Cambridgeshire Community Services NHS Trust

Report to Cambridgeshire Community Services NHS Trust

on

Safety in their Community Dental Services

Melvyn Smith, Independent Consultant

October 2018

The author

Melvyn Smith BDS, MSc, DDPH FDSRCS is a dentist on the General Dental Council's specialist lists in Paediatric Dentistry and Dental Public Health and has held academic posts in both disciplines. He has worked clinically in general dental practice, hospital settings and in large community dental services, where he had the overall clinical and managerial responsibilities. He was an examiner at the Royal College of Surgeons of England for their Membership in Clinical Community Dentistry. As Associate Director of Public Health in South Essex HA, he provided clinical leadership within the organisation for the introduction and implementation of local NHS clinical governance structures. As an NHS consultant in dental public health in subsequent Primary Care Trusts and in Public Health England he was involved in responding to serious incidents and clinical governance issues arising in local dental provision, including look back exercises. Most recently, he has provided the local clinical and managerial leadership for a busy 20 chair dental clinic in Southend offering primary care based teaching for undergraduates on outreach from the Teaching Hospital setting.

Introduction

This report was commissioned by Dr David Vickers, Medical Director of Cambridgeshire Community Services NHS Trust. It is a response to two recent serious incidents which fall within the category of Never Events occurring within the Trust's Dental Services, which had followed a cluster of Never Events reported as happening in 2017. The Terms of Reference are to:

- examine the Never Events recorded by the Trust's Dental Services in 2017 and 2018
- make observations regarding any common causes or themes
- suggest further actions to reduce the risk of further Never Events or related Serious Incidents
- undertake a rapid broad overview of safety and quality within the Trust's Dental Services provision and highlight any areas of risk.

Overview of process

I initially reviewed the reports of the five serious incidents recorded by the Trust as Never Events in 2017/18 and where possible looked at the original clinical records and also examined the report of CQC relating to the Trust Dental Services produced in June of this year, based on their visits in late March.

I made six site visits to look over the facilities and procedures in place at the dental clinics and talked to reception staff, nurses, dentists and managers there. One clinic visit was purposely made after only giving an hour's prior notice of my arrival.

I had more formal discussions with the Service Director, Ambulatory Care, the Clinical Head of Service, the two Dental Service Managers and the Practice Managers. I also had the opportunity to talk to two of the clinicians directly involved with the reported Never Events.

My report is presented in two parts. The first is a detailed consideration of the Never Events. Part Two is a broad overview of the safety and quality of the Dental Services provided by the Trust.

Summary of Main Findings

a) Having reviewed the available information about the national reporting of Never Events, given the high number of extractions undertaken by the Trust I do not regard the 4 reported (3 actual) 'wrong tooth extraction' Never Events occurring in 2017/8 as being necessarily in excess of what might occur in an organisation with similar activity and assiduous approach to reporting.

b) The Trust's Action Plans produced following the Never Events in 2017 were timely, appropriate and suitably wide-ranging, as are those in place and planned to address the additional issues raised by the two Never Events reported in 2018.

c) I could ascertain no apparent major underlying commonality linking the three actual Never Events which involved the removal of wrong teeth.

d) At all the Trust's sites where Dental Services are provided the necessary clinical environment to permit delivery of safe and high quality services is in evidence. The required policies and procedures are in place to mitigate general risk and the particular issues in higher risk areas, such as those in cross infection control and the delivery of intravenous sedation, are properly addressed.

e) The Dental Services have sound clinical leadership and an effective management structure (delivered through the Leadership Team) in place to assure quality and manage risk and to take the Service safely forward into the future.

6. There is a largely stable and well-established permanent workforce deeply committed to the specialised and challenging work undertaken across the Trust Dental Services. Regular appraisal is undertaken and they are provided with appropriate opportunities for in-service training and continued professional development.

7. Where the Trust has an arrangement to share clinic facilities with other providers there are tight lines of demarcation in place, for example, in decontamination facilities and instrument storage. I found no particular opportunity for increased clinical or reputational risk to the Trust arising from the way clinic-sharing arrangements have been set up.

8. The provision of sedation (including intravenous sedation) is delivered in appropriately-equipped clinical environments and the staff have the relevant additional training and expertise. The Trust may though wish to commission a specialised external audit to validate the safety and quality of the Intravenous Sedation treatment it carries out (for example from SAAD).

9. Delays in the supply of requisitioned items have led to reported difficulties in maintaining availability of both the disposables in routine use in dental surgeries, and the prompt delivery of more significant necessary capital purchases. This has not reached the point of being a risk to patient safety or the quality of the care delivered, but is inefficient and a distraction to the staff.

Section One. Dental Never Events

1. Never Events : NHS Policy Background

1.1 The current Policy and Framework relating to Never Events (last revision; January 2018), and list of Never Events is at: https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-revised-never-events-policy-and-framework-and-never-events-list-2018.

This applies to all settings providing NHS-funded care. Section 4 of The Policy and Framework provides the definition below:

> "4.3 Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
>
> 4.4. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event."

1.2 The categories in the List of Never Events relevant to the care provided by the Trust Dental Services are quoted vebatim below. These include all three of those in the *Surgical* section of the List:

> 1. Wrong site surgery
> An invasive procedure[1] performed on the wrong patient or at the wrong site (eg wrong knee, eye, limb, tooth). The incident is detected at any time after the start of the procedure.
> *Includes:*
> Interventions that are considered to be surgical but may be done outside a surgical environment – for example, wrong site block (including blocks for pain relief), biopsy, interventional radiology procedure, cardiology procedure, drain insertion and line insertion (eg peripherally inserted central catheter (PICC)/ Hickman lines). This also includes teeth extracted in error that are immediately reimplanted.
>
> *Excludes:*
> - removal of wrong primary (milk) teeth unless done under a general anaesthetic
> - interventions where the wrong site is selected because the patient has unknown/unexpected anatomical abnormalities; these should be documented in the patient's notes
> - wrong level spinal surgery*
> - wrong site surgery due to incorrect laboratory reports/results or incorrect referral letters
> - contraceptive hormone implant in the wrong arm

.
*Excluded from the current list while NHS Improvement works with the relevant professional organisations to ensure development of robust national barriers to prevent this incident.

[1]The start of an invasive procedure is when a patient's anatomy begins to be permanently altered. For example, this is when the first incision is made that will scar the patient and take time to heal and recover from.

2. Wrong implant/prosthesis

Placement of an implant/prosthesis different from that specified in the procedural plan, either before or during the procedure. The incident is detected any time after the implant/prosthesis is placed in the patient.

Excludes:

- placed implant/prosthesis is intentionally different from that specified in the surgical plan, based on clinical judgement at the time of the procedure
- specified implant/prosthesis is placed as planned but later found to be suboptimal
- implant/prosthesis is different from the one specified due to incorrect preprocedural measurements or incorrect interpretation of the preprocedural data – for example, wrong intraocular lens placed due to wrong biometry or using wrong dataset from correct biometry.

Includes:

- implantation of an intrauterine contraceptive device different from the one in the procedural plan.

3. Retained foreign object post procedure

Retention of a foreign object in a patient after a surgical/invasive procedure.

