Peninsula Dental Social Enterprise
Annual patient safety report

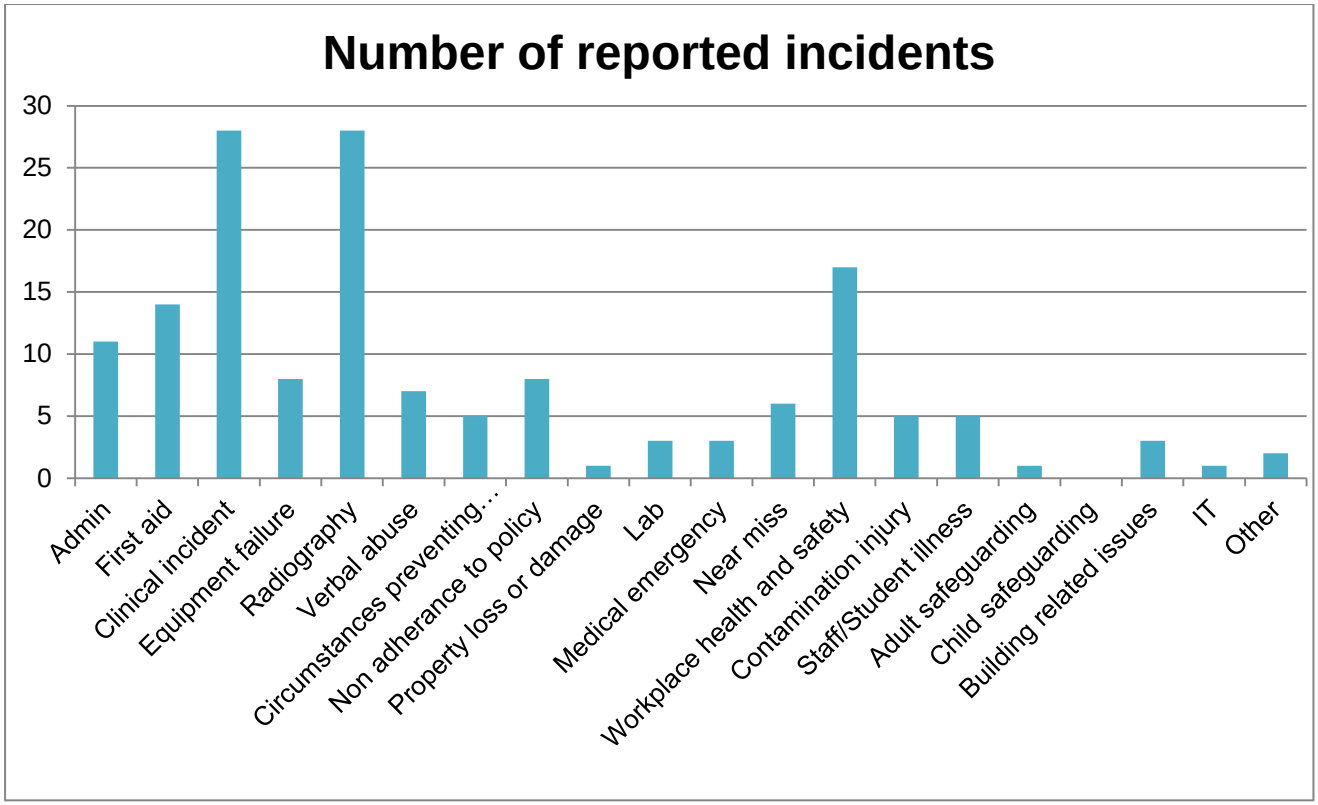
1st April 2015 – 31st March 2016

Peninsula Dental Social Enterprise, annual patient safety report

Contents

Total incidents

The full breakdown by category of incident is as follows:



There were a total of 156 reported incidents (clinical and non-clinical) in FY 15 16. Clinical and radiography incidents are the most prevalent type with 28 incidents respectively. The majority of radiography reported issues are either repeat exposure due to operator error or technical problems (IT/network connectivity). A full breakdown of clinical incidents can be seen later in this report.

