

Appendix 4 FAQs

Frequently asked questions related to Dental Wrong Site Surgery

Open reporting of dental wrong site surgery (WSS) is routine in secondary care as part of a drive to improve patient safety, however, global uptake of NHS governance and patient safety mechanisms have not yet been wholly embraced within primary care and more specifically dentistry. Within the General Dental Council 'Standards for the Dental Team', a core principle of care is to 'put the patient first', and 'you must record all patient safety incidents and report them promptly to the appropriate National body'.⁶

What is a Never Event in dentistry? The Revised Never Events policy and framework 2015 from NHS England¹ modified the list of Never Events related to dentistry to the following 3 incidents;

- **Wrong site surgery**
 - A surgical intervention performed on the wrong patient or the wrong site, including wrong tooth extraction of a permanent (adult) tooth, even if re-implanted
 - Interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block, and biopsy
- wrong implant /wrong site placement of dental implant
- retained foreign body

The 'Revised Never Events Policy and Framework – Frequently asked Questions' provides some guidance on interpretation of the Never Events Policy specifically with respect to **wrong tooth extraction**.⁷ These are as follows:

Does the wrong tooth extraction apply to deciduous teeth? No - although strong systemic protective barriers exist to prevent this incident from occurring, there is no known risk of serious harm or death.

Does the wrong tooth extraction apply to inadvertent removal of teeth (with dental caries) which would have been removed at a future appointment? Yes, as the strong systemic protective barriers exist to prevent this incident from occurring, even though it may be planned to remove the tooth in the future.

Should the immediate re-implantation of a tooth removed in error be reported as a Never Event? Yes - as the strong systemic protective barriers exist to prevent this incident from occurring and it is not known if the re-implantation will be successful.

Does wrong site surgery apply to extraction undertaken under local anaesthetic as well as general anaesthetic? YES, all wrong site surgical interventional procedures in adults are included in WSS.

Does wrong site surgery apply to giving a block on the incorrect site? YES, if it is undertaken as part of a planned dental procedure *as ‘they are a particular type of serious incident that meet **all** the following criteria: They are **wholly preventable**, where guidance or safety recommendations that provide strong systemic protective barriers **are available at a national level, and should** have been implemented by all healthcare providers’*. Reference: Never Events Framework 2015

What counts as the start of surgery for wrong site surgery? The start of surgery should be considered the point at which the patient’s physiology begins to be permanently altered. This includes the beginning of a mucosal incision or tooth extraction as this will result in scarring and requires time for healing and recovery. Dental restorations and orthograde root canal therapy are not currently regarded as surgical interventions for the purpose of Never Event reporting.

Do these standards replace the WHO Surgical Safety Checklist and Five Steps to Safer Surgery? No – the NatSSIPs are in large part based on the WHO checklist and the Five Steps, and we hope that the NatSSIPs will strengthen and enhance them in all hospitals. All of the five steps are included as standards within the NatSSIPs: Safety Briefing, Sign In, Time Out, Sign Out and Debriefing.

When should the Time Out be performed? The NatSSIPs are clear that a Time Out “must be conducted immediately before skin incision or the start of the procedure”.

Some procedures performed in the Emergency Department are so urgent that there is no time to perform steps like the Briefing and the Time Out. What should we do? The patient’s safety must always come first, and there will occasionally be patients that need immediate, life-saving procedures performed. However, these are rare, and even if the procedure is urgent, there is often time to perform a brief version of a Time Out that makes sure that the correct procedure is being performed on the correct patient, and that everyone involved knows what the clinical plan is for the patient.

Who must you inform?

Timely reporting and liaison with commissioning bodies:

- Compliance with reporting and liaison requirements with agencies such as Monitor, the Trust Development Authority, the Care Quality Commission (CQC), Public Health England, the Health and Safety Executive, and coroners. Never Events are clearly defined as serious incidents and therefore, must be reported to the CQC (NHS England Never Event Policy).

You must inform your commissioner and NRLS in accordance with Never Event Policy framework. If a student is involved, the head of school must also be notified. If a trainee is involved then the Health Education England deanery Training programme director should also be notified. You can report Never Events directly to the National Reporting and Learning System (NRLS) <https://report.nrls.nhs.uk/nrlsreporting/> (see Appendix 2).

N.B. It is acknowledged that there is a need for a simplified reporting system and therefore, work will commence on developing a revised reporting system in early 2017.

