Peninsula Dental

Social Enterprise

Annual Statement of Cross Infection

August 2018

Contents

Introduction

Peninsula Dental Social Enterprise (PDSE) operates a similar model to an NHS dental practice however the majority of care is being delivered by dental students under the supervision of qualified dentists. There are 4 Dental Education Facilities (DEFs); 2 sites in Plymouth, one in Exeter and one in Truro.

Infection Control Co-ordinators:

DEF	Name	Designation
Derriford	Rachel Watts	Registered Dental Nurse
Devonport	Hayley Bowden	Registered Dental Nurse
Exeter	Lucie Colborne-Laight	Registered Dental Nurse
Truro	Sian Bryant	Registered Dental Nurse

Reported contamination incidents and arising actions

There were 22 contamination incidents and 14 near misses and other incidents recorded over the Academic year (01/08/2017 – 31/07/2018). The PDSE contamination protocol was followed on each occasion where necessary and actions taken were recorded through clinical incident processes. All incidents involving students require completion of an additional UoP risk assessment form.

A breakdown of each incident, location and actions taken can be seen in Appendix 1 of this report.

Audit completion and actions arising

An infection control audit using the Department of Health's Infection Prevention Society audit tool is carried out at all 4 DEFS, at 6 month intervals the most recent being June 2018. A breakdown for each DEF audit and action points can be found later in the report.

A further cross infection audit is carried out termly by clinical staff. This takes a snapshot of activity in each DEF and prompts an action plan if policy and best practice is not being adhered to.

This is then actively monitored to identify trends or common issues across all sites. All reported incidents are communicated via the monthly Patient Safety and Governance Report. Audit results and any other cross infection issues are discussed at regular Infection

and Prevention Control Group meetings and Clinic Operations meetings, as well as being displayed on the monthly Clinical Dashboard.

Risk assessments undertaken and reviewed for prevention and control of infection

The risk assessment undertaken are as follows:

- BBV & Hep B – Staff Risk Assessments completed. New members of staff are asked for vaccination history or attend Occupational Health for risk assessment.
- Mantoux – Tuberculosis
- Legionella - Risk Assessments completed for Derriford, Devonport and Exeter – Truro risk assessment arrangements are to be confirmed.
- Transportation of contaminated instrumentation.
- Handling of Contaminated Sharps/Instruments

Training received by staff

All clinical staff are required to undergo PDSE induction training before they may partake in clinical activity. Additionally, all clinical staff are required to complete mandatory cross infection control training annually. The majority of training is completed via the e-learning provider Isopharm and include the following topics:

- Hand hygiene
- Sharps injuries
- Decontamination of surfaces
- Blood Borne Viruses

However, other bespoke training such as DUWLs and Legionella awareness is completed face to face. Staff training is monitored via the DEFs termly audit which is undertaken to ensure that all relevant staff are compliant with training requirements. Clinical supervisors employed by Plymouth University are required to provide evidence of training compliance via a self-certification process.

Review and update of policies, procedures and guidance

Any updates to policies, procedures and lessons learned from incidents are communicated via a Patient Safety and Governance Report. This includes all clinical incidents and lessons learned. This report is sent to all PDSE staff, students and clinical teaching staff on a monthly basis.

Up to date versions of all PDSE policies are available on the PDSE website:

http://peninsuladental.org.uk/about-us/corporate-information/policies/

Appendix 1

Cross infection incident breakdown for Academic year 17/18

Derriford Incidents			
Date	Cause Group	Details of Incidents	Outcome
Oct 17	Contamination injury - Student	After patient had left was typing up notes and noticed small red dot in finger. Reported this to nurse who then followed inoculation injury protocol	Sharps injury procedure followed correctly. No further actions.
Oct 17	Contamination injury - Student	When administering local anaesthetic, the LA needle hit middle finger on left hand.	Clinic Team Leader confirmed that the Sharps injury protocol was followed correctly. No further actions.
Oct 17	Contamination injury - Student	During a patient demonstration of how to use a single tufted brush in a periodontal pocket, it became contaminated in blood. The student rinsed this brush under the tap and handed it to the patient. The patient ran her finger over the brush and sprayed fluid, causing it to enter the eye. The nurse was informed and the inoculation procedure followed.	The patient was informed of this incident after the event, and advised to see their GP for a blood test. The patient later informed us that they have had a blood test which came back clear and will bring in the blood test results with them at their next appointment. The details of the conversations with the patients has been recorded in the notes tab rather than clinical notes. Contamination injury procedure followed correctly, no further actions.
Oct 2017	Infection Control Near Miss	The student fractured the needle off the plastic hub of an anaesthetic needle and made little attempt to find and dispose of it properly.	The Clinic Team Leader confirmed that the student was issued with a negative form P, and remediation will be given.
Jan 18	Contamination Injury – Student	Student opened up a new endo file- went to adjust the bung and put the file into their thumb, the file was clean, but the gloves might not have been.	Confirmed with CTL that the inoculation injury procedure was followed.