'Surgical/invasive procedure' includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside the surgical environment – for example,central line placement in ward areas.

'Foreign object' includes any items subject to a formal counting/checking process at the start of the procedure and before its completion (such as for swabs, needles, instruments and guidewires) except where items:

- not subject to the formal counting/checking process are inserted any time before the procedure, with the intention of removing them during the procedure but they are not removed
- subject to the counting/checking process are inserted during the procedure and then intentionally retained after its completion, with removal planned for a later time or date as clearly recorded in the patient's notes
- are known to be missing before completion of the procedure and may be inside the patient (eg screw fragments, drill bits) but action to locate and/or retrieve them is impossible or more damaging than retention.

and, in the *Medication* section:

> 8. Mis-selection of high strength midazolam during conscious sedation
> Mis-selection refers to when:
>
> • a patient is given an overdose of midazolam due to the selection of a high strength preparation (5mg/mL or 2mg/mL) instead of the 1mg/mL preparation, in a clinical area performing conscious sedation
>
> • excludes clinical areas where the use of high strength midazolam is appropriate; these are generally only those performing general anaesthesia, intensive care, palliative care, or areas where its use has been formally risk - assessed in the organisation.

2. Nationally-Reported Dental Never Events

2.1 Data from NHS Improvement (https://improvement.nhs.uk/resources/never-events-data/) show that reported dental never events are mainly because the wrong tooth/teeth have been extracted. There was uncertainty around wrong tooth extraction falling into the 'Wrong Site Surgery' category, prior to the reporting of the 2015/16 data, since when the numbers reported have increased. Further clarification now also confirms that primary (baby) teeth which are wrongly extracted should only be included when the treatment was undertaken under general anaesthetic.

Year	Wrong tooth/teeth extracted	Other 'wrong site tooth' procedure	Retained dental* foreign object post procedure
2012/13	21		
2013/14	22		
2014/15	27	2	
2015/16	33		1; dental roll
2016/17	46	2	1; endodontic file
2017/18	32		1; dental pack
2018/19 (First 6 months only)	23		1; mouth prop

* *includes only objects specifically identifiable as dental, although other objects listed in reports may have been involved in dental Never Events.*

2.2 These figures should be handled with caution when trying to assess the relative impact of the number of Never Events in one particular organisation, due to reporting bias. There is likely to be a high level of general under reporting as - although the majority of extractions are carried out in general dental practice - relatively very few wrong extractions are being reported from general dental practices. For example, recent advice from a dentists' indemnity organisation (*'Dental Protection'*) to its members (24th September) entitled *An Incorrect Extraction* fails to mention the need for NHS dentists to report wrong extractions as Never Events. The great majority of Never Event reports are from Hospital and Community Trusts. A scientific paper by Pemberton et al in the British Journal of Oral and Maxillofacial Surgery at *https://www.sciencedirect.com/science/article/pii/S0266435616301383* (February

2017) explores this issue and highlights that there is no national accurate published data from all the clinical settings involved. They suggest that "Fair and accurate reporting in all settings would help to compare the quality and safety of service, inform patient choice, and allow properly informed commissioning decisions. Collection and analysis of information on the extraction of the wrong tooth on the basis of multiple sources may also help identify common themes and possible solutions in different settings"

2.3 Reports have been produced by NHS Improvement which do adopt this approach, but only include hospital incidents. *Surgical Never Events. Learning from 38 cases occurring in English hospitals between April 2016 and March 2017* at *https://improvement.nhs.uk/documents/3213/Learning_from_surgical_Never_Events_FINAL.pdf* (September 2018) follows the same format as similar reports in 2012 and 2014. NHS Improvement requested incident investigation reports from each of the four regions of the English NHS such that the overall sample was 10% of all surgical Never Events that took place in 2016/17. Only one of the 20 wrong site surgery events reported here relates to a wrong tooth extraction. However there are learning points relevant to the Trust Dental Services across the range of Never Events analysed. I would commend the detailed study of this report as an aid to continuous quality improvement within the Service.

2.4 Given the weaknesses in national reporting, I would not view the tooth extraction Never Events occurring in 2017/18 as necessarily in excess of what might occur in any organisation with similar activity and assiduous approach to reporting**.**

3. Overview of Potential Areas for Never Events to occur within the Trust Dental Services

3.1 Category 1, 'Wrong site surgery' obviously includes situations where the wrong tooth or teeth are taken out, or other surgical 'invasive procedures' are carried out on the wrong tooth. Giving a deep local anaesthetic injection ('nerve block') on the wrong side in the lower jaw would need to be included in this category.

3.2 Category 2, 'Wrong implant/prosthesis' as defined would potentially cover any crowns, bridges or dentures intended for one patient are fitted in error in the mouth of another patient; as that prosthesis would be 'different from that specified in the procedural plan' . It is possible for the wrong prosthesis (ie one intended for another patient) to be returned from the laboratory or for a mix up at the clinic creating the situation that the wrong prosthesis is given to the dentist to fit. However, in reality crowns, bridges and dentures are always first tried in position in the mouth to check they have been correctly made before being fitted. The word 'placement' used in the rubric of this category could not reasonably be inferred to cover the temporary insertion into the mouth to check a dental prosthesis in this way.

Implants, as used in dentistry, are permanent metal fixtures buried in the bone of the jaws which are used to support crowns, bridges and dentures. At the present time the Trust Dental Service does not provide such dental implants for any of its patients.

3.3 Category 3, 'Retained Foreign Object Post Procedure' could cover whole (or more likely fragments of) dental instruments, needles and filling materials which remain in the mouth cavity or remain embedded in the teeth or soft tissues of the mouth. Breakage of dental instruments is not uncommon, particular risk coming from the cutting burs used in dental drills and the files used to clean out tooth root canals. Fracture of modern single use anaesthetic injection needles is unlikely but remains possible.

In the majority of such cases such foreign objects could and would be removed; otherwise there would be an exclusion from this categorisation as they "would be known to be missing before completion of the procedure and may be inside the patient (ie inside the patient's mouth).....but action to locate and/or retrieve them is impossible or more damaging than retention"

This category also includes any swabs, packs and cotton wool rolls not removed from the mouth at the end of a dental treatment.

3.4 Category 8, 'Mis-selection of high strength midazolam during conscious sedation' is very specific to one of the types of treatment carried by the Trust Dental Service. Midazolam is the drug given by injection to sedate the anxious or phobic patient to allow dental treatment to be undertaken. The only strength of injectable Midazolam in current use is the 'low strength' 1mg/mL preparation. Mis-selection of high strength Midazolam could only be possible if high strength formulation were ordered or delivered in error and then mistakenly selected by the sedationist, with that mis-selection also not being noted by the clinician checking the drug prior to its administration.

