Lunch and learn
Patient safety

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Learning objectives

- The attendee will have a better understanding of;
  - The three pillars of quality of care
  - Contributory factors to failing in patient safety
  - Key developments in UK patent safety impacting on dentistry
  - Key strategies in imroving patient safety
  - Patient safety incidents
  - LocsSSIPs and NatSSIPs
  - Current challenges in improving patient safety in dentistry

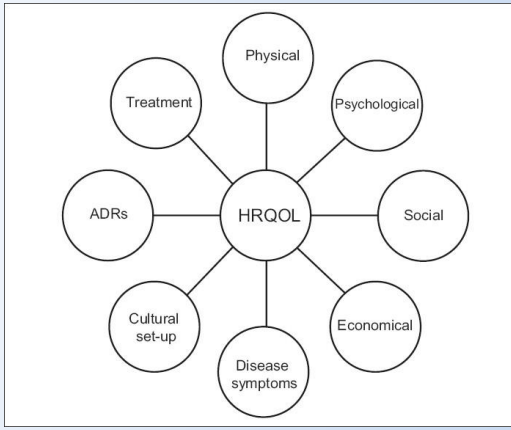
Outline

- **Defining quality improvement**
- **Patient safety incidents**
  - Near misses
  - Never events
  - Serious events / notifiable events
- **Events leading to LocSSIPs**
- **LocSSIPs**
  - National Safety Standards for Invasive Procedures' (NatSSIPs) and
  - Local Safety Standards for Invasive Procedures (LocSSIPs)
- **How can we do better?**
  - Identify threats to patient safety by incident reporting
  - Analysing incidents to improve safety
  - Communication and education in patient safety
  - Building a safety culture

Quality improvement program QUIPP

Quality of life

- In general, quality of life (QoL or QOL) is the perceived quality of an individual's daily life, that is, an assessment of their well-being or lack thereof. This includes all emotional, social, and physical aspects of the individual's life.
- In health care, health-related quality of life (HRQoL) is an assessment of how the individual's well-being may be affected over time by a disease, disability, or disorder.
- Measurement -Euroqol -Established in 1987, **the euroqol group** first met to test the feasibility of jointly developing a standardized non disease specific instrument for describing and valuing health-related quality of life: eq-5d.



Oral health

- ADA statement
  - Traditional measures of dental disease may not be appropriate any longer

  and new and improved measures may be needed.

  Michael Glick, DMD & Daniel M Meyer, DDS Defining oral health: JADA 145(6) June 2014
  - The ADA is attempting to represent dentistry through its development

  of the **Dental Quality Alliance. (2008)**
- BDA Statement:
  - Quality needs to be defined and understood before it can be measured
  - Quality improvement requires indicators of quality, measurement and targets
  - Quality improvement strategies for medicine do not apply readily to dentistry because the professions differ in significant ways that influence how stakeholders view quality
- Measurement OHIP 14, TN Facial Pain

http://www.cdc.gov/hrqol/concept.htm
https://euroqol.org/euroqol/

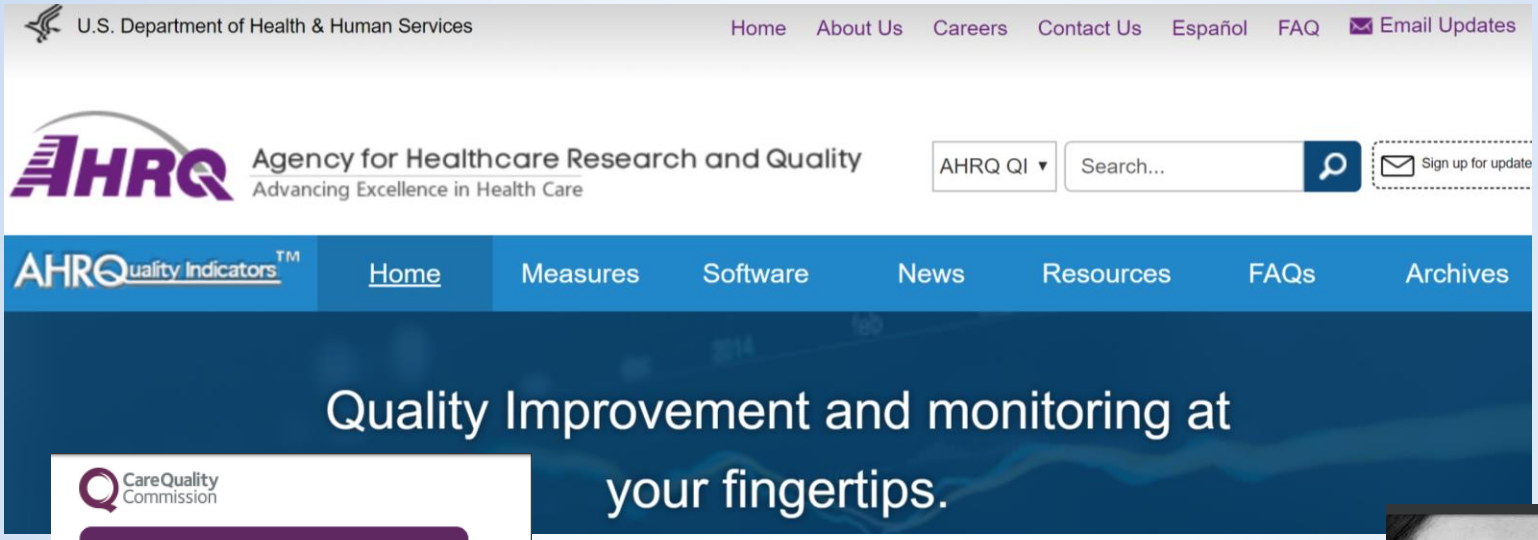
Challenges for measurement of quality in dentistry

