

## **Tool kit for ‘Local Safety Standards for Invasive Procedures’ (LocSSIPs) for wrong site extraction in Dentistry**

This toolkit is aimed at all clinical dental teams involved in dental extractions. It gathers together recommendations regarding the development of safety standards in the NHS to minimise the risk of wrong site surgery in all dental settings, focusing on the issue of wrong tooth extraction.

Dentistry provides one of the NHS’s highest activity of surgical interventions. Uniquely the vast majority of these surgical interventions occur under local anaesthesia on conscious, anxious patients. This high volume, often complex work, creates opportunity for mistakes to happen that can be devastating for both the patient and the clinician. Wrong site surgery in dentistry may not always cause significant physical harm to the patient such as the loss of a limb, but it is nonetheless potentially symptomatic of problems in the clinical systems and processes of the environment in which it occurs. By utilising simple routine good practice, it should be possible to minimise the incidence of wrong site surgery in dentistry.

**What is a LocSSIP and how is it developed?** A key initiative by NHS Improvements in 2015 was The National Safety Standards for Invasive Procedures (NatSSIPs) bringing together national and local learning from the analysis of Never Events, Serious Incidents and near misses through a set of recommendations that will help provide safer care for patients undergoing invasive procedures. This does not in any way replace the existing [WHO Surgical Checklist](#), but rather enhances it by looking at additional factors such as the need for education and training. The principle behind the NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. This will be done by organisations working in collaboration with staff to develop their own set of ‘Local Safety Standards for Invasive Procedures’ (LocSSIPs) (Appendix 1).

**Why are LocSSIPs important?** In 2009, the NHS in England identified several clinical incidents that were serious and largely preventable and designated each of these incidents as a Never Event (NE).<sup>1</sup> The NE list has been modified several times since, with the most recent guidance being released in March 2015. In this guidance (<https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf>), NHS England identified 14 NEs. Three of the NEs are particularly relevant to dentistry, namely

- ‘Wrong site surgery’,
- ‘Wrong implant/prosthesis’, and
- ‘Retained foreign object post-procedure’.

They are relevant to all patients receiving NHS funded care. The existing Framework suggests that Never Events may highlight potential weaknesses in how an organisation manages fundamental safety processes.<sup>1</sup> Never Events are different to other Serious Incidents as the fundamental principle of having the Never Event list is that even a single Never Event should be avoidable if available preventive measures have been implemented. Near misses and Never Events offer a significant opportunity to learn lessons. To quote the framework ‘NHS England are committed to ensure that learning from Never Events is the primary purpose of reporting and investigating them.’ **How are LocSSIPs connected to Never Events in dentistry?** For all invasive procedures, a local Safety Standard for invasive procedure (LocSSIP) should be implemented, based on the principles outlined in the NatSSIPs document and summarised in Appendix 1.

**What is an ‘invasive procedure’ and how does it affect dentistry?** The FAQ section of the NatSSIPs document answers this point as follows: ‘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.’ Wrong tooth extraction is a Never Event and hence there is a need for developing a template LocSSIP that can be used or adapted for use in clinical dental practice in all settings where NHS patients are treated. The template ‘Dental extraction LocSSIPs individual patient pathway’ (figure 1) provides a simple example. Other more complex LocSSIPs for dental extractions have been developed and links to some of these other examples are given below.

**How are LocSSIPs applied?** The example Dental extraction LocSSIPs individual patient pathway (Figure 1) provides an outline of good practice for the dental team when undertaking dental extractions and related procedures. By ‘PAUSING’ (for confirmation) with a minimum of two persons and routinely rechecking mid procedure, errors can be minimised. Errors are more likely to happen with interruptions, which can be commonplace in the dental surgery, so if distractions do occur, recheck the treatment plan (using displayed surgical plan and X-ray) and reaffirm with your assisting member of staff before continuing. The ultimate responsibility for wrong tooth extraction remains with the dentist. Identification of teeth is outside the GDC core Scope of Practice for dental nurses. However, by utilising an empowered dental nurse as an assisting member of staff in all stages of the pathway where necessary, it will engender the correct team mind-set and approach to improving patient safety. The LocSSIPs will be available <https://improvement.nhs.uk/resources/examples-local-safety-standards-invasive-procedures/> and other stakeholder websites including FDS RCS, FGDP and BDA.