4. Dental Never Events Previously Reported by the Trust

4.1 Events in 2017.

There was a run of three incidents, identified by the Trust as Never Events, between February and June 2017, in summary from the Trust Root Cause Analysis Reports:

	Date of event	STEIS Ref	Datix Ref	Clinic Site	Nature of Event
1	22.02.17	2017/ 5382	W47710	Addenbrookes Hospital Theatres, Cambridge	Patient, a vulnerable adult with learning disabilities had received extensive treatment (fillings and extractions) under general anaesthetic. Whilst recovering at the end of the procedure, still in the theatre under the care of an

					anaesthetist, he spat out a Raytec swab which had been left inside the mouth.
2	20.03.17	2017/ 7873	W47932	Brookfields Dental Clinic, Cambridge. Specialist Oral Surgery referral service	Patient referred for a specialist oral surgery procedure; ie the removal of the roots of the lower right 2nd molar. These roots had remained following that dentist's having attempted the extraction. The oral surgeon initially extracted the lower left 2nd molar, which did require treatment, with the informed consent of the patient. The tooth extraction for which the patient had been referred was then subsequently carried out following the patient's querying what had happened in relation to the original referral.
3	13.06.17	2017/ 15110	W48669	Dental HealthCare Hinchingbrooke Hospital, Huntingdon. Specialist Oral Surgery referral service	Patient referred for an oral surgery procedure; ie the removal of the roots of the lower right 1st molar and the lower left 3rd molar. The dental surgeon extracted the lower right 2nd molar instead of the lower right 1st molar.

The above Events were subject to a rapid Independent Peer Review (report produced 23rd August 2017) undertaken by Kevin Fairbrother, Clinical Director, Dental Services Division, Birmingham Community Healthcare Foundation Trust. He examined the Datix report sheet concerning all incidents relating to the Trust Dental Services for the preceding 6 months and reviewed in detail the Trust's Root Cause Analysis Reports for the 3 Events in the table above. I have read these reports and Mr Fairbrother's review and also examined the relevant clinical records from cases 1 and 3, and talked to the surgeon involved in the latter. The record card for case 2 was not readily available as it had been sent to archive. Based on what I have seen, read (and heard) about case 3 I am entirely in agreement with his findings and suggestions, including his comments on the recommendations in the 3 Root Cause Analysis Reports. There is little for me to add to his assessment (which the Trust has already considered and acted on) here.

Importantly, I do agree with him that Event 2 in the table above does not represent a wrong site surgery Never Event. Whilst it is the case that the tooth extraction specified by the dentist was not that initially carried out, in the first instance the Oral Surgeon undertook the extraction of a tooth that the patient had agreed and consented to have removed, and there was some reported clinical justification for its removal. I would, however, also agree that although this incident falls outside the

Never Event definition, it still raises issues of significance to be addressed by the Trust.

I did note a factual inconsistency in the Root Cause Analysis Report relating to this case. In Section 3, Incident Description it says *'The surgeon then re-reviewed the referral letter which clearly stated that the tooth to be removed was the LR7. There was no mention on the referral of an attempted extraction.....'* . In Section 6 of the same report, under Organisational Factors, a scan of that referral letter is provided stating quite legibly *'Retained root, failed extraction May require surgical extraction*'. Fortunately this error in Section 3 of the Root Cause Analysis Report has no material impact on my assessment that this case is not a Never Event.

However, the issue of the legibility, detail and accuracy of clinical information provided by dentists in referral letters is an important factor in managing risks and I shall return to this in later in this section of the Report (Section 6.2).

4.2 Trust Response

I have reviewed the way in which the Trust responded to the series of Never Events identified in 2017. Its actions were timely, appropriate and wide-ranging. The early involvement of a senior clinician, Mr Fairbrother, to produce a rapid independent external report is a particular indication of the Trust's open approach to clinical governance.

Apart from the non-contributory factual error noted in the paragraph above, the Root Cause Analysis Reports were well constructed in terms of both the quality of the analysis and the appropriateness of the service improvement action plans.

Six staff meetings were promptly organised to discuss the issues raised, including the importance of following Local Safety Standards for Invasive Procedures (LocSSIPs), one specifically involving the Oral Surgeons operating the referral service, and 5 site-based meetings on the following dates:

Oral Surgeons	17 July 2017
Ely	18 July 2017
Cambridge	31 July 2017
Wisbech	1 August 2017
Huntingdon	8 August 2017
Peterborough	21 August 2017

4.3 Events in 2018.

There were two further incidents, identified by the Trust as Never Events (both wrong site surgery) in May and June 2018. In summary from the Trust Reports:

	Date of event	STEIS Ref	Datix Ref	Clinic Site	Nature of Event in Summary
4	02.05.18	2018/ 12203	W51807	Dental Access Centre (DAC), Peterborough	Patient was first seen because of an episode of pain and swelling from a lower left molar tooth on 16.04.18 when pain relief and an antibiotic were prescribed. Clinical signs were noted suggesting infection stemming from lower first molar(s). A further appointment was made for 30.04.18 when Xrays were taken and further clinical assessment made (including the information from the Xrays), and a further appointment was made for 02.05.18 for planned extraction of the lower left 1st molar. A consent form prepared on 30.04.18 for extraction of lower left first molar. This was not signed by patient on that day. Patient attended for extraction on 02.05.18. The consent form prepared at the previous visit, initially stating the intention for extraction of lower left first molar was signed by the patient although at some point, this form was amended to seek consent for the extraction of the lower second molar. The lower second molar was extracted. Patient later made contact to say the wrong tooth had been removed.
5	25.06.18	2018/ 16328	W52438	Addenbrookes Hospital Theatres, Cambridge	Patient had a dental general anaesthetic referral to the Service (received 12.01.18) from a dental practice requesting extraction of both lower first primary (baby) molar teeth. Assessment carried out on 07.03.18 at Brookfields Clinic, Cambridge and consent form signed for removal of both upper first baby molar teeth and a CDS 'Green Card' completed also indicating that removal of these 2 upper baby teeth was indicated. Attended Brookfields on 02.04.18 in pain and antibiotic prescribed. On 25.06.18 the two upper first baby molar teeth were removed under general anaesthesia, but on finding that they were free of obvious decay, the operating dentist recognised that the two lower first baby molar teeth should have been removed and so extracted these as well.

4.3.1 I examined both the paper and electronic clinical records for Case 4, which provides a complicated chain of events for analysis. Firstly, the episode of treatment spanned three visits, which I learned was exceptional for a patient at the Dental Access Centre (DAC). Fortunately the same dentist saw the patient on all 3 occasions, and although the availability of appointments with that dentist may have had some impact on the gaps between appointments, this may equally have been deliberate (to allow some time for the infection to resolve after prescription of the antibiotic) or due to the patient's decision. Whatever the reasons I find no adverse impact of the spacing of appointments on the subsequent clinical outcome.

The clinical record includes notes entered by the dentist at the time of the patient's 3 visits to the DAC for clinical care, and a further record of a discussion between the dentist and patient two days after the extraction when an admission of a mistake, an apology, and the offer of remedial treatment at no expense to the patient were made. There is also a lengthy reflective entry made after the event.

