

## Literature Review

## Patient safety oriented to improve patient retention in oral health services

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### ABSTRACT

**Background:** Oral health service systems should be designed to promote patient health, protection, and must be in compliance with Indonesian laws that help protect patients from misuse of personal information. Patient safety is a new healthcare discipline that emphasizes the reporting, analysis, and prevention of medical or dental error that often lead to adverse healthcare events. **Purpose:** To describe correlation that patient safety would improve patient retention in oral health. Patient safety is an essential component of quality oral health care and dentist is encouraged to consider thoughtfully the environment in which they deliver dental care, while at the same time services and to implement practices that decrease a patient's risk of injury or harm during the delivery of care. **Reviews:** Designing oral health care systems that focus on preventing errors is critical to assure patient safety. Some possible sources of error in oral health services are miscommunication, failure to review the patient's medical history, and lack of standardized records, abbreviations, and processes. **Conclusion:** Patient safety would support patient satisfaction; therefore oral health services can increase patient retention.

**Key words:** patient safety, patient retention

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### INTRODUCTION

The quality of health services is one of every person's basic needs. Therefore, the approaches to quality-oriented services on patient satisfaction would be the main strategy for oral health services to exist in the global tight competition. The efforts of meeting patient's satisfaction aimed to increase patients retention in the oral health services.<sup>1</sup>

Oral health service systems should be designed to promote patient health and protection and must be in compliance with the laws that help protect patients from misuse of personal information.<sup>2</sup> Consequently, oral health service has to emphasize in patient safety service-oriented.

A number of recent international studies have concluded that action is needed to reduce the number of adverse events that occur in the health sector. Institute of Medicine in 2000 has reported 44.000-98.000 patients died in the United

States due to medical error in the central health care.<sup>3</sup> In Indonesia, 48 criminal and 160 civil cases was reported in 2004-2005,<sup>4</sup> and is cases of dental malpractice was reported in 2005-2008 by Indonesian Dental Association.<sup>5</sup>

Indonesian law No. 29/2004 on Medical Practice states the legal rights and obligations of patients will be protected, while the potential risk of service can be set with various rights and obligations of oral health services, managers and dental professions.<sup>6</sup> However, it is not easy to implement these rules without the empowerment of the effectiveness of facilities and resources, systems and procedures and professional implementation.

### Patient safety

Patient safety is a system that makes secure service to patients in health services and prevents the occurrence of injury caused by medical/dental errors due to certain action or no action that should be taken.<sup>7</sup> It is a new healthcare discipline that emphasizes the reporting, analysis, and

prevention of medical or dental error that often lead to adverse healthcare events. Patient safety as an essential component of quality oral health care encourage dental professions to consider thoughtfully the environment which they deliver oral care services and to implement practices that decrease a patient's risk of injury or harm during the delivery of care. Therefore, the dental profession has to commit providing safe dental care, which is necessary for ensuring good general health, and to minimize risks and establish an open patient safety culture, in which practitioners can learn from their own and others' experiences. The goals of Patient Safety Program should be to reduce the risk injury to patients caused by treatment and remove or minimize hazards that increase risk.<sup>8</sup>

In Indonesia, patient safety has been set in Law No. 29/2004 on Medical Practice in article II regarding patient safety and medical practices. This article was aimed to provide protection to patients, maintain and improve the quality of health care given by medical or dental professions, and to provide legal certainty to community, patient, and medical or dental professions.<sup>6</sup>

### Dental Error

Dental Error that occurred in the oral health services are potential to cause patient injury and if failed to implement, including a plan of treatment or use inappropriate treatment planning in dental error, there are known terms of "adverse event" and "near miss". Adverse Events are events that resulted patient injury that is unexpected due to implement an action or no action unpreventable adverse event is a result of complications that can not be prevented with current knowledge. Near Miss is an error due to implement an action or no action should be taken so that cause patient injury, but no serious injuries occurred because of luck and prevention. Some examples that usually occurred are seating or treating the patient incorrectly, wrong site surgery, non-sterile instruments used in patient care, swallowing/aspiration of teeth or instruments or retained foreign body, in radiographs such as mounted up side down, incorrect view, incorrectly filed, equipment not properly maintained, and lack of documented treatment plan (Figure 1).<sup>9</sup>

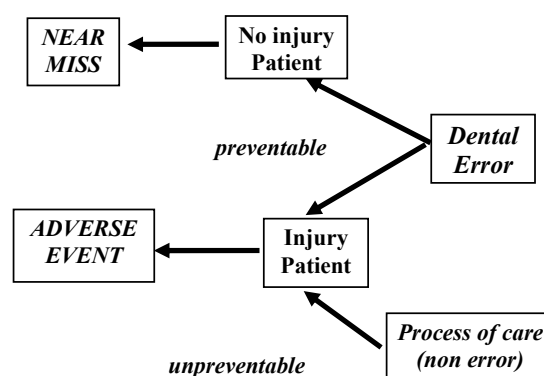


Figure 1. Dental error.