Jan 18	Contamination Injury - Student	Needle stick injury to left finger from sharp probe whilst removing a veneer.	Inoculation injury procedure followed.
Jan 18	Infection Control Near Miss	When checking the students chair at the end the after the student had been practising suturing it was noticed by dental nurses that a suture needle was on the floor.	Student was issued with unprofessional Form P. Student was addressed by Clinical Supervisor and Clinic Team Leader regarding this issue, and briefing gave to students by Clinic Lead
April 18	Contamination Injury – Student	Went to remove cavitron tip from holder. Holder slipped though hand, cut gloves and finger. Treatment stopped. Finger encouraged to bleed under running water. Supervisor and nurse informed.	Sharps protocol followed, incident recorded in patient notes.
April 18	Contamination Injury - Student	Needle stick injury to left hand, safety plus needle used for IDB	Incident recorded in patient's notes on Soel Health. Patient was attending an emergency appointment with the student. Student attended A&E and Occupational Health, and patient attended their GP for blood tests.
Devonport Incidents			
Date	Cause Group	Details of Incidents	Outcome
Oct 17	Contamination Injury – Student	Finger was touched by the perio probe. No obvious sign of a puncture wound but protocol followed as a precaution.	Patient sent to A&E. contamination injury protocol followed.
Nov 17	Infection Control Issue	Student was observed handling contaminated instruments without the appropriate PPE. Bay nurse informed and student correct on the spot.	Student was spoken to Chairside regarding this incident, and it was also escalated to CTL and CS who is arranging remediation with the student.
Nov 17	Infection Control Issue	A dental nurse noticed blood on the aspirator, student was asked to disinfect the chair, which they	Incident was discussed with CTL, who spoke to the student about this incident. The student

		did with inadequate PPE. The student was reprimanded but when the chair was later checked, it was determined not to have been disinfected appropriately. The student had left the bay without having had the chair previously checked.	apologised to CTL, and to the bay nurse. No remediation necessary, Isolated incident.
Dec 17	Contamination Injury - Student	After removing PPE a small puncture wound was detected.	Inoculation injury procedure followed, student sent to A&E. No further actions
Jan 18	Contamination Injury - Student	Sickle scaler slipped when wiping on cotton roll and briefly superficially punctured middle finger of left hand. Wound was bled and washed immediately after	Sharps injury policy followed.
Feb 18	Contamination Injury	Whilst aspirating a spot of water from the slow hand piece entered nurses eye. Procedure was halted promptly and PPE, eye was washed with eye wash and the CTL informed.	Contamination injury protocol followed, no further action required.

Feb 18	Infection Control Near Miss	Whilst treating patient on the paediatric clinic, pts father noticed a suture and needle on the floor by the chair, the father picked it up and brought it to the attention of the student. No harm was caused to the gentleman by doing this.	Suture needle was not contaminated, and was disposed of in sharps bin on clinic. Reiterated to students importance of double checking their clinical area and making sure sharps and waste is disposed of in the correct manner. Email sent to CTLs advising that when dental nurses issue the practice kits they must count out how many suture needles are issued and then ensure that the same amount of needles are disposed of in the sharps box.
Feb 18	Infection Control Issue	The Dental Student realised his exam tray had a very dirty mirror, it seems to have cement stuck on the rear, not noticed immediately so did go in the patient's mouth briefly. Tray sent back up.	Confirmation from Devonport CTL that dental tray was sent back to Decontamination unit. All Decontam staff have been briefed about the importance of being vigilant in regards to decontamination and sterilisation processes
Feb 18	Contamination Injury	Whilst in the wash room processing the contaminated load from Exeter Def. instruments, a member of staff was injured with a straight probe. Immediate first aid - bled out injury/washed/ plaster. Phone call made to CTL (VOICE MESSAGE LEFT) plus email sent to CTL to inform. Nurse to attend A&E for blood test.	PDSE Needle stick protocol followed. Nurse attended A&E for blood tests and Needle stick and has follow up Occupational Health appointment. Risk Assessment completed on behalf of Exeter patient. Patient verbally stated agreement to have their bloods taken at GPs. Exeter CTL informed and briefed staff on incident and importance of being vigilant of sharps

