



Shared Learning

from the Dental Patient Safety Foundation Reporting Tool

“What gets measured gets managed” is the DPSF philosophy to encourage reporting. All received information about patient safety events (unsafe conditions, near misses or adverse events) are de-identified contextually (confidentiality is fully protected under federal law), aggregated, analyzed and abstracted by selected experts from our DPSF committees. Reports are generated and disseminated as the only means to learn from our errors. The information in these peer-reviewed reports is provided for its educational value only, and does not purport to establish any legally binding standard of care. Feedback is encouraged.

Case 2021.4: Use of a Contaminated Needle for Local Anesthesia

Situation: Patient A presents just before office hours start in severe pain from an extraction 2 days prior. Not all staff are present. Local anesthesia is administered for pain management, but no other treatment was performed. The syringe was reloaded with a new cartridge in case there was need for additional anesthesia but that second cartridge was never used and the patient was discharged. Because the instrument tray was not removed, it appeared unused to the staff member who subsequently arrived to “set up” the room. Patient B is seated in the room for a procedure requiring local anesthesia. Inadvertently, the SAME NEEDLE used on patient A was also used on patient B.

Case Comments: It is unknown what action was taken after this deviation from safe practice became apparent. Events, such as these should trigger a look-back analysis of what happened and what can be done in the future to prevent a similar occurrence. This is called **ROOT CAUSE(S) ANALYSIS (RCA)**. By its nature, RCA is a reactive approach, which means that the error or adverse event must happen before using it. It is a systematic process whereby factors that contribute to an incident, near miss or unsafe condition are identified and remediated in such a way as to prevent a similar event from recurring. In this case; several improvements became evident, as the following latent system errors were identified: atypical working conditions, inadequate staff training and protocols. The following suggestions were embraced by the team after a debriefing session.

1. Develop a system to notify all team member when a room is ready for turnover.
2. Work as a team, so more than 1 person is aware of what is occurring.
3. Cross train all team members to function if one member is absent.
4. Simple, shared, structured, responses (SSSR) for all activities should be mentally and physically rehearsed on a repeating schedule. Each team member should function independently and without prompt from others.
5. A “**culture of safety**” will inevitably spread across the entire office and should be shared with others!

A Culture of Safety

.....is a dynamic, social environment wherein all members have a shared perception of the importance of safety, all members feel comfortable communicating safety issues, all members are preoccupied with errors, mistakes and failures and **trust** that everyone can collectively learn from these opportunities for improvement. A safety culture is a **just culture** that values **trust** and accountability over blame and shame, as the only way to strengthen systems to prevent or blunt the consequences of inevitable human error. It requires relentless time, commitment and effort to achieve a goal that can always be improved. A safety culture is never satisfied.

Safety must exist for all, or no one is safe.

Recommendations: Both patients should have been contacted and referred for appropriate post-exposure testing and treatment. This typically includes thorough patient history, testing for HIV and hepatitis and possible prophylactic medication and long-term follow-up, as recommended by medical professionals.



Safety is measured by the number and intensity of safety behaviors that a individual or group routinely participates in. It is not measured by outcomes.

The DPSF encourages frequent reporting of unsafe conditions, near misses and adverse events as the only means to close the gap between knowing how to prevent these occurrences and taking the necessary action to do so. Please visit our website.

Additional reading:

Jhugursing, M, et. al. Error and Root Cause Analysis. Brit J Anaesth 17:323-33,2017.

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