At her first visit on 16.04.2018 (according to the contemporaneous clinical record) the patient attended the DAC for initial assessment and advice, regarding pain from the lower left jaw. No Xrays were taken at this visit but it was reasonable, given the obvious clinical signs and symptoms and intended treatment, to proceed without. The clinical notes state the lower left first molar had an existing large filling but with some further decay, and had some diffuse swelling and redness [of the gum] on the side next to the cheek indicating dental infection. Given the facts as stated, this is a reasonable provisional diagnosis. Treatment offered was the prescription of a short course of amoxicillin, an antibiotic in the penicillin family, at an appropriate dose. Again this is a reasonable approach to managing the urgent episode although an alternative might have been to get access into the pulp (nerve) chamber in the middle of the tooth, clean out infected material, and place a dressing. The record states that the patient was further advised either to return for extraction of the tooth or to seek dental treatment through registration with a general dental practitioner elsewhere.

The second visit was on 30.04.18, when Xrays were taken and treatment discussed and offered. I could not examine any Xrays directly as they had been sent elsewhere and not copied. Contemporaneous information from the electronic record notes that, on Xray appearance there was infection around the roots of the lower left first molar, as evidenced by changes in the appearance of the surrounding bone. There is no further report here of the condition of the lower second molar. The notes record 'Pt booked today for extr LL6', that is the patient was booked today for the extraction of the lower left first molar. The patient had no pain and wanted to save the tooth which had been suggested for extraction and she had a dentist in Latvia where she would be going in June. This suggests that no further treatment would need to be undertaken at the DAC, however the patient made a third visit on 02.05.18. The contemporaneous entry in the clinical notes gives an account of an uneventful extraction of a lower molar tooth, the issuing of written post-extraction instructions

and the advice to register with a general dental practitioner for care in the future. The tooth described in the notes as the one which was extracted on that day is the lower left first molar. In reality the lower left second molar had been removed.

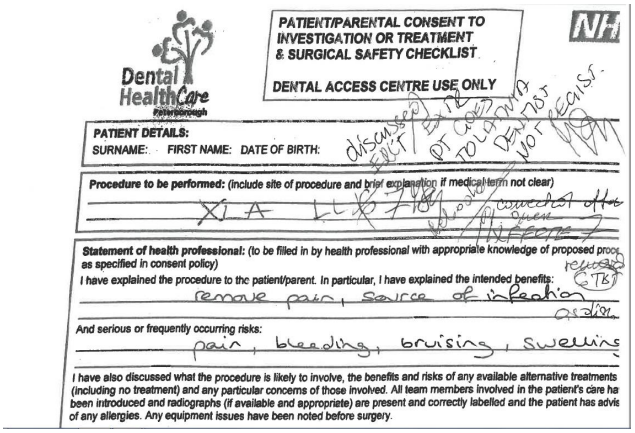
I believe the consent form has significance in the review of this event, hence the following detailed description.

A version of the Trust consent form, as routinely used in the Dental Service is present with the notes which I was able to examine closely. It is largely completed, the exception being the first boxed section, where the patient's name and date of birth have not been entered.

The second boxed section, signifying that the proposed treatment, the reasons for it and the risks associated with it have been explained to the patient has been completed and it is signed and dated by the dentist. It is clear that most of this part of the form (the benefits and risks) has been entered in a different hand, I presume by a dental nurse, and the dentist has provided only the signature and date. If this is the case, I find nothing unreasonable in a registered dental nurse writing this part of the form, as entries by either the nurse and dentist would also fall within the Trust's requirement for this being done by a 'health professional with an appropriate knowledge of the proposed procedure as specified in consent policy'. The top part of this section appears to be in the dentist's hand and will be considered later.

In the last section a further declaration, concerning the actions taken following the procedure has also been signed by the dentist. Alongside each of the dentist's two signatures are dates; written as '28/4/18' and '28/04/18'. Both of these dates are crossed out and replaced with other dates written as '02/05/18' and '02/05/8' respectively. All these original and amended dates appear to be in the dentist's hand. The patient has countersigned the form showing that they have agreed to the proposed treatment being undertaken alongside the date; 02/05/2018. This is most likely completed in the patient's handwriting.

Small amendments such as these to the dates, might be acceptable although not ideal. In my view, on balance the amended dates appear to reflect that the consent form was prepared on April 28th but not brought into use until May 2nd 2018, that is when the patient provided a record of their consent to an extraction being carried out when signing the form on that date. Amendments to the written clinical record, and this includes the consent form, may be necessary to correct errors, although any deletions must be done in such a way as to allow the original text or handwriting to remain legible. However, the value and validity of this particular consent form is compromised by the complexity and confusion of the handwritten amendments and annotations in the second boxed section of the form, as reproduced below:


Dental HealthCare Peterborough

PATIENT/PARENTAL CONSENT TO INVESTIGATION OR TREATMENT & SURGICAL SAFETY CHECKLIST

DENTAL ACCESS CENTRE USE ONLY

NH

PATIENT DETAILS:
SURNAME: FIRST NAME: DATE OF BIRTH:

Procedure to be performed: (include site of procedure and brief explanation if medical term not clear)

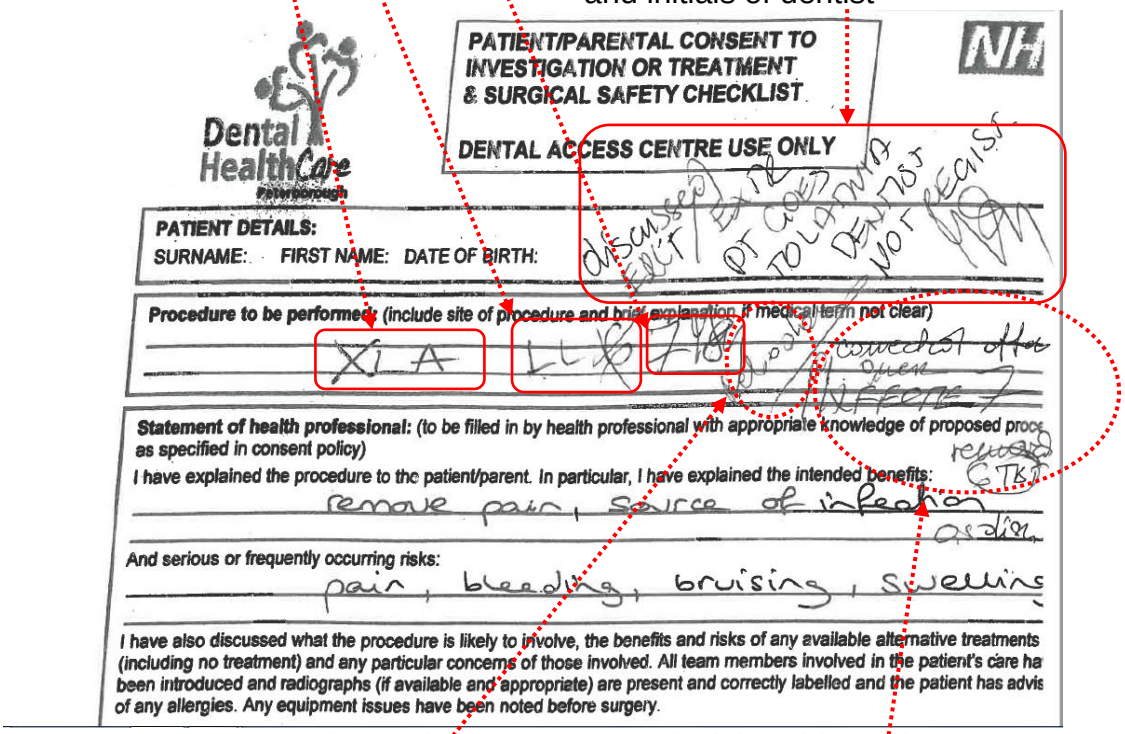
Statement of health professional: (to be filled in by health professional with appropriate knowledge of proposed proc as specified in consent policy)
I have explained the procedure to the patient/parent. In particular, I have explained the intended benefits:

And serious or frequently occurring risks:

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved. All team members involved in the patient's care ha been introduced and radiographs (if available and appropriate) are present and correctly labelled and the patient has advis of any allergies. Any equipment issues have been noted before surgery.