### Most common basic causes of medical/dental errors

There are 8 most common basic causes of medical or dental error: 1) Communication problems is the most common cause of the occurrence of medical/dental error such as failure of communication either verbal or written within the team, 2) Inadequate flow information, when that is not enough important information when the patients were referred to other places, 3) Human resources problems are error-based knowledge such as dental profession does not have the adequate knowledge to treat the patient, 4) Patient-related issues such as inappropriate patient identification, incomplete patient assessment, the failure to obtain informed consent, uneducated patient, 5) Organizational transfer of knowledge such as lack of training or orientation and the level of knowledge for running tasks 6) Staffing patterns/work-flow such as inadequate human resources, 7) Technical failures such as tool/equipment failure (dental units, dental x-ray), symptoms/treatment failure and inadequate instruction, 8) Inadequate policies and procedures such as no guidelines, poor documentation, no records or Standard Operating Procedure (SOP), important information not included when the patients were referred to other places.<sup>10</sup>

### The benefit of patient safety application

The benefit to apply patient safety programme in oral health service are increasing and developing safety culture; developing communication with patients; decreasing adverse event; decreasing clinical risk; reducing complaints and litigation; increasing quality of services; increasing the image of oral health services and public confidence, followed by increasing patient retention.<sup>7,11</sup>

### Customer retention

The quality of oral health service is very important for the Customer Retention and it can be attempted through service differentiation and competitive advantages that will attract new customers.<sup>1</sup> The quality of oral health service has a positive influence on the intensity of customers to return and recommend our service to others ("magic word of mouth") and become the informal public relations. Long-term relationship with the customer will generate profits,

therefore when customers pay and receive good services they have received “good value”, would increase their loyalty to the oral health service providers. It was reported that 5% customer retention can increase profit to 125%.<sup>1</sup>

## DISCUSSION

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 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. The main focus is on the various aspects and practice of teamwork because it has been found that 60% of dental errors occur due to a lack of communication within the team.<sup>8</sup>

The risk of adverse events is present throughout that whole procedure, relating, for example, to diagnosis, faulty equipment, general safety of the practice, poor communication to the patient or other health professionals, inadequate infection control or waste management. Reduction of adverse events and improvement of patient safety is most effectively achieved through prevention, and preventive action to reduce adverse events is in turn a facet of high quality healthcare. Quality cannot be promoted through force or sanctions from outside. It must be ensured that new measures ostensibly to improve patient safety, which can often add to the bureaucratic burden in the dental practice, do not hinder dentists from spending sufficient time with each patient, as this is an important parameter of high quality. The dental profession seeks to promote quality in many ways, including providing for continuing professional development to keep skills up to date; establishing local study groups for dentists and dental practices to learn from each others' experiences; developing systems for reporting adverse events or near misses; and ensuring compliance with infection control and waste management law.<sup>2</sup>

Patient safety programme is incomplete without its promotional campaigns. First, simply encourage 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 the most effective in reducing the number of wrong patients and dental treatment and, due to its ease of use, is ideal for practices that have a high turnover of patients throughout the day. The use of this initiative by displaying ‘time out’ posters throughout the centers and this also has the added benefits of bringing the patient into the team and emphasizing the requirement for good communication.<sup>8</sup>

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 which is aimed at optimizing patient outcomes by improving communication and other teamwork skills amongst dental professionals. The training is systematic and is spread over three phases: 1) Assessment; 2) Planning, Training and Implementation; and 3) Sustainability.<sup>8</sup>

The assessment phase is designed to be a two-way process and initially requires the practice themselves to recognize that there is a need; then they are visited to assess their suitability for this training. 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. 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. Lastly the sustainability phase is there to ensure that these new teamwork tools and behaviors have been implanted into daily practice and also monitors the ongoing effectiveness of the training to identify opportunities for continued improvement.<sup>8</sup>

In conclusion, patient safety should preferably for patient satisfaction; therefore oral health services can increase patient retention. 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. Good 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 ensuring patient safety as part of undergraduate and post-graduate dental training curricula is suggested to strengthen further patient safety culture in healthcare; encourage dentists to be actively aware of the various elements of their professional practice where patient safety can be compromised; encourage dentists and the rest of the dental team to participate in continuing professional development relating to patient safety, to keep knowledge and skills up to date; ensure that dentists have a knowledge of languages, particularly in order that they be able to communicate with patients and other professionals; ensure that patient data is safely stored and available to health professionals as and when required, in accordance with national laws; ensure official registration of qualifications of dentists; ensure transparency of the qualifications and

competences of all other members of the dental team, as required by national law; consider establishing “study groups” to provide a forum for local dentists to discuss experiences openly and learn from each other; introduce national systems for voluntarily and anonymously reporting adverse events, near misses and problems with medical devices, to enable all dentists to learn from their own and others’ experiences.

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