There were 17 health and safety incidents reported. These are generally minor in nature such as slips and falls. Some building related issues were included in this category including leaks however, with the introduction of a new online reporting system (Ulysses) these are in future being recorded in separate categories.

There were 11 administrative errors reported, again these varied greatly and included notes being misfiled, appointment errors, notes not being signed off etc.

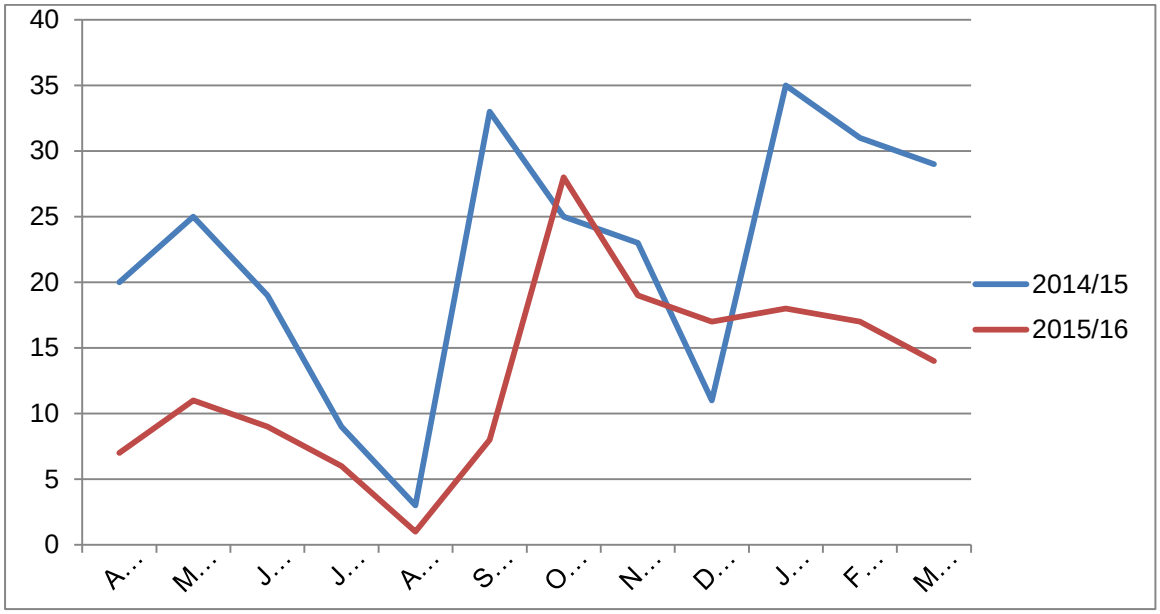
Ulysses was introduced half way though this year and much of this time has been spent learning how to use the new system effectively. As we move into 2016/17 our ability to accurately report incidents by cause and type will improve further and we will also be able to perform real time monitoring.

Ratio of incidents to appointments

There were a total of 18,697 appointments across all DEFs during this period. If only clinical related incidents are analysed (clinical, radiography, circumstances preventing treatment,