Although a wide variety of entities have independently pursued quality measure development in dentistry, an environmental scan conducted by the Dental Quality Alliance (US), **demonstrated a significant lack of standardized set of measures** between **public and private sectors and across communities, state, and national levels**. 24

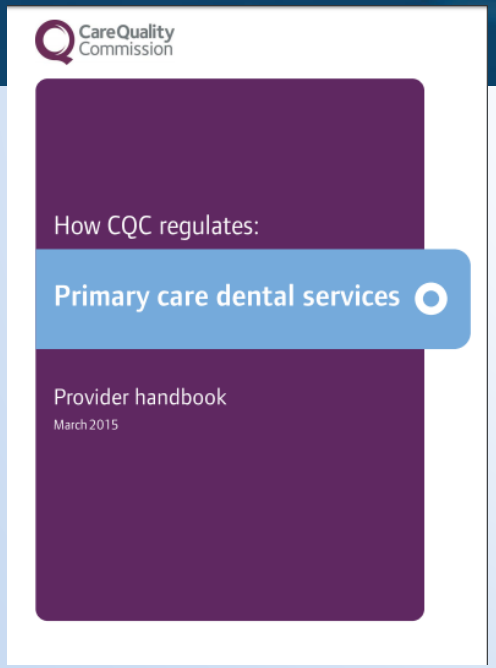
The measures that are routinely used are duplicative across different organizations (e.g., risk assessments, treatment planning, sealant and fluoride placement), **lacking information on detailed specification with numerator and denominator descriptions** and an excess of process measures rather than more outcome focused measurements.24

D. Blumenthal and J. M. McGinnis., "Measuring Vital Signs: An IOM Report on Core Metrics for Health and Health Care Progress," Journal of the American Medical Association Viewpoint, published online April 28, 2015. 24 Dental Quality Alliance (2012). Pediatric Oral Health Quality and Performance Measures Concept Set: Achieving Standardization and Alignment. Available at: http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities

Regulators of quality in dental care



NHS England
NHS Improvement
NICE



CQC values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity– doing the right thing

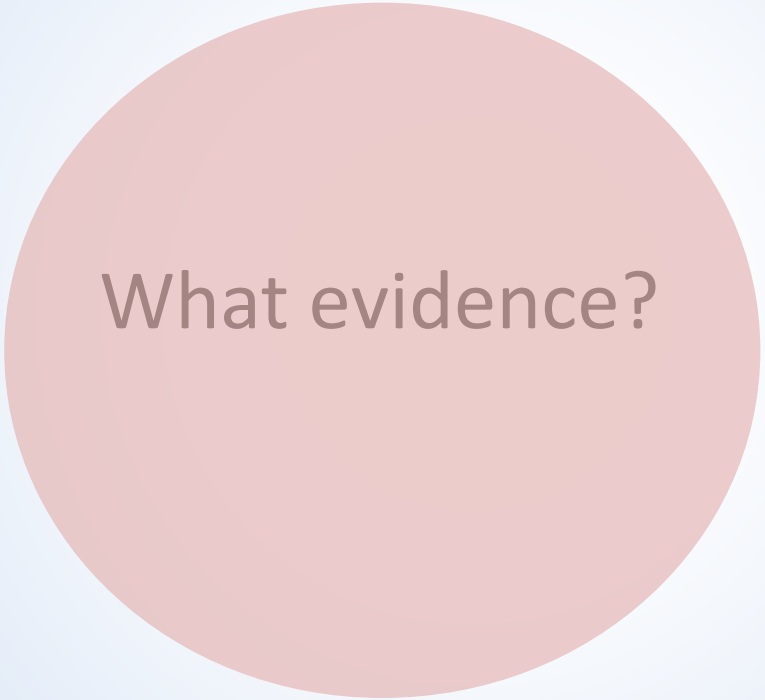
Teamwork – learning from each other to be the best we can

Your key responsibility;

