

outpatient referrals to an oral and maxillofacial department. The expectation is that if patients are being exposed to radiation that any radiograph should be diagnostic.

Therefore our gold standard is that 100% of radiographs should be diagnostic.

**Materials and Methods:** A retrospective analysis of 157 referrals were included in the audit. For the purpose of the audit the following was recorded.

1. Was radiographic appropriate
2. Was the radiographic diagnostic

The referrals and radiographs were reviewed by a consultant oral and maxillofacial surgeon, a speciality doctor in oral and maxillofacial surgery and a specialist registrar in oral and maxillofacial surgery.

**Results:** An average of 20% of the referrals was considered inappropriate, (17% by consultant, 22% by speciality doctor and 22% by SpR). An average of 48% of radiographic was considered non-diagnostic, (46% by consultant, 49% by speciality doctor and 50% by SpR).

**Conclusion:** The gold standard is not being met. Inter examiner reliability between SpR and SAS doctor was high. This was not seen when both SpR and Speciality doctor were compared with a consultant. No clear-cut reason exists for this.

#### Action Plan

1. Disseminate the results of the findings to GPs who form the referral basin for the department
2. Re-Audit in 12months

<https://doi.org/10.1016/j.bjoms.2017.08.015>

#### P7

### A Retrospective Audit to Assess the Efficacy of Delegated Consent Training for Maxillofacial Trauma

Conor Carroll

*Aintree University Hospital NHS Foundation Trust Dr Hira Nazir*

**Introduction:** Clinicians have a legal and ethical responsibility to ensure that valid consent is obtained prior to any procedure as per GMC guidelines. In the majority of clinical negligence cases, the consent has been found to be inadequate or signed by junior trainees who often have little experience of the operation being performed. We aim to assess the documentation of trauma consent forms at a Regional Maxillofacial Unit and to assess the effectiveness of delegated consent training.

**Method:** A retrospective audit was carried out of 47 randomly selected mandibular trauma patients from January–April 2016 at Aintree University Hospital. Data was collected via a proforma including type of procedure, local and general risks, grade of surgeon and timing of consent prior to the procedure.

**Results:** Dental Core Trainees (DCT) took consent for 68% (n=32) of patients during the 4 month period whilst consultants and registrars accounted for 30%. There were no statistical differences in the documentation of numbness and infection, however, only 65% (n = 21) of DCTs consented for malocclusion. 1% did not state the correct site and position of the operation. Following delegated consent training, 98% and 100% now included malocclusion and bruising as a post operative risk respectively.

**Conclusion:** The competency of Dental Core Trainees to consent varies significantly depending on their previous experience as well as exposure to different surgical procedures. We implemented a local delegated consent training programme for all Dental Core Trainees prior to consenting for maxillofacial trauma procedures which has shown significant improvements.

<https://doi.org/10.1016/j.bjoms.2017.08.016>

#### P8

### A retrospective audit to review success rates of coronectomies in the management of lower third molars at Mid Yorkshire Hospital Trust

Helen Cashman\*, Abdul Dalghous, Sunil Sah, Zahara Rizvi

*University Hospital Aintree*

**Introduction:** Coronectomies are used in the management of third molars requiring extraction which appear closely associated with the inferior dental (ID) nerve and lingual nerve. The aim of the procedure is to decoronate the tooth and therefore reduce the risk of damage to the ID nerve and lingual nerve. Within the Mid Yorkshire Hospitals NHS Trust Oral and Maxillofacial surgery department the number of coronectomies performed is relatively low in comparison to the routine removal of third molars. Currently there is no data in our department that demonstrates the success of coronectomies.

To establish standards: a literature review was undertaken to establish relevant studies and their outcomes. Our standards are as such: success: 61.7- 100%. ID nerve injury; 0-9.5%. Infection; 1-12% and mobilisation of roots; 9.4-38%.

**Methods:** Patients were identified retrospectively over a year period; February 2015 - 2016. A data collection tool was created and patient records were reviewed.

**Results:** Within 1 year we identified 14 patients:

- 100% female
- Aged 17-43 mean age 28
- 64% success rate of coronectomies.
- 29% cases failed due to intra-operative factors which in all cases was due to mobile roots
- 7% post operative failure due to recurrent infections
- Post operatively 21% required oral antibiotics.
- 67% of infections were reported in smokers

**Conclusions/Clinical Relevance:** Coronectomy is a viable treatment option and our current results show that our success rates were all within the range identified in the available evidence. The highest risk of failure is intra-operatively, and post operative infection is higher in smokers.