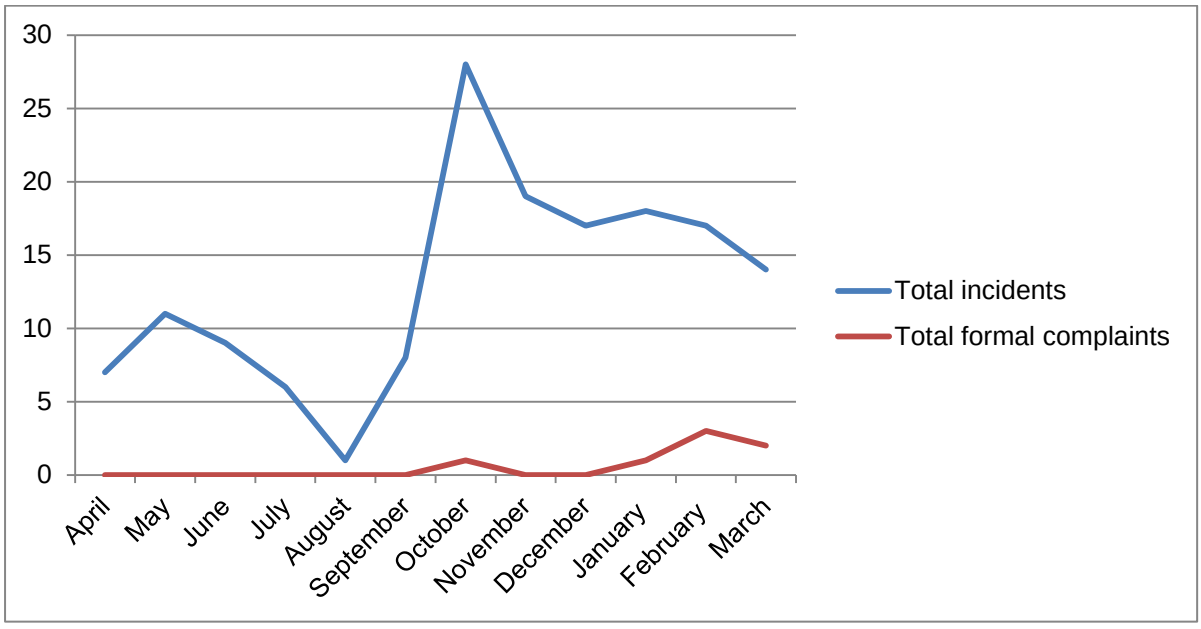
medical emergencies and contamination injuries) this would give 81 events resulting in an incident rate of 0.43% or 1 incident for every 230 appointments.

FY 14/15, 15/16 comparison



Year on year we are observing a significant decrease, 263 (2014/15) versus 156 (2015/16) in the number of incidents reported. This is may be in part due to more scrutiny over what constitutes an incident and better systems overall. The current reporting system allows us to merge and discount incidents that have been reported but do not constitute a clinical incident.