Patient safety

Duty of candour

Quality - Clinical Effectiveness



Quality indicators in dentistry

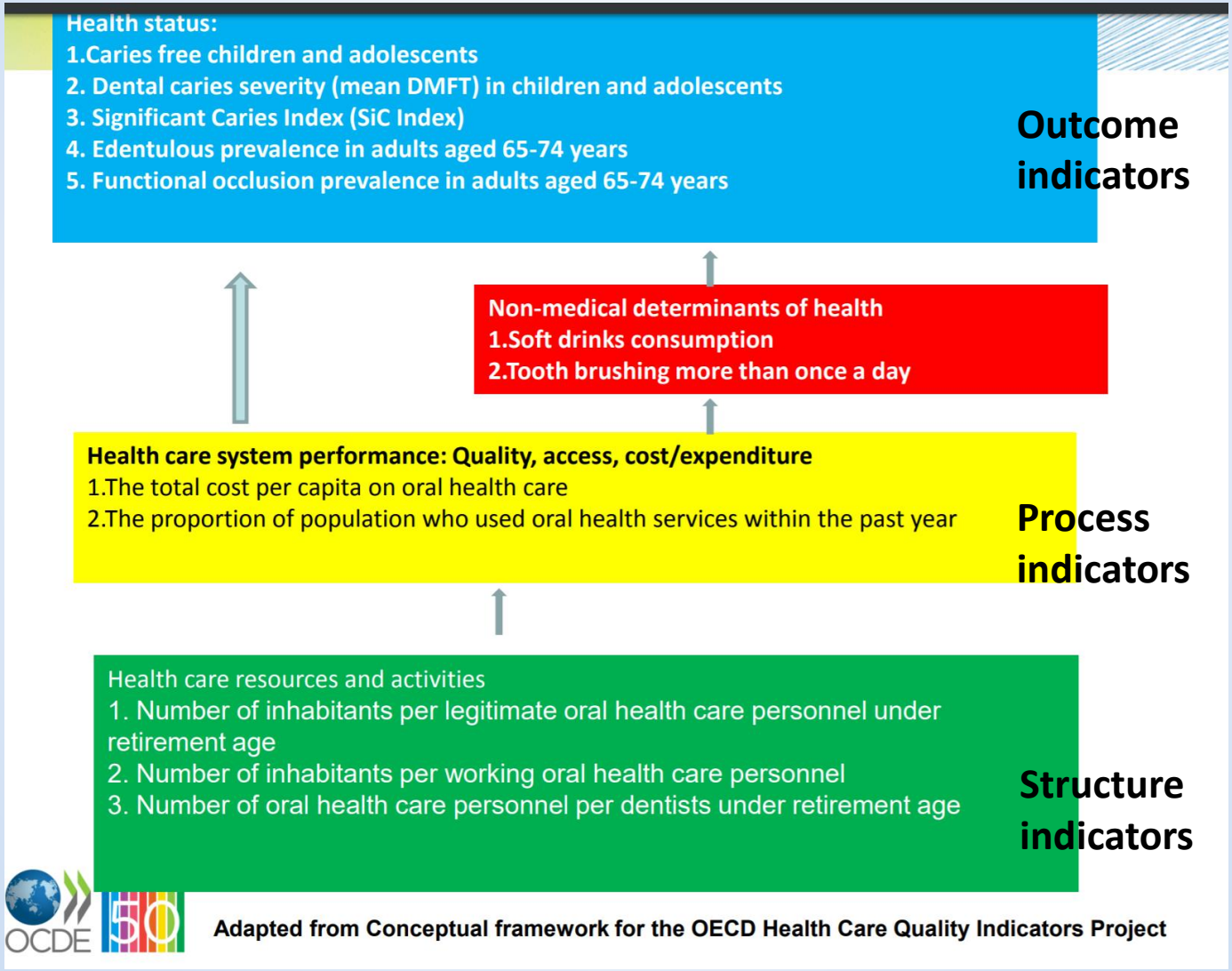
- Global indicators
- National Indicators
- Speciality indicators
  - Restorative
  - Endo
  - Oral Surgery
  - Ortho
  - Perio
  - Paeds
  - Special care

Defining and classifying clinical indicators for quality improvement. Mainz Jan. International Journal for Quality in Health Care 2003; 15(6): 523-530.