### **What happens when things go wrong?**

When errors occur the team should investigate and analyse why these may have happened and learn from the experience to minimise future problems. Reporting such errors, with or without patient harm is recommended by using established pathways, facilitating a national perspective to provide support where there are issues and to improve patient safety. An example of how to manage a never event is provided in the form of an Exemplar (Appendix 2)

If a patient safety incident occurs this can be reported to the National Reporting and Learning System which provides the opportunity for potential national learning. In secondary care this will normally be done via the organisation’s local risk management system and in primary care by use of the e-form available on the NRLS website <https://report.nrls.nhs.uk/> or via the commissioner if the practice doesn’t have access to a local risk management system. If an incident meets the definition of a Serious Incident <https://www.england.nhs.uk/patientsafety/serious-incident/> (which includes Never Events) this should be reported to STEIS which can be undertaken by informing the appropriate commissioner.

In secondary care, failure to report a Never Event which subsequently comes to light through a third party route, (e.g. a coroner’s inquest, claim, media report, or patient complaint) is a serious failing on the part of staff involved and the organisation, and is likely to constitute a breach of CQC requirements (*Regulation 16 and 18 of the CQC (Registration) Regulations 2009*) and Service Condition 33 of the 2014/15 NHS Standard Contract, which sets out provider responsibilities for reporting incidents.

**How do I learn from near miss and never events?** Learning from near misses (mistakes resulting in no harm) and Never Events is the key objective. Using these patient safety incidents is a useful way to identify any potential learning needs of the Practitioner or team and the ease of access to these educational needs. This may help direct postgraduate, undergraduate or team learning for educational establishments and future Continuing Professional Development.

Investigations of safety incidents should follow a systems-based methodology to ensure contributory factors, root causes and focused actions and learning are identified. Learning from patient safety incidents including never events requires appropriately trained and resourced staff removed from the incident or specific dedicated and trained staff. Currently, this is a role which does not exist in General Dental Practice and would require a level of training and resource which is not available and requires development. Appendix 3 provides an outline about learning from near misses and never events and a reflective log that could be used for appraisal or portfolio. Access to other examples of good practice of patient safety checklists for dental extractions are available via the FDS RCS, FGDP, and BDA website links.

**What else do I need to know?** Frequently asked questions about never events in dentistry are provided in Appendix 4. There is a list of examples of good practice in Appendix 5 .

**In summary,** the promotion of patient safety underpins good clinical practice. Implementation of LocSSIPs will involve all regulators.

The NHS in England, the General Dental Council and the Care Quality Commission are signed up to supporting NatSSIPs. In Dental Practice, the dental team will need to develop and promote a patient safety culture led by the senior clinician and /or Practice manager who provide a supportive environment where learning is encouraged after safety incidents.

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.

Health Education England will ensure that mandatory training will be developed in accordance with these standards.

The GDC supports the introduction of LocSSIPs in dentistry to minimise the potential for patient harm. The GDC also encourages incident reporting when events do occur, to encourage an open and honest learning environment for dental professionals to work within, where mistakes and isolated incidents are treated distinctly from allegations of fitness to practise. If a Never event occurs we would want to see that the dental professional had been open and honest following the incident, in accordance with the guidance on Candour and the reporting requirements set out in the Standards for the Dental Team.

The CQC welcomes the introduction of the LocSSIP for wrong tooth extraction in dentistry. This represents an opportunity to learn from such incidents and improve the overall standard of care.

This toolkit is part of patient safety culture which involves many aspects including team and human factor training, maintenance of a log book detailing near misses, patient safety incidents including Never Events and evidence of learning from these events and resultant modification of systems and processes. The tool kit will evolve with local development according to local needs and examples of locally developed LocSSIPs will be available on the NatSSIPs website (<https://www.england.nhs.uk/patientsafety/never-events/natssips/>).

**FIGURE 1 Example Dental extraction LocSSIPs Individual patient pathway**

If at ANYTIME there is an interruption, ensure you repeat the “three Rs”: Reposition; Recheck; Reaffirm with your assistant.

