

The Dental Patient Safety Foundation performs the following....

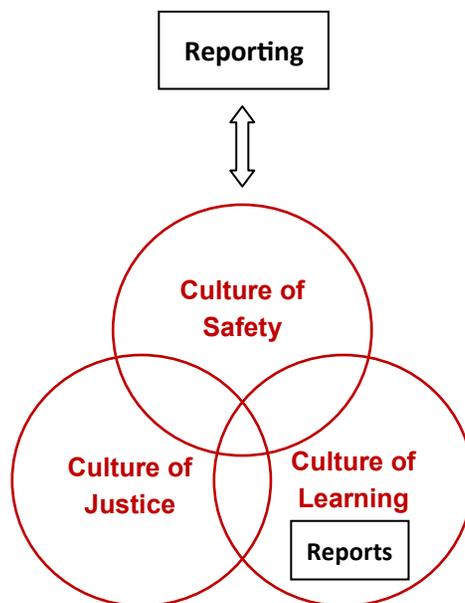
8 Patient Safety Activities

as required for listing by the Agency for Healthcare Research and Quality (AHRQ).

1. Effort to improve patient safety and the quality of care delivery
2. Collection and analysis of PSWP
3. The development and dissemination of information regarding patient safety (protocols, best practices, etc.)
4. The use of PSWP to encourage a culture of safety, and assistance to minimize patient risk
5. Maintenance of procedures to ensure confidentiality of reports
6. Provision of security measures to maintain confidentiality
7. Utilization of qualified staff
8. Maintain a PSES—patient safety evaluation system



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Where can I get more information?

www.dentalpatientsafety.org

www.pso.ahrq.gov

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What is a PSO?

A PSO is an organization that meets certain criteria established in the Patient Safety Rule of the United States Department of Health and Human Services. PSOs conduct activities to improve patient safety and healthcare quality. A PSO's workforce aggregates and analyzes patient safety events and develops and disseminates strategies to reduce or eliminate the risks and hazards associated with the delivery of health care. Confidentiality of all information is protected under federal law.

What are “patient safety events?”

Incidents - patient safety events that reach a patient, whether or not harm was involved.

Near misses (close calls) - patient safety events that do not reach the patient.

Unsafe conditions - circumstances that increase the probability of the occurrence of an incident or near miss.



FAQ'S

How can I report information about patient safety events to the DPSF?

Our reporting tool can be readily and securely accessed on our website from any computer or mobile device.

What is PSWP?

Patient Safety Work Product is the data or documents assembled for and submitted to a PSO, including patient information protected by HIPAA. PSWP cannot be used in criminal, civil, administrative or disciplinary legal proceedings.*

Does the DPSF PSO receive federal funding?

No, the DPSF relies entirely on outside donations to carry out its patient safety initiatives.

What is the difference between a PSO and a registry?

A registry captures only retrospective prevalence, i.e., the number and type of incident that has occurred in the past. A registry cannot be a PSO. A registry cannot capture near misses or unsafe conditions; and it cannot capture nuances of patient disease, evolving clinical circumstances or clinical judgement, which is vital information necessary to develop and improve strategies for improvement.

Why not rely on closed claim data?

Closed claim data will capture only those situations brought to the legal system. It typically takes years for information to be shared, if insurance companies are willing. Many settled cases are sealed. Close calls and unsafe conditions are missed.

Is voluntary reporting effective?

Yes, when all parties become aware of the importance of this vehicle. PSOs are widespread in European countries. Currently there are approximately 85 PSOs in the United States, that identify many hundreds of thousands safety events each year.

What is a Culture of Safety?

A culture of safety is a dynamic, social environment wherein all members have a shared perception of the importance of safety, all members feel comfortable communicating safety issues, all members are preoccupied with errors, mistakes and failures and trust that everyone can collectively learn from these opportunities for improvement. A safety culture is a just culture that values trust and accountability over blame and shame, as the only way to strengthen systems to prevent or blunt the consequences of inevitable human error. It requires relentless time, commitment and effort to achieve a goal that can always be improved. A safety culture is never satisfied. *Safety must exist for all, or no one is safe.*

* subject to certain specific exceptions

HOW CAN YOU HELP TO IMPROVE PATIENT SAFETY ?

1. **SPREAD THE WORD !** Encourage your colleagues and organizations to support this profession-wide culture of safety initiative.
2. **REPORT OFTEN !** Visit the DPSF website and use the reporting tool to share near misses, unsafe conditions or patient harm. Reports can be made anonymously or confidentially, for those wishing direct feedback. No one will find out ! Ever !!
3. **LEARN AND IMPROVE .** Sign up to receive notifications and monthly safety reports immediately after release.
4. **CONTRIBUTE .** The DPSF is a non-profit organization that relies solely on outside financial support.