PLAYERS IN THE DENTAL QUALITY MEASURES LANDSCAPE

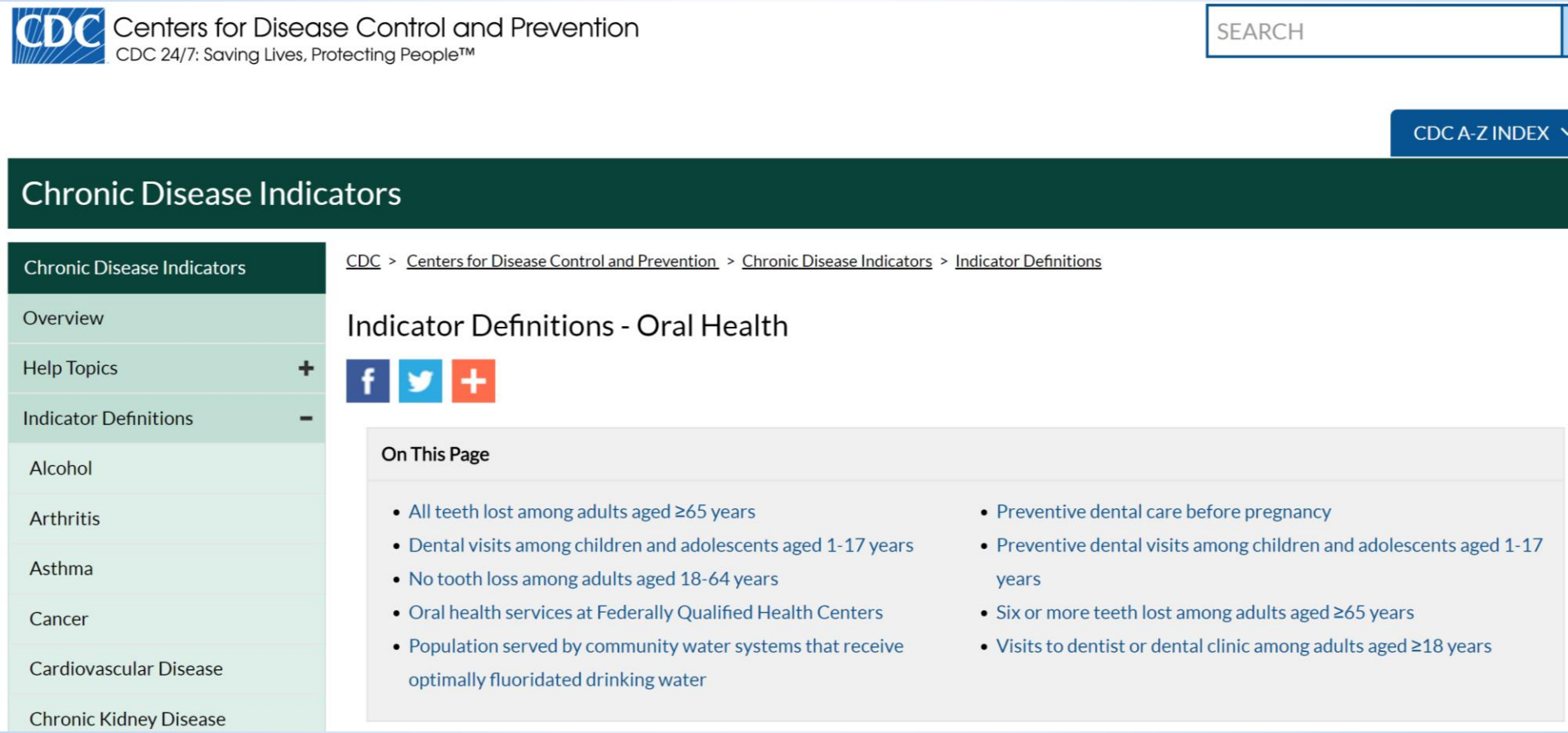
The terms "quality measures" and "performance measurement" have been largely elusive in dentistry. Two IOM reports, have identified a lack of quality measures as a barrier to improving oral health and reducing oral health disparities. [11], [12] The role of a dental and oral health measure developer has long been occupied by entities that are not traditionally from the dental industry. These activities within dentistry, until recently, have been limited to the federal agencies such as the CMS, Health Resources and Services Administration (HRSA), the Agency for Healthcare Research and Quality (AHRQ), commercial private purchasers/payers, data analytics companies supporting these commercial health plans, and leading health plan accreditation agencies such as National Commission on Quality Assurance (NCQA), which are all engaging in developing measures for the purpose of program management.

Global indicators –OECD Organisation for Economic Co-operation and Development

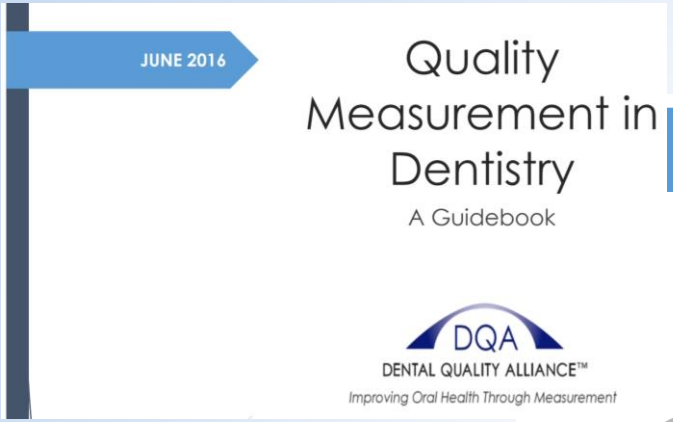


http://www.oecd.org/health/health-systems/50333335.pdf

Global Indicators - CDC



National Indicators – ADA 2016



QUALITY MEASUREMENT IN DENTISTRY

Timely — reducing waits and sometimes harmful delays for both those who receive and those who give care.

Effective — providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

Efficient — avoiding waste, including waste of equipment, supplies, ideas, or energy.

Equitable — providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Patient-centered — providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

Safe — avoiding injuries to patients from the care that is intended to help them.

Changing regulatory priorities and recent activities of Centers for Medicare and Medicaid Services (CMS)

http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2016_Quality_Measurement_in_Dentistry_Guidebook.pdf?la=en

Specialist Indicators efficacy

- Restorative
- Perio
- Ortho
- Endo
- Paeds

Changes in oral health-related quality of life during fixed orthodontic appliance therapy: an 18-month prospective longitudinal study.
Liu Z, McGrath C, Hägg U.
Am J Orthod Dentofacial Orthop. 2011 Feb;139(2):214-9.