March 18	Infection Control Issue	I noticed student touching contaminated instruments without PPE. I told the student to stop straight away and asked him to wash his hands and explained cross infection control to him and the use of PPE. No inoculation injury occurred to student.	It was the first day of 1st year students seeing patients. The nurse in question stopped him immediately and explained the importance of the use of wearing gloves when touching dirty instruments and what the outcome would be. Remediation would be the next step if this was to happen again with the same student. No further actions at this stage
Apr 18	Contamination Injury - Student	Student was witnessed wiping a scaler with a piece of gauze. Sharps injury protocol was followed and CTL was informed of the Incident. Student was sent to A and E. Patient was informed and contamination incident risk assessment form completed with patient. Incident was logged in patient's notes. Patient appointment was suspend and reappointed. Letter was also given to patient to take to his GP.	Incident recorded in patient's notes on Soel Health. Contamination injury protocol followed. Patient advised to attend their GP for blood tests - patient attended further appointments with no issues.
June 18	Contamination Injury	During packing in the clean room of Devonport's Decontamination suite a staff member accidentally stabbed their middle finger with a hollenback carver. Staff member attended A&E and protocol followed.	Contamination injury protocol followed. Staff member will be seen again for Hep B boosters

June 18	Infection control Issue	Student found clean instrument still contained cement. Tray sent back for reprocessing.	Decontamination staff reminded of importance of being vigilant with checking all instruments have been cleared of all debris and sterilised. To be monitored for future incidents.
Exeter Incidents			
Date	Cause Group	Details of Incidents	Outcome
Jan 18	Contamination Injury - Student	Student scratched themselves on the tip of a Gates Glidden bur which had been used during endodontic treatment while trying to remove the bur at the request of the supervisor	Sharps injury procedure followed. PU form sent. Student attended A&E. Patient informed
June 18	Contamination Injury - Student	Cartridge from a dirty IDB needle was changed into a new infiltration injection. Before injecting the patient, the needle accidently pierced the left thumb to therefore cause bleeding.	Incident recorded in patient's notes on Soel Health. Student's clinical partner took over the remainder of the appointment, which patient was happy with. Contamination injury protocol followed.
Truro Incidents			
Date	Cause Group	Details of Incidents	Outcome
Nov 17	Non-Adherence to Policy.	Student observed by a supervisor picking up two instruments that had fallen on the floor and then moving to put these instruments back on to a treatment tray on the bracket table which was still in use with the patient sitting in the chair. Following this the same student then put the instruments he picked up on to the working surface among used instruments and packaged, unused instruments rather than putting them directly in to a dirty box or the dirty sink. The Supervisor intervened at this point and asked the student to place the	The incident was dealt with by the clinical supervisor chairside. Checked the ADB to confirm that a negative form P was issued for this incident

		instruments in to a dirty box together with other instruments that they had touched on the work surface and clear and clean that area.	
Dec 17	Near Miss	Student was running late and brought in the next patient before PDSE nurse had had time to wipe down after the previous patient. Student had asked supervisor if he could bring his patient in but supervisor was unaware of the breach of cross infection. Nurse managed to wipe the chair down before the patient sat down but the dirty instruments, used loaded syringe, amalgam and all other dirty bibs etc. were still out on the side and were being cleaned and tidied away whilst the next patient was in the chair	CTL informed and remediation given.
Jan 18	Contamination Injury - Student	Student removed PPE and washed hands. They then noticed a puncture wound.	Once this incident was reported to the staff, the inoculation incident procedure was followed. No further actions.
Jan 18	Infection control near Miss	Whilst putting away stock a nurse found a used local anaesthetic cartridge was found in the materials trolley.	Bay nurses briefed students on IC principles
March 18	Contamination Injury - Student	During removal of a restoration extra Local anaesthetic was required. When doing so - needle stick injury caused to the left thumb.	Contamination injury protocol followed. No further actions at this stage

