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| **Appendix 2 Exemplar Scenario**<br><br>**A 13 year old boy is referred back to his own GDP for Orthodontic extractions.**<br>**The Specialist Orthodontist requests extraction of maxillary first premolars and mandibular second premolars as part of the Orthodontic treatment plan.** | **History:**<br><br>**a) Medical History: Nil relevant**<br>**b) Dental History: Phobic – previous experience of difficult deciduous extractions**<br>**c) Social History: Attends with Mother who is also dental phobic** | **Risk Factors:**<br>**a) Dentist had already carried out Orthodontic extractions that same day, for another teenage boy, but the previous case had needed mandibular first premolars as part of their treatment plan.**<br>**b) Dentist is working with a bank nurse who is unfamiliar with the clinic and team and regular processes and systems for the practice.**<br>**c) It has been a busy day and they are running late.**<br>**d) There is only a printed DPT available.**<br>**e) Dentist double checks with the child and mother with regard to their understanding of the teeth to be extracted, and they are unsure. However, they agree that today, the teeth on the right side will be extracted.**<br>**f) The child is nervous and requires reassurance and extra time. He becomes upset following the administration of the local anaesthetic and extraction of maxillary right first premolar. The Dentist offers referral for conscious sedation as an alternative treatment plan, but Mother has taken time off work and is keen to get as many extractions completed today as possible. She is unhappy that all 4 extractions will not be completed at today's appointment.**<br>**g) The dentist feels under pressure to remove the mandibular premolar as swiftly and atraumatically as possible. The mandibular first premolar is extracted instead of the second premolar.**<br>**h) The practice does not routinely use a WHO surgical check list.** |
| **Dentist immediately realises the error which has been made.** | | **Immediate steps in relation to patient:**<br>**Explanation to Parent and Child:**<br>**a) Dentist gives a complete and honest explanation of the error in accordance with 'Being Open' and 'Duty of Candour'.**<br>**b) Dentist gives a full apology.**<br>**c) Dentist explains next clinical steps and that the Orthodontist will be informed and that they will need to consider possible treatment options.**<br>**d) Dentist explains next steps with regards to reporting and investigation.** |

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| | | **Immediate steps in relation to administrative Process:**<br>a) Dentist ensures that there was a full and contemporaneous record made within the clinical notes.<br>b) Dentist ensures that the nurse also writes a full and contemporaneous record.<br>c) Dentist ensures that the nurse feels supported and is given the opportunity to debrief.<br>d) Dentist informs appropriate person (senior member of staff) within the practice e.g. Partner, Associate, Manager. They should in turn ensure that the dentist is supported throughout the investigation. (This should include all members of the team involved e.g. dental nurse).<br>e) Dentist or Manager (as appropriate), advises the Commissioning Body of the wrong site extraction.<br>f) The Commissioning Body report the wrong site extraction within 2 working days, via STEIS.<br>g) The Registered CQC Manager for the practice, notifies the CQC.<br>h) A report is submitted to NRLS and the wrong site extraction is recorded on the Local Risk Management System e.g. DATIX.<br>i) An appropriate senior manager is designated to carry out an investigation.<br><br>**Investigation:**<br>a) A full investigation is instigated including a Root Cause Analysis<br>b) All processes/systems and protocols within the practice, are reviewed.<br>c) All Contributory Risks factors are considered as part of the investigation.<br>d) An Action Plan is developed.<br>e) Preventive measures are put in place to reduce the risk of a repeat occurrence, including use of WHO surgical checklist, and Pause before Pulling.<br>f) Learning outcomes are shared across the practice.<br>g) Any training needs within the practice are identified and implemented.<br>h) A culture of safety is promoted within the practice.<br>i) The patient and parent are informed of outcomes of the investigation. |