Community Dent Health. 1998 Mar;15(1):22-6.
Assessing oral health outcomes for orthodontics--measuring health status and quality of life.
O'Brien K, Kay L, Fox D, Mandall N.

Evaluating Quality of Care

Measure Name	Description	NQF #	Data Source	Measure Domains	Level of Measurement
Oral Evaluation	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.	2517	Administrative enrollment and claims	Process	Program, Plan
Topical Fluoride for Children at Elevated Caries Risk	Percentage of enrolled children aged 1–21 years who are at "elevated" risk (i.e., "moderate" or "high") who received at least 2 topical fluoride applications within the reporting year.	2528	Administrative enrollment and claims	Process	Program, Plan
Sealants for 6–9 Year-Old Children at Elevated Caries Risk	Percentage of enrolled children in the age category of 6–9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.	2508	Administrative enrollment and claims	Process	Program, Plan
Sealants for 6–9 Year-Old Children at Elevated Caries Risk	Percentage of enrolled children in the age category of 6–9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.		Electronic Health Records	Process	Practice
Sealants for 10–14 Year-Old Children at Elevated Caries Risk	Percentage of enrolled children in the age category of 10–14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year.	2509	Administrative enrollment and claims	Process	Program, Plan
Care Continuity	Percentage of all children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.	N/A	Administrative enrollment and claims	Process	Program, Plan
Care Continuity	Percentage of all children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation in both years.	N/A	Electronic Health Records	Process	Practice

doi:10.1111/j.1365-2591.2006.01180.x

QUALITY GUIDELINES

Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology

European Society of Endodontol

Abstract

European Society of Endodontology. Q
for endodontic treatment: consensus report
Society of Endodontology. *International End*
39, 921–930, 2006.

The assurance of the quality of a service
member of the dental profession is an esse
any system of peer review in dentistry.
addresses two essential elements: (i) app
treatment modality and (ii) quality or lev
rendered. In revising these guidelines

Root canal treatment has an unfavourable outcome
This occurs when
1 The tooth is associated with signs and symptoms of infection.
2 A radiologically visible lesion has appeared subsequent to treatment or a pre-existing lesion has increased in size.
3 A lesion has remained the same size or has only diminished in size during the 4-year assessment period.
4 Signs of continuing root resorption are present.

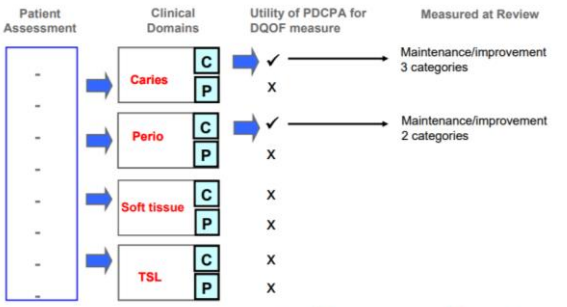
In these situations it is advised that the tooth requires further treatment.

Exception An extensive radiological lesion may heal but leave a locally visible, irregularly mineralized area. This defect may be scar tissue formation rather than a sign of persisting apical periodontitis. The tooth should continue to be assessed.

DH Department of Health

Dental Quality and Outcomes Framework

The clinical effectiveness outcome indicators included in the DQOF are based on the standardised PDCPA and the associated risk screening process. The clinical elements of the assessment will be used to inform quality and outcome payments.



Oral Surgery
What is the Health benefit or cost benefit of M3M surgery?

- Health benefit M3M surgery
  - Ruta DA, Bissias E, Ogston S, Ogden GR. Assessing health outcomes after extraction of third molars: the postoperative symptom severity (PoSSe) scale. Br J Oral Maxillofac Surg. 2000 Oct;38(5):480-7.
  - Jay W. Friedman. The Prophylactic Extraction of Third Molars: A Public Health Hazard Am J Public Health. 2007 September; 97(9): 1554–1559.
  - Cunha-Cruz J, Rothen M, Spiekerman C, Drangsholt M, McClellan L, Huang GJ. Northwest Practice-Based Research Collaborative in Evidence-Based Dentistry. Recommendations for third molar removal: a practice-based cohort study. Am J Public Health. 2014;104(4):735-43.
  - Lee CT, Zhang S, Leung YY, Li SK, Tsang CC, Chu CH. Patients' satisfaction and prevalence of complications on surgical extraction of third molar. Patient Prefer Adherence. 2015 Fe

