engage in Conversations

• Patient safety incidents were openly discussed within the clinic at continuing education events – focusing on system improvements and not the individual’s role

• Introduced patient safety terminology
  – Incident, harm, near miss
EXERCISE - TRIZ

• What can we do to reliably get the worst culture of patient safety imaginable?

• How does this list compare to what we do now?

• What first steps will help us stop what we know creates terrible results?
Share what you have learned with others

- The best way to prevent recurrence is to share what happened to your patient, or what almost happened to your patient

- Chances are if it happened to you, it has happened or will happen to someone else
  – Pay it forward!
“I always wondered why somebody didn’t do something about that. Then I realized I was somebody”

~Lily Tomlin
The Patient Safety Alert

• System-level approach to proactively mitigate patient harm

• Communication tool

• Disseminated throughout the CFHS organization
CF H Svcs Gp Patient Safety Alert 2014-001

Preventing inadvertent use of unsterilized instruments

Incident Category: Harmful Incident
Degree of Harm: Mild

This alert describes a patient safety incident where unsterilized instruments were used on a dental patient. One process for sterilization involves packaging the instruments in a cassette, washing the instruments, wrapping the cassette, and securing the wrapping with an external chemical indicator tape before placing it into a steam sterilizer.

The external chemical indicator tape changes colour to show that the cassette has been through the steam process.

In this case, an instrument tray had been washed and prepared for sterilization. A new type of indicator tape was used on the clean but not sterile cassette which, when not sterilized, looked similar to the indicator tape post-sterilization which was previously used in the clinic (Figure 1).

![Sterilized and Not Sterilized Tape](image)

Figure 1: Example of non-sterilized tape (right) that looks very similar to sterilized tape (left)

An internal chemical indicator was not placed inside the cassette and the cassette was left pre-loaded into the steam sterilizer, without having run the sterilizer.

Related Preventive Measures

Preventive measures to decrease the likelihood of recurrence of this type of incident are provided.

Environment / Equipment

1. Standardizing the indicator tape to be used across the organization; pre-sterilization markings should be easily distinguished from post-sterilization markings.

   ![Example of Indicator Tape](image)

2. Mandatory use of internal chemical indicators in all cassettes and bags, regardless of size or type of packaging.

3. No pre-loading of sterilizer until cycle is ready to be run.

Communication

1. Stress the importance of education and training when new products are introduced.

2. Post pictures of what pre- and post- sterilization cassettes and bags should look like.

3. Label storage areas for sterile and non-sterile cassettes and bags.

Rules / Policies / Procedures

1. Update the RCDC Infection Control Guidelines Prevention Program to reflect mandatory use of internal chemical indicators in all cassettes and packages to be sterilized and not only in large packages wrapped in cloth as it currently reads in the policy [link].
Make it Fun!

You wouldn’t reuse this without cleaning it.
Hands are no different.
Always clean your hands properly before and after every patient encounter.

National Patient Safety Week 27 Oct 14 – 31 Oct 14
Celebrate by completing the Patient Safety Word Search.

Submit your completed puzzle to the Patient Safety Officer and you could win a Prize.

Please consider attending a 15min Fall Prevention presentation in the Galley
Tomorrow
Thursday 30 October 14
at
1215
Our Next Steps

• Continue to educate and increase awareness around patient safety in dentistry

• Share lessons learned

• Recognize people for their contributions to patient safety

• Targeted quality improvement initiatives that will support patient safety in dentistry

• Assess patient safety culture again this Fall
What does Patient Safety mean to our Staff?

“Not causing any undue harm.” ~Dental Technician

“It means many things to me.... It means me being competent. It means the patient’s well-being always coming first.” ~Dental Officer

“The first thing I think of when I hear Patient Safety? That would be sterilization, making sure nothing is compromised.” ~Dental Assistant

“Means putting patients health and well-being as a priority in all health care deliveries” ~Dental Officer

“Having the Patient comfortable by gaining their trust” ~Dental Officer
What does Patient Safety mean to our Staff?

“Anything you can do to make them safe from a splash of water to a sharp instrument while using infection control” ~Dental Hygienist

“I make sure they are not sick or feeling well, dizziness or if they had sedation, I make sure their escort is here. I also keep their information confidential” ~Reception

“A Clean sterile environment, proper barriers for the patients and us.” ~Dental Assistant

“Making them feel Calm and safe and trusting in us” ~Dental Technician

“Having a good relationship, respecting our patients’ rights. Having informed consent, providing quality care. Maintaining equipment, highest quality of asepsis, staying current with CPR and CE. Always maintaining our professional standards and using common sense to avoid errors and mistakes” ~Dental Assistant
Developing a Culture of Safety...

- Requires a major change in behaviours and attitudes – complex change
- Learning a non-blaming systems-oriented approach
- Lessons must be embedded into an clinic’s culture and practices
- Communication across professions
  - Different vocabulary, approaches, understanding of issues and values
“The best way to improve safety is to learn from mistakes, and the surest way to learn from mistakes and mitigate against them is to create an environment where we can acknowledge errors and act to correct what underpins them.”

Health Council of Canada, 2006
Thank you!

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