Significant Event Analysis
STANDARD REPORT FORMAT

Title: Overbooked Appointments

Date of Significant Event: 15th June 2016

Date of Event Analysis: 29th July 2016

Lead Investigator(s): Pamela Kent

1. What happened?
(Describe what actually happened in detail and chronological order. Consider, for instance, how it happened, where it happened, who was involved and what the impact or potential impact was on the patient, the team, the practice and/or others).

During this week of analyses, all other three dentists were off on holiday leaving only myself as the single dentist in the practice. Having my own patients booked in for regular treatment over the week, I was also responsible for seeing all emergencies for not only my own patients, but also the other dentists. This resulted in a severely overbooked appointment list especially on the afternoon of Wednesday 15th June resulting in a high level of stress for myself and my dental nurse.

Patients were kept waiting for their appointments, regular treatment had to be carried out at a faster pace than normal and I was seeing patients for the first time - some of which were in a great deal of pain and very anxious. High time constraints meant treatment had to be limited to the essential only and some patients expressed annoyance at being kept waiting for their appointment which lead to stress at reception. Of course, patient emergencies are a priority to be seen but this particular afternoon resulted in a great deal of stress for all involved.

2. Why did it happen?
(Describe the main and underlying reasons – both positive and negative – contributing to why the event happened. Consider, for instance, the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event).

The main reason this event happened was due to all other dentists taking summer holidays at the same time. Having one dentist cover all emergencies as well as regular treatment resulted in an unprofessional service which reflects the professional imagine of the practice as a whole. Reception's lack of knowledge of the complexity of certain clinical treatment put myself and my dental nurse under a great deal of pressure in one afternoon in additional to the stress of delivering a high standard of dental care expected at a private practice. Furthermore, reception did not obtain details of the patient's emergency when the patient called looking to book an appointment - some of which were not emergencies and could have been seen the following day or even week by the patient's regular dentist once back from holiday.

3. What has been learned?

(Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education & training; the need to follow systems or procedures; the vital importance of team working or effective communication).

From this experience, individually I have learned that I cope well under pressure however much of this specific pressure and stress could have been avoided by efficient planning and preparation. On reflection, all patients were seen and treated appropriately and as a team, my dental nurse and I work well and efficiently together under pressure. However there was a distinct lack of information obtained from the patient regarding their emergency by reception when the patient called to book an appointment, and the reason for the patient's emergency appointment was not communicated to myself. Furthermore, I appeared unprofessional to patients whom I had never met before by keeping them waiting, and for example - for a patient with a lost filling, I had to place a temporary filling and ask them to make another appointment to return and have it permanently filled.

4. What has been changed?

(Outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a letter of apology to a patient or a new protocol).

At the following practice meeting, I brought up the issue of this event. I explained the impression it gave patients on the practice but also myself as a dental care professional. In addition to the stress it caused for all dental team members involved and the pressure my nurse and I were under especially that particular afternoon. It was decided that we would have regular dentist meetings to agree holiday dates to try to avoid only one dentist being in the practice. Furthermore, if one dentist was in the practice alone, sections of the appointment book both morning and afternoon were to be blocked off and taken by emergencies only.

Following this, I then had a separate meeting with the receptions to explain the different types of dental emergencies that could be possible and explained the information required to be obtained from the patient when they call to book which would be useful for the dentist in advance of the appointment. If unsure how long an appointment is required for a particular emergency, reception is to consult the dentist with the information obtained over the phone from the patient and the dentist will decide when it is most appropriate for them to be given an appointment. All team members were happy with this new protocol and are more knowledge about the different types of dental emergencies. Overall, communication within the practice should be improved resulting in a more professional service with better patient care.

Since these meetings and education on dental emergencies, I have found the team has had improved communication with regards to emergency appointments. However, there are always unforeseen circumstances and with this topic I feel it will continue to be a learning process for all!