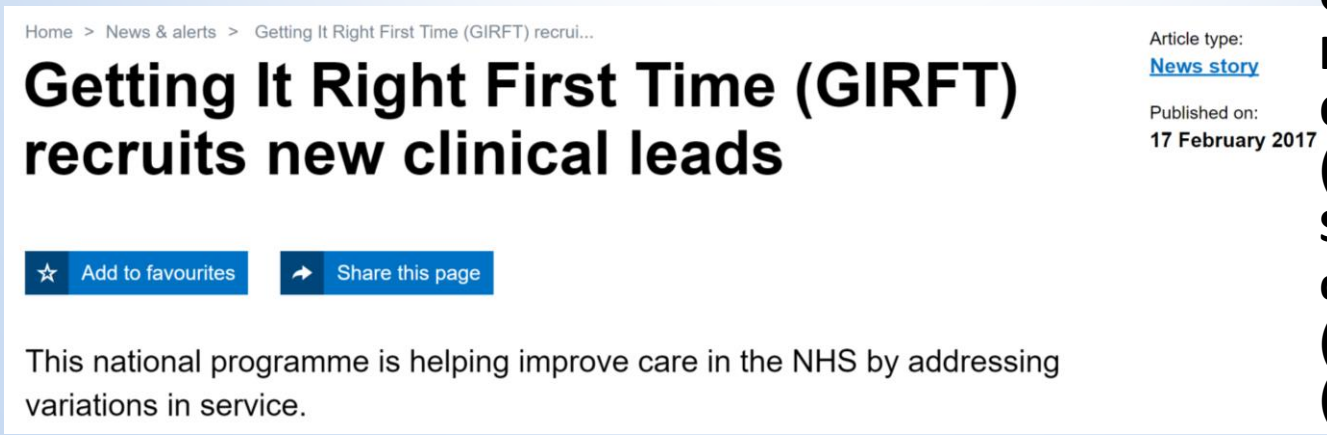
Low evidence level for cost and health benefit
4 Prospective cohort trials

- **Cost effectiveness of M3M surgery**
  - Edwards MJ, Brickley MR, Goodey RD, Shepherd JP. The cost, effectiveness effectiveness of removal and retention of asymptomatic, disease free third [illegible]. Dent J. 1999 Oct 9;187(7):380-4.

  - CoFernandes MJ, Ogden GR, Pitts NB, Ogston SA, Ruta DA. Actuarial life-table analysis of lower impacted wisdom teeth in general dental practice. Community Dent Oral Epidemiol. 2010 Feb;38(1):58-67

Optimal efficacy assessment requires standardised and consistent coding

- Patient
  - demographics
- Coding needed
  - Diagnostic
  - Interventional (Only code currently coded by NHS)
  - Outcomes
- **Getting It Right First Time**, a programme designed to improve clinical quality and efficiency within the NHS by reducing unwarranted variations, has announced that it is recruiting new clinical leads as it grows to cover more than 30 clinical specialties.


Home > News & alerts > Getting It Right First Time (GIRFT) recrui...

Getting It Right First Time (GIRFT) recruits new clinical leads

Article type: News story

Published on: 17 February 2017

☆ Add to favourites Share this page

This national programme is helping improve care in the NHS by addressing variations in service.

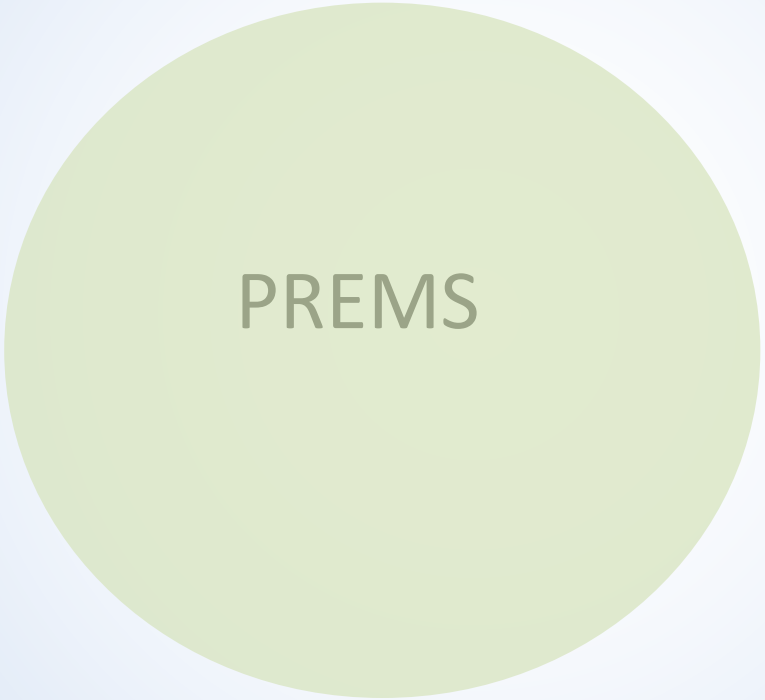
Get it right first time leads
OMFS Maire Morton (2017)
Secondary care dentistry Liz Jones (2018)
(Peads, Oral surgery and Special care)

But…….

Not everything that can be counted counts, and not everything that counts can be counted.

– Albert Einstein

Quality - Patient experience



Patient centred Quality assessment

- In America the **National Quality Forum (NQF)** is a private, not-for-profit organization, that works towards improving the quality of healthcare by building consensus on national priorities and goals for performance improvement and working in partnership to achieve them.
- Endorsement of
  - nnational consensus standards for measuring and publicly reporting on performance
  - promoting the attainment of national goals through education and outreach programs.
  - An NQF endorsement reflects rigorous scientific and evidence-based review, input from patients and their families, and the perspectives of individuals throughout the healthcare industry.

