All members of the dental team have an ethical duty to put patient safety first. Quality assurance systems enable dental practices to monitor their services, ensuring care is provided in a safe environment and meets the needs of patients.
Dental practices are expected to have a quality assurance system in place to monitor and, if necessary, improve services. This is a requirement of the current NHS General Dental Services contracts and is likely to be a requirement of any future contracts.

Quality assurance covers all areas of dental practice. The aim is to maintain and improve standards of patient care and safety.

Evidence of effective quality assurance by dental service providers is also required by the different regulatory bodies in England, Scotland, Wales and Northern Ireland. Following the Francis Report on Mid-Staffordshire NHS Trust, the Care Quality Commission (England) proposes to change the way it regulates, inspects and monitors services based on what has the most impact on the quality of patient care. It envisions that inspectors will use the following criteria when assessing services.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people’s needs?
- Are they well-led?

**Key points**

1. Quality assurance requires an organisational culture where:
   - openness and participation are encouraged
   - education and research are valued
   - people learn from mistakes
   - good practice is freely shared.

2. Quality assurance should ensure consistency, so that patients can be confident that they will always be treated safely and appropriately.

3. Quality assurance requires effective procedures and policies for the following:
   - infection control
   - safeguarding children and vulnerable adults
   - dental radiography
   - safety of patients, staff and the wider public
   - evidence based practice in line with relevant guidance
   - data protection
   - employment, training and development
   - patient information and involvement
   - fair and accessible care
   - investigating and learning from complaints
   - raising concerns
   - clinical audit and peer review.

(Adapted from the 12 themes of clinical governance in the Primary care dental services clinical governance framework, Primary Care Contracting, May 2006.)

4. Practice policies and procedures should reflect authoritative national guidance from organisations such as the General Dental Council (GDC), the British Dental Association (BDA), the Faculties of Dental Surgery and General Dental Practice at the Royal Colleges, the specialist societies and the UK Departments of Health.

### Checklist

- Does your practice have a quality assurance system in place?
- Can you demonstrate that you participate in regular clinical audits and review the delivery of healthcare to ensure patient safety and best practice?
- Do you hold significant event audits to learn from things that have gone wrong and highlight examples of good practice?
- Does your practice have policies in place to ensure it meets its legal obligations e.g. infection control, IRMER, data protection, anti-discrimination and child protection?
- Do staff have the opportunity to contribute ideas and raise concerns?
- Do you discuss and act on the findings of patient satisfaction surveys in your practice?
- Have your training needs been reviewed recently? What about those of any employees and/or team members?

### Our advice

Ensuring you have a good quality assurance system in place covering all aspects of patient care is important for patients but it will also help your practice work more efficiently and reduce the kinds of incident that can lead to a complaint or claim.

Consider a review of your practice policies and procedures to check they are fit for purpose and encourage members of staff to get involved by highlighting areas where problems commonly arise, from referrals to professional development.
Many everyday clinical and administrative processes may seem routine and familiar to dental professionals, but even routine processes can go wrong if not carried out conscientiously. There may be consequences for patients, and for your professional reputation.

While it is impossible to eliminate the inherent risks of providing dental treatment, it is in everyone’s interest that dental professionals carry out effective risk management to identify, prioritise and manage all significant threats to patient safety. At the same time, adverse incidents should be investigated to see what lessons can be learned in order to improve the quality and safety of patient care.

Key points
1. Areas of risk include:
   - administrative lapses e.g. failure to follow up referrals
   - system failures e.g. lax data security protocols leading to inadvertent breaches of patient confidentiality
   - clinical lapses e.g. failure to monitor patients for periodontal disease or failure to take radiographs of diagnostic quality at recommended intervals.

2. Effective risk management is a five-stage process. It involves:
   - identifying areas of risk within the practice
   - assessing those risks for frequency and severity
   - removing those risks that can be eliminated
   - reducing the effects of those risks that cannot be eliminated (i.e. implementing risk-containment processes)
   - weighing up the costs of risk (getting it right versus the costs of getting it wrong).