Examined in detail, at the top of the form are boxed sections headed:
PATIENT DETAILS:
SURNAME: FIRST NAME: DATE OF BIRTH: This section has not been completed.

Procedure to be performed: (include site of procedure and brief explanation if medical term not clear)
Entry in this section begins *XLA* [ie extraction under local analgesia]
LL 6 [indicating Lower Left <u>first</u> molar], but the number *6* is crossed out
[Number] *7* [replacing crossed out number 6, and initials of dentist]
Reads: discussed [?] ERCT/EXTR Pt GOES TO LATVIA DENTIST NOT REGIST and initials of dentist


Dental HealthCare Peterborough

PATIENT/PARENTAL CONSENT TO INVESTIGATION OR TREATMENT & SURGICAL SAFETY CHECKLIST

DENTAL ACCESS CENTRE USE ONLY

NH

PATIENT DETAILS:
SURNAME: FIRST NAME: DATE OF BIRTH:

Procedure to be performed: (include site of procedure and brief explanation if medical term not clear)

Statement of health professional: (to be filled in by health professional with appropriate knowledge of proposed proc as specified in consent policy)
I have explained the procedure to the patient/parent. In particular, I have explained the intended benefits:

And serious or frequently occurring risks:

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved. All team members involved in the patient's care ha been introduced and radiographs (if available and appropriate) are present and correctly labelled and the patient has advis of any allergies. Any equipment issues have been noted before surgery.

Reads 'rebooked' Indecipherable writing

Importantly, entries in this second section indicate that a change was made, probably by the dentist, to the written description of the tooth intended for extraction, ie from LR6 (the lower right first molar) to LR7 (the lower right second molar). The dentist intialled this change, although as it is not dated it cannot be ascertained at what point this occured. Given the other amendments on this consent form (that is the changes to the dates from 28th April to May 2nd) it is quite possible that the consent form, when given to the patient for their signature on May 2nd indicated, through the amendment, that the tooth intended for extraction was the lower right second molar (LR7). The tooth that was extracted on May 2nd was this lower right second molar. If this sequence of events is actually the case, then the 'wrong' tooth was not extracted and a Never Event did not occur.

However, because of the extensive additions and annotations to this consent form other interpretations are also quite possible. Most importantly, I would suggest that this form does not provide a defensibly valid record of the patient's confirmation of their consent to a particular dental extraction being carried out.

I was provided with a copy of the Concise Root Cause Anlaysis Investigation Report for this case, in final draft form, which indicates that during interviews it was determined that changes were made to the consent form after the event : " ‘LL6’ was later scored out by the Dentist and replaced with ‘LL7’ after they identified that the wrong tooth had been removed".

The further relevance of the process of securing informed consent and completion of consent forms to the avoidance of wrong site surgery will be discussed later in this part of my Report (see Section 5).

The Trust Investigation Report also identifies that the dental nurse providing chairside assistance in this case had only recently met the dentist and so they had not established a close working relationship. Although the nurse was familiar with the Clinic having worked there previously in a substantive post, she was working as locum at the time. It is also reported that on the day the extraction took place the she had to "regularly needed to leave the room to find equipment" as it was not fully stocked.

Finally, the timeline outlined in the Concise Root Cause Anlaysis Investigation Report shows there was a delay of a week before this Incident was formally reported.

I was mindful of these issues when undertaking my programme of visits to the Clinics and the relevant findings are covered in the second part of this report.

4.2.2 I also examined the clinical record for Case 5, which included both the documentation of the initial outpatient assessment visits at the Brookfields clinic and the paper records of the subsequent hospital daycase extractions. There was a

substantial amount of paper record in total. I had the valuable opportunity to discuss with one of the dentists involved, the pathway and procedures followed when a patient referred to the Trust Dental Service subsequently has treatment carried out under general anaesthesia in Addenbrookes Hospital.

In this particular case, the patient, a healthy 5 year old boy, had been referred by a local dentist requesting the extraction of the lower left first primary ('baby') molar tooth (*LLD*), the referral form saying "Needs extn LLD under sedation - Patient didn't collaborate when we attempted in surgery couldn't even use anaesthesia". The referral was received on January 10th 2018, it was triaged 2 weeks later and the patient attended an assessment appointment on 7th March.

At that appointment an electronic patient record was completed. This includes a dental chart, that is a diagram representing the surfaces of the patient's teeth on which the condition of each tooth can be represented, for example decayed or filled surfaces, and the necessary treatment required indicated, and subsequently recorded. This chart showed the recording of decay in the lower first baby molar teeth on both sides of the mouth.

A 'Green Card' - the Special Dentistry Clinical Record Card - was also used to record the appointment. This also includes a dental chart. In this instance the chart had been used only to indicate the extractions to be carried out (but not the status of the other teeth) and the date of its use not is not indicated. Unfortunately, the teeth indicated for extraction both on this chart, and also as the written treatment plan, were the upper first baby molar teeth; D | D (rather than the decayed lower first baby molar teeth).

An panoramic Xray film is present dated 07.03.18. It is of good quality and whilst this is not the type of film which would usually provide much helpful information about the condition of the primary teeth in a patient of this age, there is clear evidence of bone loss consistent with chronic infection around the roots of the lower left first primary molar (LLD). There is no firm Xray evidence of decay in either of the primary molars on the right hand side, neither is this particular film helpful in establishing whether the upper primary molar teeth are affected by decay. I could see no written reporting of the findings of the Xray in the 'Green Card' clinical record.

Also among the paper notes is a 'Consent Form 2' signed by the examining dentist and patient's mother giving consent to a procedure described as "XGA D | D EUA and any other carious teeth". 'XGA' means extraction under general anaesthetic, 'D | D' signifies the upper first primary molar teeth and ' EUA' is examination under anaesthetic. It also states "remove source of pain/chronic infection" (as intended benefits) and "pain infection damage to permanent teeth".

Arrangements were made at some point around this time for the patient to be placed on the waiting list for admission as a paediatric day case patient at Addenbrookes Hospital for extractions.

