# Dental Anesthesia Incident Reporting System (DAIRS)

## Quick Start Guide

Version 1.1

## 1. Background

The Dental Anesthesia Incident Reporting System (DAIRS) is an anonymous, self-reporting tool created to facilitate reporting, collection and analysis of anesthesia-related incidents that occur during oral and maxillofacial surgery (OMS) procedures.

This document outlines the process a provider needs to follow to access DAIRS and report anesthesia incidents to AAOMS.

The target audience for DAIRS and this Quick Start Guide is the OMS clinician and support staff.

## 2. Log in to DAIRS

| Step | Action | Notes |
|---|---|---|
| **Step 1** | DAIRS link on AAOMS website: https://omsqor.aaoms.org/DAIRS/IncidentReportModule.aspx<br><br>**OR**<br><br>DAIRS link within OMSQOR®: https://omsqor.aaoms.org/Dashboard/Login.aspx | Only OMSQOR® participants may access DAIRS within OMSQOR®; however, the DAIRS application is the same regardless of which link is used to access it. |
| **Step 2** | DAIRS welcome screen displays with introductory language and **I Agree** button | For technical support, contact aaoms.support@bot.figmd.com |
| **Step 3** | Click **I Agree** to proceed to complete an incident report. | |

## 3. Overview of DAIRS

The DAIRS collection form consists of nine tabs listed in steps 4-12 below. As you answer questions, additional questions based on specific responses to questions may appear. You can navigate throughout the tabs but cannot submit the report until all required information is completed.

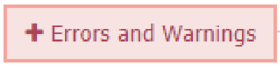
| Step | Action | Notes |
|---|---|---|
| **Step 4** | **Provider Information**<br>This tab captures demographic information about the provider and the support staff present during the incident that you are reporting.<br>1. Always select **Real** when submitting an actual incident. You will be able to review all information prior to submission.<br>2. Complete all information as accurately and completely as possible. | You can navigate to the next tab ONLY after completing the mandatory fields within this tab. |

| Step | Action | Notes |
|---|---|---|
| **Step 5** | **Patient Pre-Op Assessment**<br>This tab requests key patient demographics and clinical details captured before the procedure was performed.<br>1. Click **Add Procedures** field to view procedures listed in the table.<br>2. Select the applicable **planned or performed procedures**. | For planned operative procedures, you may select the category first to limit the number of codes shown in the table.<br><br>You may also search by code or description. |
| **Step 6** | **Anesthesia Procedure**<br>This tab captures the billing codes applicable to anesthesia used during the procedure.<br>1. Click **Add Procedures** field to view procedures listed in the table.<br>2. Select all applicable anesthesia codes for the anesthesia administered during the procedure in which the incident occurred.<br>3. Enter the number of units of anesthesia billed. | Here again, you may select the category first to limit the number of codes shown in the table.<br><br>When entering Billed Units, keep in mind that one unit is equal to 15 minutes. |
| **Step 7** | **Monitors**<br>This tab captures information about the patient vital signs that were monitored and documented during anesthesia. | Select all monitors used during sedation. |
| **Step 8** | **Medication Administered**<br>This tab captures information about the medication given to the patient during the procedure/visit.<br>1. Click to **Add Medications** field.<br>2. Begin typing the name of the medication in the **Search Medications** box.<br>3. Select the administered medications by clicking the checkbox to the left of the medication name.<br>4. Enter dosage, units, number of doses and administration timing. | Click **Add Medication** button to add medication that is not listed.<br><br>The newly added medication and its corresponding information is added to the previously selected medication list.<br><br>If you select **Other** for units, enter the units into the text field that is provided. |
| **Step 9** | **Complications/Incidents**<br>This tab captures information about the complications/incidents that occurred during the visit.<br>1. The boxes in this section allow you to select more than one complication/incident.<br>2. Make your first selection, then return your mouse to the box to choose your next selection. | The default is set to **YES** for the first question.<br><br>Click **X** next to your selection to delete it, if needed. |
| **Step 10** | **Narrative**<br>This tab captures detailed information related to anesthesia administered to the patient during the visit and the complication/incident. | |

| | | |
|---|---|---|
| **Step 11** | <u>**Additional Information**</u><br>This tab captures additional details regarding the complication/incident and how your team responded. | AAOMS is capturing this information to share best practices with AAOMS members and OMSQOR® participants. |
| **Step 12** | <u>**Submit**</u><br>This tab allows you to share the information corresponding to the incident with AAOMS. Before you submit the report, you may review all information entered.<br>1. Click **Preview** to view the DAIRS report before submitting.<br>2. Click **Submit** to send the report to AAOMS. | You cannot submit the report until you resolve any existing errors.<br><br>Once you submit the report, it is final and you cannot make any additional changes.<br><br>Once you click submit, a PDF of the report may be downloaded to your computer for your records. |

## 4. Errors and Warnings

The **Errors and Warnings** box is displayed to the top right of the screen.




It expands automatically when the system encounters an error and lists the questions that require your attention before you can submit the incident report.

- The issues listed in the **Errors and Warnings** box are hyperlinked to the question that needs attention.
- Once the error is addressed, the item is removed from the Errors and Warnings box.