Who must you report to if the Never Event involves a dental trainee (e.g. Dental Foundation DF, Dental Core Trainee DCT or Dental Specialty DS)? In addition to following the agreed for any clinician:

- For DF: their designated trainer should be made aware who will escalate to both their programme training director / lead and Postgraduate Dental Dean at HEE.
- For DCT & DS: their Educational Supervisor should be informed who will escalate to both the Specialty Training Programme Director and Postgraduate Dental Dean.
- This allows appropriate support and guidance to be given to the trainee at a very difficult and vulnerable time of their career. It will also ensure that HEE is in a position to react quickly to issues that may compromise patient safety.

Exemplar - How to manage a wrong site extraction (See Appendix 2)

How do you learn from a never event and demonstrate learning? (See Appendix 3)

Will the CQC, GDC and NHS England be alerted? –

You must inform CQC and dental commissioners (NHS England) but CQC and NHS England dental commissioners recognise the importance of a supportive, learning culture in dental practices. Learning from incidents and near misses is a key part of practice and team development, to ensure a safe service for patients. The timely reporting of a Never Event will be considered in this light as a positive indicator of a learning culture within the practice.

You do not need to inform the GDC.

What about site marking in dentistry?

NatSSIPs England State on Page 34 Section 4.6 Procedural verification of site marking, Point 4:

*'Reliable marking of surgical sites such as teeth, which may be small, broken down, filled or buried, may not be possible. Tooth notation must be standardised such that only the **Palmer notation is used, and this must be clearly documented on the consent form, checklist and whiteboard for verification by the team.** To minimise the risk of a surgical site error, the correct procedure must be verified by full review to ensure consistency of the clinical record, diagnosis, treatment plan, investigation results, written consent, intraoral surgical site check and confirmation by with the patient. Reference to radiological imaging may be useful'.*

NatSSIPs England <https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf>

There is recognition that various numerical international dental notation formats may add to confusion in confirming treatment planning. Alpha numerical systems (for example UL4 or LR8) may be preferred option for text communication in referral letters and operating lists.

If stages of the LocSSIPs are omitted because of the urgency of the procedure, this should be noted in the patient records and reviewed afterwards to see if local standards can be modified to include as many safety checks as possible before very urgent procedures.

Further FAQs are available from the Revised Never Events Policy and Framework can be found at

<https://www.england.nhs.uk/wp-content/uploads/2015/03/nepf-faqs.pdf>

Further FAQs about NatSSIPs can be found at <https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/05/NatSSIPs-faqs-updated.pdf>

Is the creation of Local Safety Standards for Invasive Procedures (LocSSIPs) based on the NatSSIPs mandatory? The Patient Safety Alert published in September 2015 supports the introduction of the NatSSIPs, which represent current best practice and were created by a number of key organisations with expertise and experience in delivering patient care and setting safety standards. Supported by bodies such as NHS Improvement, Health Education England, the CQC, GDC, GMC and NMC, we are helping providers to build these safety standards into their working practice by creating LocSSIPs based on them. Although the Patient Safety Alert in itself cannot mandate the introduction of these standards, the widespread professional and regulatory support for them, and the likelihood that the CQC will assess providers' compliance with them in the future, means that all organisations providing NHS funded care in England should introduce LocSSIPs in line with the Patient Safety Alert.

What does the September 2016 deadline that is referred to in the Patient Safety Alert 'Supporting the introduction of the National Safety Standards for Invasive Procedures' actually mean? The fourth action of the Patient Safety Alert asks organisations to 'Commence implementation of procedures and practice compliant with LocSSIPs within cycles of continuous improvement including consideration of teamwork and training, human factors and cultural aspects of compliance'. This does not mean that organisations were not expected to have all their identified LocSSIPs developed and in place by September 2016, but must be able to demonstrate progress that they have made with implementation.

What are invasive procedures? The National Institute for Health and Care Excellence (NICE) defines an "invasive procedure" as a procedure used for diagnosis or for treatment that involves

- Making a cut or a hole to gain access to the inside of a patient's body - for example, when carrying out an operation or inserting a tube into a blood vessel, or
- Gaining access to a body cavity (such as the digestive system, lungs, womb or bladder) without cutting into the body - for example, examining or carrying out treatment on the inside of the stomach using an instrument inserted via the mouth, or
- Using electromagnetic radiation (which includes X-rays, lasers, gamma rays and ultraviolet light) - for example, using a laser to treat eye problems.