Example of national derived and trialled PREMS (experiential) PROMS (quality) British Association Oral Surgery 2017

G. Gerrard, R. Jones. R. J. Hierons How did we do? An investigation into the suitability of patient questionnaires (PREMs and PROMs) in three primary care oral surgery practices
BDJ **223**, 27–32 (07 July 2017)

Abstract

Introduction With the expansion of oral surgery services into the primary care sector there is a need to monitor the quality of the care provided. The Guide for Commissioning Oral Surgery and Oral Medicine proposed a set of questions to be used as patient related experience and outcome measures (PREMs and PROMs).

Aim The British Association of Oral Surgeons (BAOS) primary care group (which includes the authors) were tasked by the Chief Dental Officer for England to test the suitability of these PREMs and PROMs.

Method The questions as published in the commissioning guide were piloted in primary care oral surgery practices and patient feedback was sought. The authors then proposed and implemented an amended series of questions that they felt would be more practical as generic templates for oral surgery services.

Results Our data demonstrates that the revised questions have produced data that is easy to interpret and attracted a greater number of feedback comments from patients.

Discussion and conclusion The revised questionnaires incorporate the NHS Friends and Family Test as the collection of this data is normally a contractual requirement for providers of NHS services. They also use questions from other validated healthcare satisfaction survey tools. The use of Likert scales provides a richer data set which makes the interpretation of data easier and highlights areas for improvement. It is important to note that the data provided by PREMs and PROMs is subject to a number of biases and should be used for local quality improvement and longitudinal analysis of outcome data rather than comparison between providers.

British Association Oral Surgery PREMS (experiential)

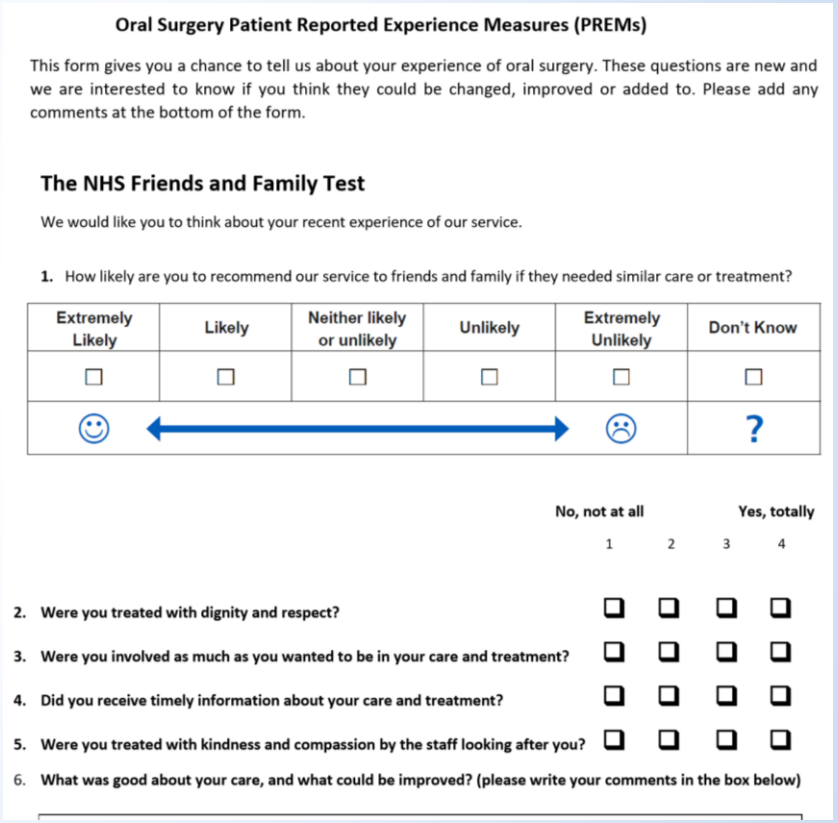
Oral Surgery Patient Reported Experience Measures (PREMs)

This form gives you a chance to tell us about your experience of oral surgery. These questions are new and we are interested to know if you think they could be changed, improved or added to. Please add any comments at the bottom of the form.

For each of the questions below, please circle the answer you feel best applies

Did the clinical team (clinician) involve you in your treatment decision in terms that you understand?	Yes	No	Not sure
Did you receive information about the risks/ benefits in terms that you can understand before the operation?	Yes	No	Not sure
Was your pain managed well during the procedure?	Yes	No	Not sure
Did you receive information, in a format that you could understand, about care after the operation and a contact number to call for help?	Yes	No	Not sure
Were you given the opportunity to ask questions?	Yes	No	Not sure
Did a member of staff tell you about medication side-effects to watch out for when you went home?	Yes	No	Not sure

Comments



Oral Surgery Patient Reported Experience Measures (PREMs)

This form gives you a chance to tell us about your experience of oral surgery. These questions are new and we are interested to know if you think they could be changed, improved or added to. Please add any comments at the bottom of the form.

The NHS Friends and Family Test

We would like you to think about your recent experience of our service.

