Dental Sterilization and Infection Control Events – A Dirty Topic

By Mr. Suwaid Khan

Lately, there have been many reports submitted to the Patient Safety Reporting (PSR) System related to sterilization and infection control. The reports fell into the categories of either reportable events not requiring a Root Cause Analysis (RCA) or adverse events which require an RCA. Either way, in some form or fashion, all these events had consistent commonalities.

During many times, as both providers and ancillary personnel, we get into a routine which may eventually lead to some degree of complacent behavior. That’s simply called human nature. We do it in our personal lives and sometimes it follows us to work. So, the question is, “how do we ensure our complacency doesn’t affect our patients?” The simple answers are self and situational awareness.

Be aware of yourself and what is going on. Get into the routine of checking things in some progressive or sequential order and follow those steps to maintain the continuum. Situational awareness comes into play when assumptions play a role with errors. Assumptions are one of the major factors which lead to continued errors. We all love to trust each other, however, trust is not the issue here. As vigilant providers and ancillary personnel, we should effectively communicate and cross check to ensure that assumptions are delineated and not just assume that an individual has completed the required task. If corrections are made, make them professionally, and don’t be demeaning about it or take it as a personal attack. Remember, the focus here is one team.

Some key questions to ask yourself when viewing your sterilization process are:

1) Is there a memorandum posted that distinguishes who is authorized to work in the sterilization room and trained to an acceptable efficiency level? Note the key words are “acceptable” and “efficiency.” Anyone can be trained but was the training received appropriately and can the task be retained and accomplished by the individual?

2) Are proper handoffs being conducted between organizational personnel during periods of absences? Troubleshoot potential situations that could go
Recently, there was confusion when an adverse event occurred with oral surgeons and ancillary personnel conducting a clinical/surgical procedure in the operating room of a servicing medical center/activity.

The location of this event ultimately made the event a “Joint Commission Reportable Event” and required Root Cause Analysis (RCA). This didn’t automatically exclude dental personnel from participating in the RCA. In this instance the DENTAC Patient Safety Officer assigned to investigate the issue partnered with the RCA team and with the Medical Center/Activity’s Patient Safety Office.

A Commander’s Critical Incident Report (CCIR) was submitted through both channels in an Executive Summary (EXSUM) format along with a copy of the MEDCOM Form 732 and Charter Letter. This ensured that both reporting channels were in the loop. However, only one Patient Safety Report needed to be submitted into the system. The submission may be done by the oral surgeon who witnessed the event or was part of the event. The submission can also be done by ancillary personnel that were part of the event. Both teams developed a “joint venture” and conducted the RCA process together.

HINT: Once the RCA is complete, the original goes through the Medical Command PS channels and the other copy flows through the Dental Command Patient Safety channels.

**The Root Cause**

By LTC Cindy Renaker

**The Root Cause**

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National Patient Safety Awareness Week Posters

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