The patient had a further emergency appointment at the Brookfields Clinic on 2nd April 2018 because of an episode of pain from the infected lower left first primary molar (LLD). According to the contemporaneous clinical record the dentist "attempted to get him to have LA [*local anaesthetic*] extn [*extraction*]". This appears to mean that the dentist, sensibly, chose to advocate and get agreement for this safer avenue of treatment. Unfortunately the patient did not cooperate with this approach. An antibiotic was prescribed and the previously planned extractions under general anaesthetic were reinstated as the chosen treatment plan. There was an opportunity at (or as consequence of) this emergency visit to make a check to ensure that the proposed treatment on the paper 'Green Card' was appropriate to address the problem presenting at that emergency visit. Had this happened, the error of recording the wrong teeth for extraction made on March 7th should have been discovered.

I note there is no mention of this patient visit or its possible significance in the Concise Root Cause Analysis Investigation Report for this Never Event.

The patient was seen for extractions under general anaesthetic on 25th June. The operating dentist saw the patient with his parents prior to the start of the list. Although there was a conversation confirming that the patient had attended for the removal of two teeth, there was no re-examination of the mouth or verbal clarification of which particular teeth the parents were expecting would be removed, which could have highlighted the error in the treatment plan. The operating dentist signed and dated the Consent Form 2.

In theatre, initially two upper teeth were extracted in line with erroneous treatment plan. The operating dentist noted, after they had been removed, that these teeth had no visible decay and recognised on further examination that the two lower first baby molar teeth were in fact those requiring extraction. These two teeth were also removed following discussion and agreement of this course of action with the dental nurses in theatre.

5. Are there Common Causes Linking the Never Events?

5.1 Retained Foreign Objects Post Procedure

Never Event 1 involves a gauze pack left in the mouth at the end of a long episode of dental treatment under general anaesthetic. It was discovered and removed by the anaesthetist whilst (s)he was recovering the patient in the operating theatre. This incident can be attributed to a failure to follow established procedures for counting the number of packs/swabs. This is the only Never Event in this Retained Foreign Objects category and there is no common link between this and the other reported Never Events, other than a human failure to adhere to a policy.

5.2 Wrong identification of the tooth to be extracted in one quarter of the mouth.

Never Event 3 involves a patient referred for surgical removal of a lower right first molar (LR6), where the lower right second molar (LR7) was instead removed in error. This can be attributed to misidentification of the tooth. Application of the LocSSIPs requires the dentist to undertake a verbal count of the dentition from midline whilst pointing with an instrument to each tooth, and whilst being observed by the nurse, to confirm the surgical site. This observed counting did not take place on that occasion.

Similarly, Never Event 4 involves the removal of the lower left second molar (LL7) where the anticipated extraction was the lower left first molar (LL6). Unlike Event 3 this was not in a patient referred for extraction of a specific tooth but one seen to deal with pain occurring from somewhere in that quarter of the mouth. The LocSSIPs requirement to count teeth did not take place, but was not observed by the nurse. There is another difference in that the dentist appears to have lost clarity of intention as to which tooth actually needed to be removed, as both teeth had featured in previous lengthy conversations with the patient as possible candidates for extraction.

5.3 Teeth in wrong jaw recorded as requiring extraction

Event 5 was initiated by a transcription error in preparing a paper record from the electronic record which wrongly indicated that two upper teeth should be removed, rather than the two corresponding lower teeth. There were later opportunities to identify this error but unfortunately this did not occur. There are no major similarities with other Wrong Tooth Events other than broad issues around securing Consent which are discussed in Section 6.

6. Securing and Recording Consent as an aid to avoiding Wrong Site Surgery

6.1 Quality of Communication.

I have read the Trust's *Consent to Examination, Treatment and Sharing Information Policy* (version 4.4,March 2016) which is a model of detail and clarity. Section 5.4.4 of this policy is explicit on the need for written consent where treatment such as dental extraction is carried out under local (or general) anaesthetic.

Sections 5.5 - 5.7 cover the issues to be addressed when the proposed treament is discussed, and written consent obtained, ahead of the treatment appointment and in particular the importance of ensuring that the intended treatment is still relevant and the patient still agrees to give to consent to its being carried out:

> "If a form is signed before the patient arrives for treatment, however, a member of the healthcare team must check with the patient at this point whether they have any further concerns and whether their condition has changed. This should be recorded in the patient's health records. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. (section 5.7.2 of the Policy)
>
> When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?" " (section 5.7.3 of the Policy)

There are principles outlined above which have relevance to Never Events 4 and 5 above, and probably also the incident reported as Event 3 from 2017.

A 'wrong tooth' Never Event happens when a particular tooth is planned for extraction and informed consent secured for removal of that specific tooth - but when treatment is actually carried out a different tooth is removed. Good communication between dentist and patient is needed to ensure that the patient understands what is being proposed. The communication during the process of securing written consent forms an important part of the dentist's mental preparation for extraction of the correct tooth. The choice of language and use of non-verbal communication is also an important factor.

Following the model outlined in the Trust's Consent Policy cited above, in Event 5 the operating dentist (who had not seen the patient before) had a conversation with the parents to check the intended procedure. Had the dentist included as part of this an instruction such as 'point to (or show me) the teeth which you are expecting to have removed today', wrong site extractions should have been avoided.

In Case 3 a patient was seen on referral from a general dental practitioner by an Oral Surgeon working on a sessional basis for the Trust. The referring dentist had requested the extraction of the root of a lower molar on patient's right side. I could not examine the hard copy clinical records but an account of events can be found the Concise Root Cause Analysis Report. It reports the clinical narrative as follows:

> "On initial examination the Specialist Oral Surgeon was only able to see a single mandibular [*lower jaw*] molar tooth – left mandibular second molar; LL7. It was not immediately obvious to the Surgeon why the tooth needed to be removed and therefore the patient was asked to provide some history and confirm why the extraction was required. The patient was referring to LR7 [*the lower right second molar*], however as this tooth was not visible as the gingiva [*gum*] was healed over, the Specialist Oral Surgeon considered the history to relate to LL7 and as he was happy with the history provided and reasoning given he proceeded with the extraction of LL7".

There was clearly poor communication. Again, had the surgeon simply asked 'point to (show me) the tooth which you are expecting to have removed today', he would have immediately been reminded which tooth actually required his attention.

In the event, the patient had consented to the removal of the lower left second molar (which apparently had evidence of decay) and so a Never Event had not occurred when it was removed.

6.2 Time of the securing informed consent.

In Event 4 the clinical narrative of the Concise Root Cause Analysis Report records:

> "At interview, the dentist reports that a re-assessment of the teeth was not re-done before extraction due to time pressure due to the business of the clinic and a concern that the appointment would overrun".

I believe that using a consent form which had been prepared at a previous appointment (several days earlier) denied an opportunity for the dentist to achieve a better mental focus for extraction of the correct tooth. Had the discussion about which tooth needed to be removed, as part of to securing consent, happened immediately prior the extraction the adverse outcome might have been avoided.

I accept that there are situations where it is appropriate to have a consent form signed ahead of the surgical procedure but this should not usually be necessary when patients are being seen for planned extractions under local anaesthetic in the outpatient clinic setting.