March 18	Contamination Injury - Student	Student dropped unknown material in bin. Unknown material bounced up and hit him in eye. Eye wash used only due to low risk. Was fine over weekend. But flared up over weekend. Student now seeing occupational health.	Eye was immediately irrigated with eyewash. Incident form later completed. Student attended Occupational Health and remediation given.
Apr 18	Contamination Injury - Student	student splashed saliva from a wax knif into eye but did not report it until after the appointment and the patient had left the building. Student attend out of hours A&E. Numerous attempts were made to contact the patient but we were unable to. CTL made a best interest of the student and sent the student to A&E for bloods.	Incident recorded in patient's notes on Soel Health. Contamination injury protocol followed. Clinic Team Leader attempted to contact the patient on two further occasions to no avail. Letter sent to patient on 03/05/18 requesting them to attend their GP for blood tests. Patient has further appointments booked. Policy updated to include incidents where the patient is unable to be informed prior to information being shared with A&E.
Apr 18	Contamination Injury - Student	Whilst talking to patient at reception, some spit from the patient went into the eye of a student. Eye rinsed with eye wash.	Student's eye rinsed with copious amounts of eye wash solution and student attended Occupational Health.
May 18	Contamination Injury - Student	Needle stick injury after an infiltration injection. Forced the finger to bleed under water, informed the patient and completed a risk assessment.	Incident recorded in patient's notes on Soel Health. Contamination injury protocol followed
June 18	Near Miss	blood found on 3 x luxators that had come back from de-contamination	Error noticed prior to instruments being used. Instruments sent back to SDU for reprocessing. SDU Team Lead made aware of incident and briefed team to be vigilant when inspecting

*****Number of incidents at each site will vary depending on scope of practice of year group and size of year group.

Appendix 2

IPS audit breakdown and action points

DEF	% Score	Action point	Action plan
Exeter	98%	Small rip in bay 5 chair 7	To monitor in case of increase in size and re-upholster where necessary
Derriford	98%	Minor rips/tears in some chairs	Relevant persons contacted for quotes to repair
		Cleaning: Are instruments that are not decontaminated immediately, kept moist until they are decontaminated?	Enzyme foam spray used to keep instruments moist overnight and at weekend prior to collection
		Do all floor coverings in clinical and decontamination areas have coved edges that are sealed and impervious to moisture?	Clinical floor seals damaged. This has been reported on the last 2 audits and has been raised to senior management
		Are all surfaces i.e. walls, floors, ceilings, fixtures and fittings and chairs free from damage and abrasion?	General wear and tear to walls awaiting appointment of facilities manager to rectify
Truro	97%	Impression material, prosthetic and orthodontic appliances: Are prosthetic and orthodontic appliances decontaminated before being placed in the patient's mouth?	No – Inputted in error. All lab work is decontaminated prior to fitting using appropriate solution
		Dental Unit Water lines (DUWLs): Is there an independent bottled-water system used to dispense distilled, reverse osmosis (RO) or sterile water to supply the DUWL?	No – Tap water is used and treated using ICX tablets
		Sterilizers: Is the reservoir drained and left clean and dry at the end of each day?	N/A sterilisers are now decommissioned and all instruments are processed at PDSE central facility in Devonport DEF
		Dental Unit Water lines (DUWLs): Are the DUWLs drained down at the end of every working day?	As per manufacturers instruction bottles are left on the chair

			overnight and DUWLs are purged for 2 minutes at the end of clinic
		Dental Unit Water lines (DUWLs): Are self-contained water bottles (bottled water system) removed, flushed with distilled or RO water and left open to the air for drying on a daily basis, and if necessary overnight, and in accordance with manufacturer's guidance?	No – As above
		Decontamination Environment: Does the practice have a system in place to ensure that storage of non-wrapped instruments does not exceed: 1 day if stored in a clinical area; or 1 week if stored in a non-clinical area (i.e. clinical area not in current use, or in the clean area of a decontamination room)?	No - Error?
		Are free standing or ceiling mounted fans used in clinical/ decontamination areas?	Yes
Devonport	97%	Are instruments that are not decontaminated immediately, kept moist until they are decontaminated?(6+ hours)	Instruments are kept overnight. This is in a closed, marked box.
		Are all surfaces i.e. walls, floors, ceilings, fixtures and fittings and chairs free from damage and abrasion?	Floors have now been replaced but there are still some areas awaiting silicone re-sealing
		Are hand hygiene facilities clean and intact (check sinks taps, splash backs, soap and paper-towel dispensers)?	Some silicone sealant has come away from behind the sinks in changing areas and patients toilets
		Are yellow striped black bags used for offensive/hygiene waste such as non-infectious recognisable healthcare waste e.g. gowns, tissues, non-contaminated gloves, X-ray film, etc., which are not contaminated with saliva, blood, medicines, chemicals or amalgam?	All clinical waste is disposed of using waste bags which are HTM01-05 compliant. Extracted teeth, Amalgam and precious metals are segregated accordingly

		Are black/clear bags used for domestic waste including paper towels?	
		Is there evidence the practice is segregating waste in accordance with HTM 07-01?	All waste is segregated at point of use