

### Patient safety

We take patient safety very seriously and aim to ensure that incidents affecting patient safety directly and indirectly are kept to a minimum at all times. No matter how careful people are with the work that they undertake, mistakes can sometimes happen. Within our practice we encourage everyone to report mistakes and near misses as soon as possible so that action can be taken promptly.

The following procedure should be followed:

- if an event happens that affects patient safety or potentially affects patient safety
  - if you feel something within the practice might affect patient safety in the future
1. Gillian Haskell has been appointed the Patient Safety Officer within this practice. All patient safety incidents, near misses or concerns should be reported to her.
  2. The Patient Safety Officer will immediately enter the incident, near miss or concern in the incident report book and begin investigations on what happened, how it happened and why. She will consider with the clinician concerned whether the defence organisation should be informed.
  3. Where an incident has caused a patient harm or distress, the Patient Safety Officer will ensure that the patient has been given a full explanation of the incident and what action is being taken by the practice. Where appropriate, an apology will be given and followed up in writing if necessary. All communications with the patient (verbal and written) will be recorded.
  4. The Patient Safety Officer will also consider whether the patient, the immediate family of the patient, members of the team involved in the incident and those responsible for reporting the incident need further support. We aim to encourage reporting of adverse incidents and will not blame individuals when mistakes are made.
  5. When the details of the incident have been established, and if appropriate, the Patient Safety Officer will discuss the matter with the other members of the dental team at a practice meeting. Solutions or changes to current policies and protocols will be discussed fully and action agreed upon. If relevant, changes will be notified to the patient.
  6. The effectiveness of the solutions and/or changes will be reviewed at agreed intervals and the findings reported at practice meetings.
  7. The Patient Safety Officer will ensure that the incident is fully recorded and that the practice risk assessment is updated in the light of the proposed solutions or changes.
  8. The Patient Safety Officer will, where required, report adverse incidents to the Patient Safety Manager at the Primary Care Organisation/Health Board, according to locally agreed guidelines.
  9. Incidents involving a suspected adverse drug reaction or a side effect from a medicine shall be reported to the Medicines and Healthcare products Regulatory Authority (MHRA). Adverse incidents involving medical devices shall also be reported to the MHRA using its online reporting service at [www.mhra.gov.uk](http://www.mhra.gov.uk)