

# a new hat



in the hygiene operator

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**T**he role of the dental hygienist has grown tremendously during my 30-year career. Now I see another new hat hanging in our operatories. We have mastered our roles as clinicians, educators, motivators, team players, and infection-control experts. We now have a new opportunity in the area of patient safety.

Although written accounts of medical errors date back to Hippocrates, the recent patient-safety crisis has unsettled the public's confidence in our health-care system. It started in 1999, when the Institute of Medicine (IOM) published its landmark

report, "To Err is Human," and public awareness has remained high. The report cited staggering statistics about medical errors in hospitals, alarming the nation and creating a new awareness of patient-safety initiatives. The IOM estimated between 44,000 and 98,000 hospital patients die each year from avoidable medical errors, and that deaths from medical errors in hospitals out-ranked deaths from HIV, motor vehicle accidents, and breast cancer.<sup>1</sup>

Many of the key patient-safety lessons from the hospital setting can be translated to the dental office. For example, the Joint Commission on Accreditation of Healthcare Organizations

(JCAHO) states that communication, orientation/training, and patient assessment are the top three causes of medical errors.<sup>2</sup> This author proposes that all three are interrelated, and if a deficiency exists in one area, it directly impacts the other areas, exponentially increasing the opportunity for error.

There are two hospital-focused definitions hygienists should know: error and near miss. The National Patient Safety Foundation (NPSF) defines a health-care error as “an unintended health-care outcome caused by a defect in the delivery of care to a patient. Health-care errors may be errors of commission, omission, or execution. Errors may be made by any member of the health-care team in any health-care setting.”<sup>3</sup> Doing the wrong thing (anesthetizing the wrong quadrant), not doing the right thing (not performing an oral cancer exam), or doing the right thing incorrectly (missing the apex of a tooth on a periapical X-ray) all have the potential for patient injury.

In many cases, an opportunity for harm or patient injury may be identified and corrected before an accident or injury occurs. This is a near miss. A medication dosage error that is caught before it reaches the patient is an example of a near miss. Another example is failing to recognize a lesion, but the patient suffers no harm. Near misses represent an ideal opportunity to proactively address a process or procedure in order to prevent a situation from occurring again. The practice of dental hygiene is not exempt from errors or near misses.

Technology, coupled with increased communication, has heightened the public's awareness that medical errors occur regularly at every level of care.<sup>4</sup> The number of injuries and deaths reported in hospitals has caused patients, regulators, and policy makers to become concerned about the safety of care provided in settings such as doctors' offices, nursing homes, and ambulatory surgery centers.

Where does patient safety fit into dental hygiene? Risk management and patient safety have always been a concern for dental practices, but in our litigious society the hazards increase every year. By nature of dental care, patient injury/death is less frequent compared to our medical counterparts; however, patient safety is as important in the dental hygiene operator as it is in a hospital operating room. While hygienists are not performing life and death surgery, we are performing procedures and/or administering medications that affect a patient's total health and safety and very possibly his or her life.

To initiate a patient-safety program in your office, start with the three areas highlighted by JCAHO — communication (patient and interoffice), staff orientation/training, and patient assessment from the safety perspective:

➤ Numerous authors and researchers have addressed effective *patient-clinician communication*. Medical research shows that clinicians allow patients only 18 seconds to present the story of their illness before interrupting.<sup>5</sup> Effective patient communication strikes a balance between good listening and good interviewing skills. Not only is effective patient communication

a predictor of outcomes in malpractice cases and treatment, it is also a vital tool for preventing errors.

➤ The most valuable *staff training programs* address the safety/risk gaps identified through an office safety analysis. Successful training results in both short- and long-term patient safety awareness and practices. Training should provide real-life examples and guidelines so that staff members will not only gain knowledge, but have reference materials readily available for handling different situations.

➤ Proper *patient assessment* begins with the basics, meaning you must perform the basic preventive assessments and services taught in dental hygiene school including, but not limited to, intra/extraoral exams, oral cancer screenings, and periodontal charting. Thorough and timely gathering of data reduces the opportunity for medical errors and ensures the delivery of quality care.

To sustain a high level of patient-safety effectiveness, set up an ongoing program that is transparent in day-to-day operations, yet serves as the foundation for quality care and practice management.

Once you evaluate your practice in these three areas, identify which areas you have direct control over and which areas you may be able to influence. This will help you determine where the new hat fits and where it might need some adjusting to serve you well in the future. **RDH**

#### References

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- <sup>5</sup> Mock KD. Effective clinician-patient communication. Physicians News Digest Feb. 2001. <http://www.physiciansnews.com/law/201.html>. Accessed 7/16/2006.

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