<https://doi.org/10.1016/j.bjoms.2017.08.017>

**P9**

### **Determining the time from mandible fracture admission to treatment as a marker of clinical care**

Rhea Chouhan\*, Prav Praveen

*Queen Elizabeth Hospital Birmingham Major Johnno Breeze*

**Introduction:** Time from admission to treatment of mandible fractures is one of the primary markers of service in Queen Elizabeth Hospital Birmingham (QEHB). The standard is currently 24 hours, but other standards include treatment by the end of the next working day. Such standards are based upon an 8am- 5pm working day that does not include weekends.

**Methods:** All patients with mandible fractures treated surgically between 01 August and 30 September 2016 were identified from a retrospectively collected database. Time from admission to treatment in theatre was determined. The definition of the working day included both 5pm and 8pm but in this instance did not include weekends. Patients with multiple comorbidities admitted under the Major Trauma Service were excluded recognising that they would have to be medically optimised first.

**Results:** 93% (25/27) of patients were treated by 5pm the following day, or 67% (18/27) within 24 hours. Increasing the working day altered those receiving treatment by 8pm to 26/27 (96%).

**Conclusions:** The advent of the seven- day National Health Service will have important implications on service provision and markers of clinical care. In addition more flexible working hours means that emergency cases are often routinely treated up till 8pm at which point most junior doctors hand over. We would therefore recommend that the standard of practice for mandible fractures should be treatment by 8pm the following day including weekends.

<https://doi.org/10.1016/j.bjoms.2017.08.018>

**P10**

### **National audit investigating Oral and Maxillofacial Surgery out of hours ward cover senior house officer background, experience and training**

Zachary Cole-Healy

*Kings College Dental School Introduction/Aims*

Senior House Officer (SHO) level cover in Oral and Maxillofacial Surgery (OMFS) is provided by dentally or

medically qualified staff. Variations in training and experience between these two groups may have implications for patient safety out of hours(OOH).We aimed to assess background of OMFS SHOs providing OOH cover nationally and to evaluate levels of training and experience in medical problems/emergencies and non-surgical practical skills.

**Methods:** An online survey was distributed by email and telephone to each OMFS centre nationally. Results were collated and analysed using Microsoft Excel.

**Results:** There were respondents from 70 OMFS centres, and 114 responses in total,92% of respondents were dental SHOs. In 64%of respondent centres OOH SHO cover was provided by dental SHOs(n = 70).67% of responders had managed a specified set of medical problems whilst 46% had training previously to deal with those problems (n = 72). 78% of responders had interpreted a chest x-ray, 40% had training to do so (n = 72). 68% of responders had performed a set of medical procedures, 63% had training in them; 96% of responders had performed phlebotomy, 79% had training (n = 72). 30% of responder had worked outside of their range of competencies during their post (n = 72).

**Conclusion:** Our results show that currently the majority of out of hours OMFS ward cover is provided by dentally qualified SHOs. There is scope to improve training of SHOs in managing common ward problems and performing common medical procedures which may lead to benefits in patient safety OOH.

<https://doi.org/10.1016/j.bjoms.2017.08.019>

**P10**

### **National audit investigating Oral and Maxillofacial Surgery out of hours ward cover senior house officer background, experience and training**

Zachary Cole-Healy

*Kings College Dental School*

**Introduction/Aims:** Senior House Officer (SHO) level cover in Oral and Maxillofacial Surgery (OMFS) is provided by dentally or medically qualified staff. Variations in training and experience between these two groups may have implications for patient safety out of hours(OOH).We aimed to assess background of OMFS SHOs providing OOH cover nationally and to evaluate levels of training and experience in medical problems/emergencies and non-surgical practical skills.

**Methods:** An online survey was distributed by email and telephone to each OMFS centre nationally. Results were collated and analysed using Microsoft Excel.

**Results:** There were respondents from 70 OMFS centres, and 114 responses in total,92% of respondents were dental SHOs. In 64%of respondent centres OOH SHO cover was provided by dental SHOs(n = 70).67% of responders had managed a specified set of medical problems whilst 46% had training previously to deal with those problems (n = 72). 78%