If it is still not clear whether one of the procedures you perform comes under the NatSSIPs, you should ask yourself whether the procedure has the potential to lead to a Never Event if it is not handled well – if the answer is "yes", this would bring it into the remit of the NatSSIPs. Even if it is not an 'invasive procedure' as defined above, we hope that the NatSSIPs will still be useful to you when developing your standard operating procedures for these outpatient procedures. There are many important principles in the NatSSIPs that can be applied to most invasive and non-invasive procedures and can help minimise accidental harm to patients.

We have implemented our LocSSIPs but have had a Never Event in spite of the standards being followed. What should we do? First of all please ensure that this is reported and investigated in

accordance with the Revised Never Events Policy and Framework 2015. As part of the investigation, please check carefully that your LocSSIPs are fully compliant with the relevant NatSSIPs, and whether the LocSSIPs were properly followed for the patient who suffered the Never Event. We would appreciate it if you would share an anonymised summary of the investigation report with us, highlighting key learning and actions points, so that we can share the learning from it and if appropriate, develop the NatSSIPs further to make sure that this does not happen to another patient. Please email us on patientsafety.enquiries@nhs.net.

The standards say that we MUST do something but this is not relevant to the procedures for which we are developing the LocSSIPs. What should we do? The healthcare professionals, human factors experts and lay representatives who developed the NatSSIPs were really careful only to use the word “must” when they thought that the action described needed to be taken for all invasive procedures. If you feel unable to take the action that the NatSSIPs require you to, then this should be discussed with your local governance or safety lead and, if appropriate, your commissioner. If it is agreed that the action is inappropriate, then this should be documented. Please also let us know through patientsafety.enquiries@nhs.net to inform future revisions to the NatSSIPs.

I work in a private hospital. Can I use the NatSSIPs to create local standards? The NatSSIPs must be used to create LocSSIPs in all organisations that provide NHS funded care in England. If your private hospital does not provide NHS-funded care, you can still create LocSSIPs that are compliant with the NatSSIPs, and we hope that you will review your standard operating procedures to see if they are compliant. We think that the NatSSIPs will help improve the safety of patient care wherever patients are treated.

Why are these standards not more detailed when it comes to specific workforce requirements?

The range of invasive procedures performed across the NHS is so large that it would have been impossible to define exact workforce provisions for each procedure. Furthermore, local circumstances differ, and the LocSSIPs must be based on local experience as well as the NatSSIPs. The multidisciplinary team performing the procedures should work with managers and patients to agree the number and skill-mix of the staff, and this should be written into the LocSSIP, along with the actions that will need to be taken if the workforce does not match these standards. Examples of workforce standards are amongst the guidance referenced in Appendix A of the NatSSIPs document.

What if I do procedures in a Primary Care setting? This applies to procedures whether they are performed within a Primary or Secondary setting.

The definition of an ‘invasive procedure’ is above. We hope that the NatSSIPs will be useful to you when developing your standard operating procedures for relevant procedures that are undertaken in a primary care setting. As we learn about the creation of LocSSIPs, and the implementation of new ways of working in response, we will consider any specific requirement for general practice and share examples of LocSSIPs as appropriate.

Is the expectation that we develop a LocSSIP for each NatSSIP that is relevant to our clinical practice? We expect organisations to base their LocSSIPs on the structure of the NatSSIPs, but we understand that local circumstances will mean that some steps and standards are combined, and that there may not necessarily be a LocSSIP for each NatSSIP. The important thing is that all steps are considered when creating LocSSIPs.

Do we need to rewrite our current standard operating procedures (SOPs)? You need to review your current procedures to make sure that they are compliant with the NatSSIPs. It may well be that some SOPs will need very little modification to make them LocSSIPs that are compatible with the NatSSIPs. However, some SOPs will need more changes to make them fully compliant.

Should there be a LocSSIP for every procedure? Action two of the Patient Safety Alert asks organisations to 'Identify all procedures undertaken across clinical settings in your organisation that the NatSSIPs are applicable to'. This does not mean that every procedure should have its own LocSSIP, as it may be appropriate for a LocSSIP to cover a number of procedures, e.g. speciality-specific minor procedure lists.

For further information

<https://www.england.nhs.uk/patientsafety/never-events/>

<https://improvement.nhs.uk/resources/never-events-data/>

<http://www.nrls.npsa.nhs.uk/resources/collections/never-events/core-list/>

<https://www.england.nhs.uk/patientsafety/never-events/natssips/>

<https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf>

<https://www.england.nhs.uk/2015/09/natssips/>

<http://www.ahsn-nenc.org.uk/wp-content/uploads/2016/05/Joan-Russell.pdf>

<https://improvement.nhs.uk/resources/create-local-safety-standards-invasive-procedures/>