Summary of: Patient safety in dentistry – state of play as revealed by a national database of errors

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FULL PAPER DETAILS

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Introduction Modern dentistry has become increasingly invasive and sophisticated. Consequently the risk to the patient has increased. The aim of this study is to investigate the types of patient safety incidents (PSIs) that occur in dentistry and the accuracy of the National Patient Safety Agency (NPSA) database in identifying those attributed to dentistry. **Methods** The database was analysed for all incidents of iatrogenic harm in the speciality of dentistry. A snapshot view using the timeframe January to December 2009 was used. The free text elements from the database were analysed thematically and reclassified according to the nature of the PSI. Descriptive statistics were provided. **Results** Two thousand and twelve incident reports were analysed and organised into ten categories. The commonest was due to clerical errors – 36%. Five areas of PSI were further analysed: injury (10%), medical emergency (6%), inhalation/ingestion (4%), adverse reaction (4%) and wrong site extraction (2%). **Discussion** There is generally low reporting of PSIs within the dental specialities. This may be attributed to the voluntary nature of reporting and the reluctance of dental practitioners to disclose incidences for fear of loss of earnings. A significant amount of iatrogenic harm occurs not during treatment but through controllable pre- and post-procedural checks. **Conclusion** Incidences of iatrogenic harm to dental patients do occur but their reporting is not widely used. The use of a dental specific reporting system would aid in minimising iatrogenic harm and adhere to the Care Quality Commission (CQC) compliance monitoring system on essential standards of quality and safety in dental practices.

EDITOR'S SUMMARY

Because of the way in which we organise ourselves and our lives in general, but particularly in terms of practising dentistry, we have a tendency to compartmentalise. An obvious example might be preparing and sterilising sets of instruments for particular procedures, the focus being on examination or restoration but not on prosthodontics, which we have disregarded at a previous stage of diagnosis.

This logical attention to detail may mean that we miss the bigger, or wider, picture. So when the matter of patient safety is raised we might similarly think of it in relation to discrete actions; protecting the airway, not fracturing an endodontic instrument etc rather than as a continuum of the patient's progress or journey through the practice.

Taking a wider perspective, this paper uses data reported to the National Patient Safety Agency as a starting point to

analyse the issues of patient safety in the dental setting. In doing so it not only alerts us to the paucity of information on the subject to date but also raises awareness of the ways in which we need to regard the overall welfare of those we treat. Mixed into this picture is also the somewhat delicate matter of the extent to which errors and mistakes are reported, and the mechanism by which this recording takes place.

Iatrogenic seems almost to be a polite euphemism. Why should dentistry and medicine be graced with a term for mistake, or error, which has no application elsewhere despite the consequences affecting those who are served? A piece of baking tin in a slice of bread does not make in an iatrogenic loaf, so why should we attempt to hide behind a special word to try and ameliorate our failings in patient care, and similarly our reporting of them?

The issues raised here should not be considered critical of our patient care *per se* but rather as comment on the way in which we construct our view of patient safety as an overall concept, from polished floor in reception to instructions after an extraction.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 213 issue 3.

Stephen Hancocks
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IN BRIEF

- Highlights the presence of an anonymous reporting system for iatrogenic harm to patients in a dental setting.
- Outlines the effects of implementation of the CQC's compliance monitoring system.
- Emphasises the need for dental practitioners to check correct patient notes are being used, correct consent forms signed and accurate records kept.

COMMENTARY

At a time when the effectiveness of treatments and patient safety and satisfaction are under the spotlight this paper addresses an important issue that is relevant to all members of the dental team. Given the importance of patient safety it is interesting that this is an area that has received little if any attention by researchers. This study considered dental reporting to the National Reporting and Learning System housed by the National Patient Safety Agency and the results are startling. Equally of interest is the low level of dental reporting and the fact that it is optional. In essence, the results of this study can therefore be assumed to be a significant under-recording of the actual number of patient safety events occurring.

The authors quite rightly point out that with the increasing complexity of dentistry being provided, the probability of a patient safety issue occurring is likely to be higher. This of course can be mitigated by appropriate training and case selection. It would seem, however, that most errors (48%) reported in this study did not relate to actual treatment but were related to pre- and post-procedural checks. In a similar vein equipment failures accounted for up to 15% of events recorded. This doesn't come as any surprise. As professionals we focus rightly on the procedures we perform on patients and pay less attention to clerical and equipment matters. This study highlights the importance of all the things we do, especially activities that fall

around the procedure themselves, particularly when errors in these non-clinical domains put patients at risk of adverse events.

The development of protocols and more patient centred guidelines would, it is suggested, reduce the number of patient safety events in dentistry. It would be sensible to involve patients in the development of these. In addition, further data collection is needed to establish the true nature of the problem.

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AUTHOR QUESTIONS AND ANSWERS**1. Why did you undertake this research?**

There is sparse published literature exploring patient safety in dentistry. The reason for this may lie in the current framework of regulation and the lack of information regarding reporting adverse incidents. Furthermore, 'minor' injury caused by a dentist may be deemed too insignificant to record.

Since April 2011 the CQC requires all dental practices in England to comply with established guidelines, in effect to record and act upon patient safety issues in dentistry.

The objectives of this study were to:

- Investigate the typology of PSIs that occur in dentistry
- Suggest approaches to providing greater emphasis on patient safety within the specialty.

2. What would you like to do next in this area to follow on from this work?

It is clear from the study that iatrogenic harm does occur in dentistry. The NPSA database is a voluntary reporting system and this in turn may suggest that the level of harm is significantly under reported.

We would like to do a systematic review of all published literature and any grey literature of documented iatrogenic harm due to dentistry worldwide to establish an adverse error rate.

In this paper we make recommendations on how the recording of PSIs in the NRLS database could be improved. It is hoped that the agency that is to house and maintain the database will engage with us and allow further analysis of the dental data.