6.3 Written Information Provided on the Consent Form

In the Trust consent forms I have seen during this review process the written descriptions of the procedure to be undertaken have sometimes used longhand descriptions, eg "removal of the lower left wisdom tooth under local anaesthetic" but more frequently employed dental shorthand terms such as "XLA LL6" (as in Event 3) or " XGA D | D EUA and any other carious teeth" (as in Event 5). Although using jargon free plain English may take slightly longer it does fulfil the requirement, as stated in one part of the consent form, for a 'brief explanation if medical term not clear'. It might also signify that the consent form had been used as a record of a meaningful discussion of the proposed treatment with the patient in terms they could understand and help the dentists clarify their understanding of the necessary intervention.

7. Other Reflections Arising from the Review of Never Events

7.1 Where patients are referred by outside dentists into the Trust Dental Service for extraction of specified teeth, or where one Trust dentist generates a treatment plan for another to follow (for example when a patient is passed on for treatment under sedation or general anaesthesia) the ultimate responsibility for avoiding a Wrong Tooth extraction rests with the dentist removing the tooth. If there is any uncertainty about whether a tooth, or which tooth, should be removed this should be resolved by a discussion between the dentists involved before any extraction is carried out. In such circumstances challenging a treatment plan in a reasoned way is good professional practice.

7.2 I noted that sometimes the clinical information provided by the referring dentist was inaccurate, apparently overstating the difficulty of the problem perhaps to justify the patient being referred into a specialised service. For example in Event 3 the referral requested the removal two teeth. One was a wisdom tooth with no reported symptoms where extraction was not indicated when the relevant NICE guidance was a applied by the Trust surgeon and the other was an apparently largely intact tooth which was described as 'broken down to bone level'. This tooth remained in the mouth following the Wrong Tooth extraction and has subsequently been root filled and restored. Staff should feel confident not to carry out treatment if other options more appropriate options exist, even if the patient has other expectations based on what they have previously been told. I recognise this can lead to difficult conversations with the patient or referring dentist.

The Dental Access Centre patient in Event 4 initially had an episode of pain from an infected tooth which was apparently successfully treated with antibiotics pending substantive further treatment. The patient had expressed doubts that a tooth needed to be removed as another dentist had told her it could be saved. It would have been reasonable for the Trust dentist to have discharged the patient to the care of this other dentist at that point.

7.3 Where an Incident has been reported, case notes should not be archived but remain easily accessible. All relevant Xrays (radiographs) relating to incidents should be retained; Xrays from Event 4 were no longer available for review as they had been sent (with good intention) to a dentist who had taken over care of the patient.

Section Two. Safety and Quality of the Trust Dental Services

1. Starting Point; The June 2018 CQC Report

1.1 The CQC carried out an inspection of the Trust's Community Dental Services and its Community Health Services for Adults earlier this year. Their team of five inspectors, five specialist advisors and an executive reviewer carried out visits to clinical sites (including the paediatric day surgery facility at Addenbrookes Hospital) on 27th / 28th March; the date of their report being 20th June 2018. This report can be found at: https://www.cqc.org.uk/sites/default/files/new_reports/AAAH1997.pdf

1.2 The CQC inspection included the domain *'Is the service safe?*' and the team rated the Trust Dental Service as 'Good', listing indications for this finding. Of particular relevance to dental Never Events they reported:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

The CQC did though highlight in their report two safety issues where a requirement for action was indicated, that is:

- The Trust should review the storage of patients' dental care records to ensure they are held securely and confidentially at the Brookfields location.
- The Trust should review the process around medicine management and daily medicine fridge temperature monitoring to improve consistency across the whole service

In addition it was noted that "Staff did not secure the clinical waste bin at the Brookfields location and it was accessible to the public".

I looked into subsequent progress on these three matters when I was carrying out my own review of the Dental Service. At Brookfields, the cabinets used to store patients records can be, and were, securely locked at the time of my visit. The bulk clinical waste bins were locked shut and chained and locked in position outside the surgery. In my view this does not present a risk to the general public at present. Work is however planned to construct a secure enclosure around them.

I determined that medicines management and the medicine fridge temperature monitoring processes have been addressed.

2. Approach and structure of my review

2.1 Given that the extensive inspection by the CQC was recent and positive, and a further fully comprehensive review was impractical in a short space of time, my approach was based on a rapid appraisal of the clinical facilities and structured discussions with selected members of the staff responsible for and working in them. Over several days I visited the clinics in Cambridge, Ely, Huntingdon, Peterborough and Wisbech. I also took the opportunity of chance conversations with the other staff I met to clarify and validate what I had been told about the operation of key policies and procedures. It must be said from the outset that I encountered complete cooperation in organising my visits and meetings and encountered the highest level of openness and willingness to engage in the process from all the Trust staff involved. I did not seek to differentiate between the various clinical activities of the Trust Dental Service (special care, dental access and oral surgery referrals) in my approach or reporting.

The particular surgeries where reported Never Events had occurred were viewed to assess whether the clinical environment might have had some impact and I was able to meet the dentists involved in two of these incidents. They were honest and candid at these meetings and I commend their professionalism in the way they handled what must have been for them quite difficult and personally traumatic discussions.

2.2 In my review of the environment of care at the clinics I gave most attention to a number of areas which might have put patients at greatest risk, including

- decontamination and cross-infection
- sedation, particularly intravenous sedation
- ionising radiation (Xrays),
- equipment and procedures to manage adverse medical events and patient collapse
- pressure vessel safety.

I also followed up issues raised in the reviews of Never Events including equipment stocks, staffing and chairside teamwork, and the involvement of staff in training events.

The issue of the risks to staff in dealing with patients, and the support provided to them personally and professionally by the Trust was also considered.

3. General Findings

Presentation of findings will be relatively brief and focus on exception reports. The lack of detailed reporting of the other, positive, aspects of the Trust Dental Services through this pragmatic decision should not be misinterpreted. It is my clear overall impression that the Trust provides high quality and safe dental services.

3.1 Overview of Clinics

All the clinics I visited were clean, tidy and seemed well organised. The decor and atmosphere were calming and although necessary notices and health information were displayed it was not overwhelming in quantity. Without exception the clinical environment was entirely suitable to permit delivery of safe and high quality dental care.

The Brookfields, Cambridge site, despite having been extended, is somewhat crowded and this is mainly reflected in limited office space and the number of computer stations available for administrative work. The reception and main waiting area are also rather small.

At Wisbech there are some constraints on the design of the clinic, presumably imposed by the layout of the building. One of the surgeries is both lacking in daylight and quite cramped, with in places little space between the cabinetry and the dental chair. Although this is likely to have little impact on the patients, it does not appear to be a particularly comfortable working environment.

3.2 Management and Organisation

The Trust Dental Service is clinically led by a very experienced dentist who is on the General Council's specialist list in Special Care Dentistry and has other relevant clinical interests such as sedation. The Service covers a large area and there is a geographical division of managerial responsibilities between Cambridge/Ely/Wisbech and Huntingdon/Peterborough which reflects the two areas covered by the precursor organisations. There is a Dental Service Manager and a Practice Manager for each. The staff named above are key members of the Leadership Team for Trust Dental Services which is headed by the Service Director, Ambulatory Services. I inspected recent minutes of the Leadership Team which usually meets every month. They are recorded in an exemplary fashion with clear action points and progress monitoring. The Service Director links upwards into the Trust's structures providing oversight of governance and quality throughout the organisation.