Total incidents and formal complaints for calendar year



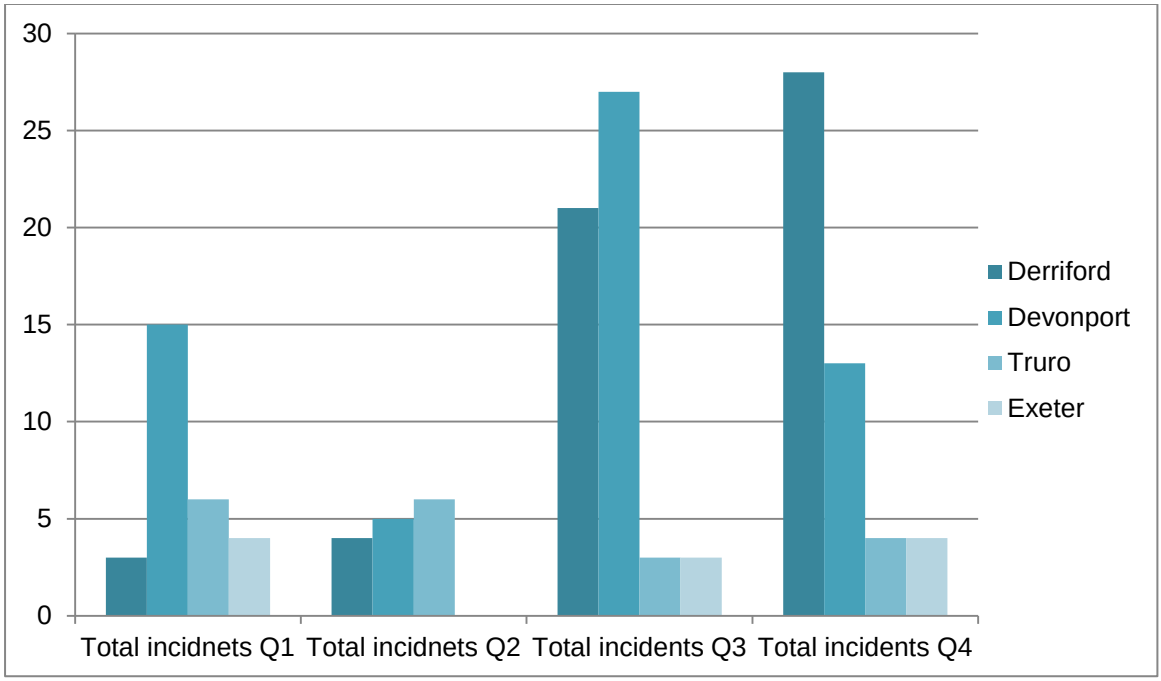
Formal complaints

We received a total of 7 formal complaints in the year. Breakdown as follows:

- Administrative - patient being sent a “did not attend” letter in error
- Various issues including clinical treatment and professional conduct
- Patient requesting expenses/treatment taken longer than anticipated
- Patient unhappy as not accepted for treatment at triage
- Patient unhappy as not offered implants
- Lack of confidence in student
- Alleged lack of professional conduct by students

This is low given the number of patient seen in this time. All apart from one have been resolved satisfactorily with one outstanding clinical complaint still undergoing investigation.

Breakdown of incidents by DEF FY15/16



Incidents rate by DEF

DEF	Total appointments	Number of clinical reported incidents	Incident rate (%)
Derriford	8898	35	0.39
Devonport	6336	30	0.47
Truro	2022	12	0.59
Exeter	1441	4	0.27

Each DEF has varying levels of clinical activity and different year groups with different clinical experience and as a result facilities cannot be directly compared.

Full breakdown of clinical incidents

Month	DEF	Incident details
April	Truro	Patient caught on lower left commissure with diamond crown prep bur.
April	Devonport	Used apex locator and leads found attached to machine in drawer
April	Devonport	Bur became detached from high speed handpiece during treatment. Bur found in suction filter
May	Derriford	Patient administered LA with no date or batch number on cartridge
May	Exeter	Patients lip caught with rainbow kit course disc
September	Derriford	Burr fell out of handpiece into patients mouth
October	Derriford	Master impression tray stuck in patient's mouth.
October	Derriford	Burn to patients mouth from eucalyptus oil during RCT.
October	Derriford	Patients lip caught with bur during treatment. Minor injury.
October	Derriford	Perforation
November	Derriford	Perforation
November	Derriford	Right internal commissure caught with bur
November	Devonport	Patients lip caught with polishing disk. Minor injury
November	Derriford	Patients tongue caught with bur. Minor injury
December	Derriford	Patient reported unpleasant taste in mouth during RCT. No apparent injury
December	Devonport	Patient 'bit' student's gloved finger. No apparent injury.
December	Devonport	Minor burn to patients lip with green tip ultrasonic scaler
December	Devonport	Patients lip caught with polishing disc. Minor injury
January	Derriford	Upper impression tray stuck in patient's mouth. Had to be sectioned to remove
January	Derriford	Polishing disk caught patient's cheek whilst smoothing composite filling.
January	Devonport	Mucosa on floor of mouth caught with ultrasonic scaler.
January	Derriford	Laceration to buccal mucosa with rainbow disk.
February	Derriford	Patient detected taste of bleach when hypochlorite was placed in canals during molar endo
February	Devonport	Cut to buccal mucosa with polishing disk
February	Truro	Patients lip caught with composite disk
March	Derriford	Chemical burn to lip, unknown cause
March	Truro	Cut to lower lip whilst using purple polishing disk
March	Derriford	Patient had to return to DEF post treatment as left with retraction chord still in situ in mouth.
March	Devonport	Patient's lower lip caught with needle during buccal and palatal infiltration.

