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Cherry Tree Dental Care

Patient Safety – Reporting and Managing Untoward Incidents

We take patient safety seriously and aim to ensure that incidents affecting patient safety directly and indirectly are kept to a minimum at all times. No matter how careful people are with the work that they undertake, mistakes can sometimes happen – the best people sometimes make the worst mistakes. All incidents, near misses and mistakes must be reported as soon as possible so that action can be taken promptly.

Should an incident happen, those involved will be treated fairly and supported. No disciplinary action will be taken against any member of the practice team unless it is clear that the incident occurred due to personal misconduct or recklessness.

The aim of this policy is to ensure that untoward incidents are properly investigated, the relevant action is taken and that lessons are learned. This will help to ensure that the risk of similar incidents occurring in the future are minimised. The steps set out in this policy fulfil our obligation to provide Local Safety Standards for Invasive Procedures (LocSSIPs) which are based on the high-level National Safety Standards for Invasive Procedures (NatSSIPs). Adverse outcomes reasonably associated with routine dental care are excluded from this policy.

Definition of a serious incident

1. A serious incident requiring investigation is defined as an incident that occurred in relation to patient care and resulted in:

    - Unexpected or avoidable death
    - Serious harm where the outcome requires life-saving intervention, major surgical or medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
    - A disruption to the delivery of services from the practice
    - Allegations of abuse
    - Wrong site surgery, such as wrong tooth extraction (apart from milk teeth) even if re-implanted or another ‘Never Event’ published by the Department of Health in England

2. Serious incidents may involve patients, patients' relatives or visitors, team members or contractors and suppliers.

What to do

3. Take immediate action at the scene of an incident to minimise injury and, where necessary, obtain appropriate treatment for individuals. Consider what immediate action may be required to prevent further injury and, if appropriate, summon assistance.

4. The incident must be reported to S.Dadabhai & I.Patel who will prepare a summary of the incident along with details of immediate action taken, date, time and location. This summary will not refer to the affected individual by name or include information that might identify the individual affected.

5. S.Dadabhai & I.Patel is responsible for notifying, where appropriate, the Primary Care Organisation within two working days in England and other organisations such as the Health and Safety Executive, the police and the Care Quality Commission or the Medicines and Healthcare Products Regulatory Agency (MHRA).

6. Where an incident results from malfunctioning equipment, the equipment should be isolated and clearly marked 'DO NOT USE' and an adverse incident report submitted to the MHRA. The equipment should be retained in a secure location pending further advice.

Investigation

7. S.Dadabhai & I.Patel will investigate the incident and all team members must co-operate fully and openly with the investigation. When investigating an incident, the practice manager will be supportive and concentrate on work practices and procedures. Incidents will not be regarded as a disciplinary matter unless an individual has acted deliberately or recklessly.

8. The focus of the investigation is to establish what happened and will include a time-line of events and statements from staff and other witnesses.

9. Where an incident has caused a patient harm or distress, S.Dadabhai & I.Patel will provide the patient with a full explanation of the incident and what action is being taken by the practice. Where appropriate, an apology will be given and followed up in writing, if necessary. All communications with the patient (verbal and written) will be recorded.

10. An analysis of the incident, the way it was handled and the cause will be undertaken by the S.Dadabhai & I.Patel and recommendations and an action plan developed. A report on the incident will be produced.

11. Solutions or changes to current policies and protocols will be discussed fully and action agreed upon. If relevant, changes will be notified to the patient. The practice risk assessment will be updated in the light of the proposed solutions or changes. The effectiveness of the

solutions and/or changes will be reviewed at agreed intervals and the findings reported at practice meetings.

12. Where enforcement agencies are involved, all team members must co-operate fully and openly with any investigation undertaken by those organisations.

Support following an incident

13. Being involved in an incident can be stressful for the team members involved, the wider team and the practice. S.Dadabhai & I.Patel will ensure that adequate support mechanisms are made available to staff, which may include counselling, special leave or the appointment of additional staffing.

Learning lessons

14. The report of the investigation will be used to:

    - Debrief team members
    - Address any necessary training issues within the team, and
    - Implement the recommendations for avoiding such incidents in future.

15. Patient safety will be discussed at practice meetings. All members of the team are encouraged to be critical about the practice and ask questions or challenge a process or procedure if they feel it might affect patient safety. Patient safety is included in the induction training programme for new staff.

Signed: Claire Witchell

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