3. Risk-reduction processes should be audited at intervals to ensure they meet current standards and practice needs.

4. Practices should gather information about the safety and quality of their service from all relevant sources, including incidents that have, or could have, harmed patients. These should be investigated and if appropriate, considered as part of a significant event audit (see overleaf: Significant event audit) to identify the causes and implications for patient safety. A system for recording and reporting patient safety incidents is a GDC requirement (Standards for the Dental Team 2013, paragraph 1.5.4).

5. Focus on the learning points from investigations and audits so that practice systems and training can be improved to protect patients from unsafe care.

6. The National Reporting and Learning System, part of NHS England, enables practices in England and Wales to report adverse events which could have, or did, lead to harm for a patient receiving NHS-funded healthcare. Practices in England have a statutory duty to notify the Care Quality Commission (CQC) of a death or serious injury to someone using the service.

Our advice
Effective risk management requires practices to produce written protocols which set out the processes for handling routine and non-routine activities, from infection control to raising concerns. They can then be put in a folder and should be made available to all members of the dental team, including new members of staff at induction, so helping achieve a common understanding and consistent working practices. Such protocols can also be helpful in demonstrating that you have appropriate and robust patient safety systems during practice inspections.

Checklist
- Have all non-routine procedures and activities e.g. surgical extractions or hospital referrals, been identified, prioritised and a strategy formulated for managing any potential risk they present?
- Do you report all adverse incidents?
- Do you review your risk management procedures regularly?
- Do you make appropriate changes following reviews?
**Significant event audit**

This is a way of formally reviewing incidents at your practice using a structured root cause analysis to determine what happened and why, agree what lessons need to be learned and ensure the necessary action is taken to provide better patient care.

SEAs are ideal for analysing more complex cases which have implications for the overall quality of care, particularly system failures. They are not intended to apportion blame so one-off mistakes by individual members of staff should probably not be the subject of an SEA, unless there is suspicion they are the result of underlying system factors, such as confusing protocols.

An a SEA meeting can be useful to allow others in the practice to contribute. To be effective, such meetings require careful preparation and protected time. If it is decided that further action is necessary, a designated person, such as the practice manager, should agree an implementation plan with the relevant staff which prioritises the changes required, identifies a project leader, establishes a timescale and the timing of progress reports.

It is essential to keep a detailed, written record of a SEA, anonymised to protect patient confidentiality, to demonstrate that it was completed satisfactorily.
Patients and other members of the dental team can be a good source of feedback on the quality of dental care and treatment provided by the practice.

The GDC sees complaints as an opportunity to learn and improve service. It also states that those in leadership positions ‘must promote a culture of openness in the workplace so that staff feel able to raise concerns’ if they believe patients are at risk (Standards for the Dental Team 2013, paragraph 8.3.1).

Key points

1. Regular patient satisfaction surveys are a source of useful information about areas for improvement such as appointment times, as well as more serious concerns. Ask a representative sample of patients to complete the survey anonymously following their appointments and analyse the results. Patient satisfaction surveys can also be a good topic for clinical audit (see section 8.4 Clinical audit, peer review and CPD).

2. Details of your complaints procedure should be readily available on the practice website and displayed in the practice where patients can see it. The issues raised in complaints should inform the practice’s quality assurance system.

3. Members of staff should be encouraged to raise concerns about the risks to patient safety posed by colleagues, equipment or practice policies. The GDC says practices should have a written policy in place which is readily available to staff. Once someone has raised concerns they should be taken seriously and offered support.

4. Members of the dental team should have the opportunity to identify priorities for peer review and clinical audit (see section 8.4 Clinical audit, peer review and CPD).

Our advice

It’s important to encourage all patients to give feedback on the quality of the service and care they have experienced so that instances of good practice can be celebrated and problems highlighted. Some patients may express pleasure or dissatisfaction with your practice through the NHS Choices website so it is worth monitoring comments here too.

Checklist

- Do you carry out regular patient satisfaction surveys or invite feedback on your service?
- Does your practice review complaints as adverse incidents so that lessons can be learned? Are improvements communicated to patients?
- Do you have a written policy on raising concerns which has been communicated to all staff?
- Do you invite staff to raise quality assurance and risk management issues during their appraisal or at practice meetings?
Clinical audit and peer review are central to effective quality assurance, ensuring that best practice is being followed and highlighting improvements needed to address shortfalls in the delivery of care.