Contamination injuries

There were 6 contamination injuries during the year as follows:

- Probe punctured thumb holding crown whilst removing core
- Burr from high speed hand piece punctured skin on finger
- Skin of finger punctured with needle after depositing local anaesthetic
- Skin punctured with sickle scaler
- Scratch from endo file
- Thumb spiked with endo file

Medical emergencies

There were two recorded medical emergencies in the year, the first involved a type 1 diabetic patient who became unwell whilst in Truro DEF. Patient became disorientated clammy and pale. Clinical staff were aware of the patients medical condition and as a result blood glucose level was checked and action taken. The patient was subsequently treated and monitored by staff. Paramedics called, patient stabilised and sent home.

The second involved a patient who became unwell during treatment, suffering from wheezing, shaking and looked unwell. The patient was treated at the chair and recovered fully before leaving the DEF. The patient was advised to visit their GP.

Lessons learned

The following are lessons learned which are featured in the monthly patient safety and governance report based on the result of incidents recorded for that month.

- Impression tray got stuck in patient's mouth as it did not have stops. When requesting special trays, please ensure stops are specified and where they stops should be. This will help prevent this re-occurring.

- Patient's mouth was burned during root canal treatment. Eucalyptus oil was employed as the irrigating solution. Burns to skin and soft tissue can occur if the correct preventive measures are not taken including proper use of rubber dam and caulking.

- Various incidents relating to patient notes. Clinical notes are an essential component of the patient's visit, and form a legal document detailing what occurred at each visit. All students should be familiar with the guidelines regarding clinical notes. A link to PDSE clinical note taking guidelines follows. Please review.

  http://www.peninsuladental.org.uk/wp-content/uploads/2015/04/Clinical-Note-Taking-Guidelines.pdf

- Diamond bur 'fell out' of the handpiece and into the patient's mouth during treatment. This is not an isolated incident. It is vital that the burr is checked and secure before use. Any incident report involving equipment failure must include the serial number or identifiable equipment information as prompted.

- Zero tolerance posters will now be placed in the waiting rooms of each DEF to ensure patients are aware of the policy with regard to verbal and aggressive behaviour.

- Light shield fell off overhead light and on to patient. This is the second time this has occurred recently and has the potential to cause harm. Please take additional care when checking the light covers as part of your daily surgery check list.

- There has been another incident reported where items have been left on trays and sent to decontamination. On this occasion it was a needle, previous items have included sealed glass vile of Oraquix gel and other syringes. It is the responsibility of the student to ensure the tray is clear of these items and the nurse to double check before returning to decontamination. Please be vigilant when carrying this out.

- As a result of the complaints received regarding expectations and treatment types offered, PDSE have reviewed the triage process and literature. What we offer, treatment times and types are now more transparent and we give a clear explanation if patients are unable to be accepted due to criteria.

- There were various items found in the waste amalgam pot including sharps and a tooth. It is important to ensure that these are separated and disposed of correctly.

- Sharp found in clinical waste bin (matrix band). Again, it is vital that sharps are safely and effectively disposed of, ensuring that risks or potential risks of contamination or infection both within and external to the practice are minimised.

- A retraction cord was left in patient's mouth after treatment. Patient had to be called and return to DEF to have removed. Although there was no lasting issues in this case, please be aware when using this method.

- There have been further incidents reported where items have been left on trays and sent to decontamination. It is the responsibility of the student to ensure the tray is clear of these items and the nurse to double check before returning to decontamination. Please be vigilant when carrying this out.

Summary

Over the past year there have been significant developments in incident reporting and investigation.

Ulysses was implemented in September 2015. This has allowed us to gain much greater accuracy and control over the incident reporting process. Real time notifications allow us to act, investigate and determine root cause analysis in a timely fashion and we have an up to date and accurate database. This, together with the monthly Patient Safety and Governance Report ensure a complete system of reporting, investigation, learning and communication which in turn supports on going improvement, patient and staff safety.

Moving into the next year we will be able to compare statistics accurately and see where improvements have been made.

As a large dental clinical education provider, accidents including clinical incidents are inevitable however through this system we can now demonstrate where learning has taken place and a prevention strategy implemented.