I am confident that this approach to managing and organising the Dental Services is a good model for quality and safety to be monitored, maintained and improved.

Highly qualified clinicians such as the Head of Dental Service constitute a very valuable resource in delivery of Special Care Dentistry. Achieving a productive balance of time between managerial, training and treatment roles is paramount. The Trust should consider, in the context of both succession planning and providing cover for absences, how to ensure that the current high standard of clinical leadership is secured into the future. If the Trust has ambitions to provide Dental Services across a wider area in future, ensuring access to adequate senior clinician sessions to provide both specialist treatment and leadership will be paramount.

3.3 Staffing

There is a largely stable and well-established permanent workforce. In talking to staff I encountered a high level of commitment to the work of the Service. For example, I heard that one nurse, having moved from working in a private practice in London, initially got temporary work in one of the Trust clinics and then - because of the professional fulfilment she found - applied for a permanent post, even though there was a significant associated burden of travel. The service provides an environment for Foundation Training of recently qualified dentists and I was pleased hear at first hand about the supportive environment being offered for career development. I talked to a dental nurse who was currently working on her Record of Competence in pursuit of additional qualification in Special Care Dental Nursing, with the support of the Trust.

Dental nurses, whilst they might have more regular sessions providing chairside support to a particular dentist, also worked in other surgeries and with other dentists. This is helpful in developing working relationships and gaining familiarity with other kinds of work and work environments. It was clear that duties such as stock checking and safety routines were properly scheduled and allocated to named responsible staff members and records maintained.

Appropriate arrangements are in place for staff appraisal, in-service training and continuing professional development. It is important to ensure that all staff, including those contracted to work on a limited sessional basis, can attend staff training events, particularly (in the context of this report) those associated with responses to serious incidents.

There may be a risk of staffing levels not being adequately maintained in the future. When recruitment is necessary, the Service is in competition with other employers, including private dental practices where employment packages can be significantly better. Unfortunately the current relatively short term approach of NHS commissioning does not encourage clinicians seeking long term career moves to consider Trust employment.

3.4 Higher Risk Areas

Sensibly the Trust has avoided going down the route of using a hospital Central Sterile Services Department (which frequently leads to loss of instruments and supply chain problems) and provides local decontamination of non-disposable instruments in each clinic. I could see that the Trust has implemented (as fully as possible within the constraints of space) the current guidance on decontamination equipment, policies and procedures and I could see no cross infection risk to patients arising from local decontamination. In particular I examined the dates on some packs of sterile instruments at all locations to ensure they were not out of date.

At Wisbech there is currently no functioning washer/disinfector and this has been the case for about six months. Alternative procedures are in place which are safe but inefficient. This will covered in more detail in Section 3.5.

Sedation service are properly conducted and appropriate policies and procedures are in place to ensure safe practice. Intravenous sedation, which carries a higher level of risk of morbidity is carried out only at Brookfields, Cambridge in an appropriately spacious and properly equipped clinical environment. The staff involved have received necessary training and indeed some have been approved as trainers in their own right. I appraised the facilities there and found them entirely satisfactory. However as this is a high risk area of practice the Trust may wish to commission a specialist external audit to validate the safety and quality of the Intravenous Sedation treatment it carries out, for example from SAAD (The Society for the Advancement of Anaesthesia in Dentistry).

Radiographs (Xrays) are taken at each clinic, both in individual surgeries and in dedicated rooms where panoramic films are taken. There is an aim to move entirely to digital technology, which has many advantages and is to be commended. Correct policies and procedures are in place to manage the risks associated with use of ionising radiation.

I was reassured that staff were aware of what was required when patients became unwell or were facing collapse and there was an appropriate schedule of training involving dental teams in each clinic to manage such adverse events collaboratively. Emergency drugs are supplied under contract from hospital pharmacy and are checked by them on a regular basis to ensure they are not out of date.

Autoclaves are used to sterilise non-disposable dental instruments under pressure which is a risk. To be safe and work correctly to ensure sterility they must be properly serviced and maintained. I was satisfied that appropriate arrangements were in place for this.

3.5 Availability of supplies and equipment

I heard on more than one occasion that supplies of consumable equipment can sometimes not arrive in a timely way or that the expected product has not been supplied as somewhere in the chain of requisitioning and supply a decision is made to substitute an alternative without reference back to the original order. It is apparently not uncommon for consumables in routine use to be taken from one surgery to another to meet shortfalls. Ordering in the past had been more direct (as it remains for the Wisbech clinic) but more recently a third party, Serco, has been introduced into the chain of requisition and supply within the Trust. This supply problem has not reached the point of being a risk to patient safety or the quality of the care delivered, but is inefficient and a distraction to the staff.

The lengthy delay in replacing the Eschmann washer/disinfector at the Wisbech clinic (see 3.5) appears at least in part to relate to the complexities in the requisitioning/supply process.

3.6 Risks at Interfaces with Other Organisations

The Trust has entered into contractual arrangements to share its clinic facilities with other providers. This is a both a useful efficiency and a benefit to the local community. However, there can always be risks in this kind of arrangement when lines of demarcation and areas of responsibility are not clearly agreed and enforced. I was pleased to see that, for example where the decontamination area was shared, key items of equipment and storage facilities were kept entirely separate**.** I found no particular opportunity for increased clinical or reputational risk to the Trust arising from the way clinic-sharing arrangements have been set up.

The users of Trust Dental Services are of many nationalities and a significant number have little understanding of English. The reception staff routinely attempt to ensure that such patients attend with someone who is able to translate. If not, the fallback is through the use of a telephone translation service commissioned by the Trust. I was told that this service does not always reliably produce someone able to talk to the patient in their own language. This makes dealing with their clinical problem more complicated and risky. Although the staff I talked to about this understood how to manage the risk it is frustrating when the translation service does not reliably work as it should.

3.7 Risks to Staff

I discussed the risks associated with a 'sharps' ('needlestick') inoculation injury with several members of staff who were all clearly aware of the policy and necessary actions in relation to themselves and the 'source' patient. The Trust has a contractual arrangement with Addenbrookes for Occupational Health services and this would be the immediate point of contact for a member of staff sustaining an inoculation injury in normal working hours. However, as the Trust Dental Service provides extended hours appointments it would be useful to make practical checks that staff members at all sites do have secure access to appropriate advice and timely availability of post-exposure prophylaxis if needed outside normal working hours.

When I visited the Peterborough clinic it was clear that the reception desk is quite low. Whilst this is helpful for patients attending in wheelchairs, it does leave reception staff rather exposed and vulnerable to any visitors who may become aggressive.

At the Wisbech clinic there is a small area where gas cylinders are in correct safe racked storage, but access is rather cramped and so it might be difficult for staff to correctly lift and safely move a heavy full cylinder.

4. Summary

From what I took away from my visits, formal interviews and other discussions with people I met, together with the clinical notes and papers I reviewed, I am of the firm opinion that overall the Trust delivers safe and high quality dental services. There is the culture, and the necessary structural elements in place, to learn from occasional adverse incidents in pursuing continuous quality improvement.

Melvyn Smith

10th October 2018