All dentists working in the UK are required to carry out clinical audit although arrangements differ depending on jurisdiction. For example, in Scotland audits are part of dentists’ NHS terms of service, while in England the CQC will expect dental providers to show evidence of audit activity.

**Key points**

1. The aim of the clinical audit scheme is to encourage dental professionals to become more **critical and structured** in the way they analyse and learn from their experiences.

2. A clinical audit project (see overleaf: Clinical audits) requires those managing a dental practice to:
   - **examine** different aspects of their practice
   - **implement** improvements where necessary
   - **re-examine** audited areas to ensure that a high quality of service is being maintained or further improved.

3. Peer review enables groups of between four and eight dental professionals to work together to improve the quality of service (see overleaf: Peer review). They do this by:
   - **reviewing** aspects of practice
   - **sharing** experiences
   - **identifying** areas for change.

4. Clinical audit and peer review activities are considered part of dental professionals’ compulsory **continuing professional development** (CPD). All registered dental professionals are required to complete a specified amount of CPD in order to maintain their registration. There are also defined core areas of CPD activity for each group of registrants. The GDC requires all registrants to keep a written record of CPD activity, and to produce this record if requested.

**Our advice**

Dental professionals should ensure they are involved in clinical audits and/or peer reviews. Consider taking the initiative in contacting other practices to form a peer review group.

**Checklist**

- Do you conduct clinical audits regularly?
- Do you re-audit at appropriate intervals?
- Are you a member of a peer review group?
- Do you maintain records of all audits and peer reviews?
- Do you keep a record of all CPD activity you have undertaken?
Clinical audits

Local arrangements vary and we suggest you contact your NHS England local area team or health board for details of schemes in your region. Dental audit and peer review schemes will list a number of possible audit topics (such as decontamination, record-keeping and managing emergencies) and will generally set the timescale for completion. Audits undertaken through formal schemes will often be approved as verifiable CPD. Alternatively, you can decide on an audit project within your practice.

All audits should have a project outline including:
• aims and objectives
• summary of the methodology
• timetable
• a detail of educational source material.

You should keep a full record of the audit, including changes made as a result of the audit findings. You may be asked for proof of participation by the CQC, other similar national bodies, or your local NHS body.

Peer review

Peer review allows dental professionals to engage with their colleagues in the dental community. Projects can be organised informally or overseen by local dental audit and peer review schemes (where approved projects may count towards verifiable CPD). Each group of 4-8 dental professionals will discuss which topics they wish to review over a series of meetings and one member will act as convenor.

A peer review project may cover both clinical and administrative aspects of practice but topics must be clearly identified and researched before the meetings; must be relevant to the objective of improving patient care; and demonstrate how changes can be achieved. Meetings must be minuted and any conclusions noted, with an action plan to implement any necessary changes.
I first proposed restorative treatment for the patient when he complained of sensitivity in the upper right quadrant. My examination revealed caries in the lower right second molar (LR7) and upper right second premolar (UR5) and bitewing radiographs were taken. I advised the patient that on completion of treatment he would be referred for extraction of his wisdom teeth.

Unfortunately, the receptionist failed to record the appointment for the restorations in the practice appointment book and when the patient turned up for the appointment I was too busy to see him. As there was a considerable wait until the next available appointment, he was placed on a cancellation list. However, no cancellation appointment became available and, in due course, he was sent a routine appointment, which he cancelled and remade. I was then forced to postpone this appointment as I was going to be away on leave.

During my absence the patient complained of pain and was seen by a colleague. He was referred to a general anaesthetic clinic where his wisdom teeth were extracted shortly afterwards. The removal of the wisdom teeth failed to alleviate the pain and a radiograph later revealed a large cavity in LR7 necessitating extraction.

The patient later alleged that I failed to diagnose and treat the decayed LR7 which had resulted in a year of pain and suffering, and the eventual loss of the tooth.

How we helped
It was clear that there were shortcomings in the practice’s administrative procedures which had contributed to the unusually long delay between diagnosis and treatment in this case. After discussions and with our member’s agreement, we made an out-of-court settlement without admission of liability.