1. How likely are you to recommend our service to friends and family if they needed similar care or treatment?

Extremely Likely	Likely	Neither likely or unlikely	Unlikely	Extremely Unlikely	Don't Know
☐	☐	☐	☐	☐	☐
☺ ⟷				☹	?

	No, not at all 1	2	3	Yes, totally 4
2. Were you treated with dignity and respect?	❑	❑	❑	❑
3. Were you involved as much as you wanted to be in your care and treatment?	❑	❑	❑	❑
4. Did you receive timely information about your care and treatment?	❑	❑	❑	❑
5. Were you treated with kindness and compassion by the staff looking after you?	❑	❑	❑	❑

6. What was good about your care, and what could be improved? (please write your comments in the box below)

Elspeth Kalenderian's group UCSF Assessment of 'adverse events'

- Reports from clinicians and patient
- 5 different bodies
  - Total adverse events 2,533,922
  - Total dental adverse events 34,343
  - Endo files 832
  - Dental cements 904
  - Bone plate 1127
  - Bone cutting instrument 1554
  - Denture adhesive 1722
  - Implants 18,163

US Dental Adverse Event classification after consultation with patients and clinicians

- Allergy /toxicity/ FB response
- Aspiration/ ingestion FB
- Infections
- Wrong site wrong procedure wrong patients
- Bleeding
- Pain
- Hard tissue damage
- Soft tissue damage
- Nerve injury
- Other systemic complications

- Severity
- Permanent harm?
  - Yes permanent
    - Moderate to severe Y(G2)/N (G1)
  - no temporary
    - Moderate to severe 4Y(E2)/N (E1)
- Requires transfer to A&E- F
- Requires intervention to sustain life H
- Death I

Peter Maramaldi, et al How dental team members describe adverse events JADA **October 2016**Volume 147, Issue 10, Pages 803–811

US Adverse Event categories according to patients

- Pain
  84
- Hard tissue damage
  46
- Soft tissue damage
  45
- Nerve injury
  37
- Infection
  28
- Other facial harm15
- Allergy 13
- Bleeding 11
- Other system harm 9
- WSPPs 1
- Aspiration ingestions 5
- **More than one category 27**
- Total 321

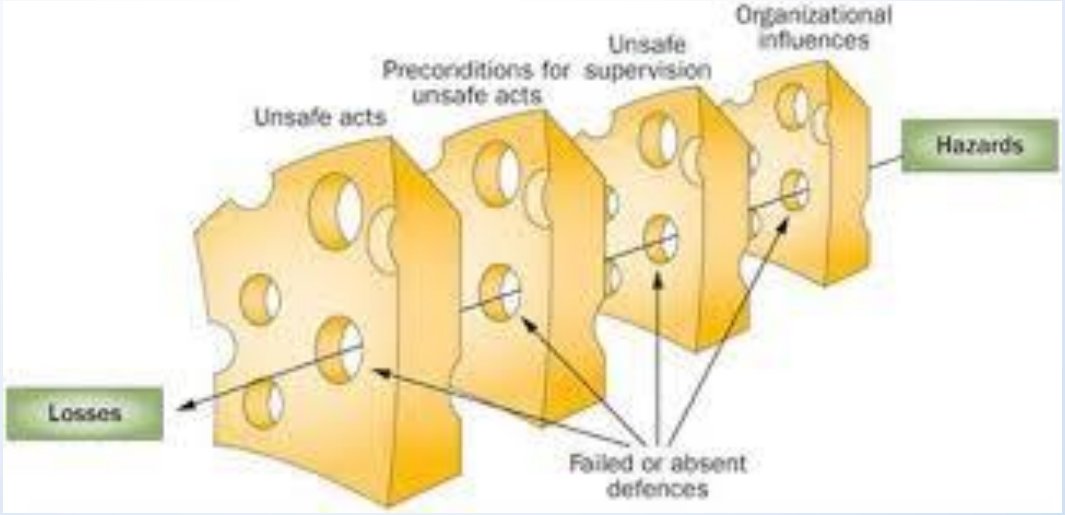
- Practice study 958 charts 4 sites
- 127 Aes
- 100 Aes verified
- Distributions of Aes
- Pain 57
- Infection 16
- Hard tissue damage 11
- Nerve injury 6
- Soft tissue inj 5
- Allergy T FBR 1
- Aspiration 1
- Other systemic harm 1
- WSPP0
- Bleeding 0
- Other harm 0

Peter Maramaldi et al How dental team members describe adverse events JADA **October 2016**Volume 147, Issue 10, Pages 803–811

Quality

Definition

Patient safety is the absence of preventable harm to a **patient** during the process of health care. The discipline of **patient safety** is the coordinated efforts to prevent harm, caused by the process of health care itself, from occurring to **patients**.



Contributory factors

These errors or Patient Safety Incidents (PSIs) may be due to one or more of the following:

Human Factors

Human factors refer to environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety. A simple way to view human factors is to think about three aspects: the job, the individual and the organisation and how they impact on people's health and safety-related behaviour

Systems Failures

Working with systems that are designed to provide safe care will help to reduce the incidence of adverse events in healthcare. Reducing error through systems changes include:

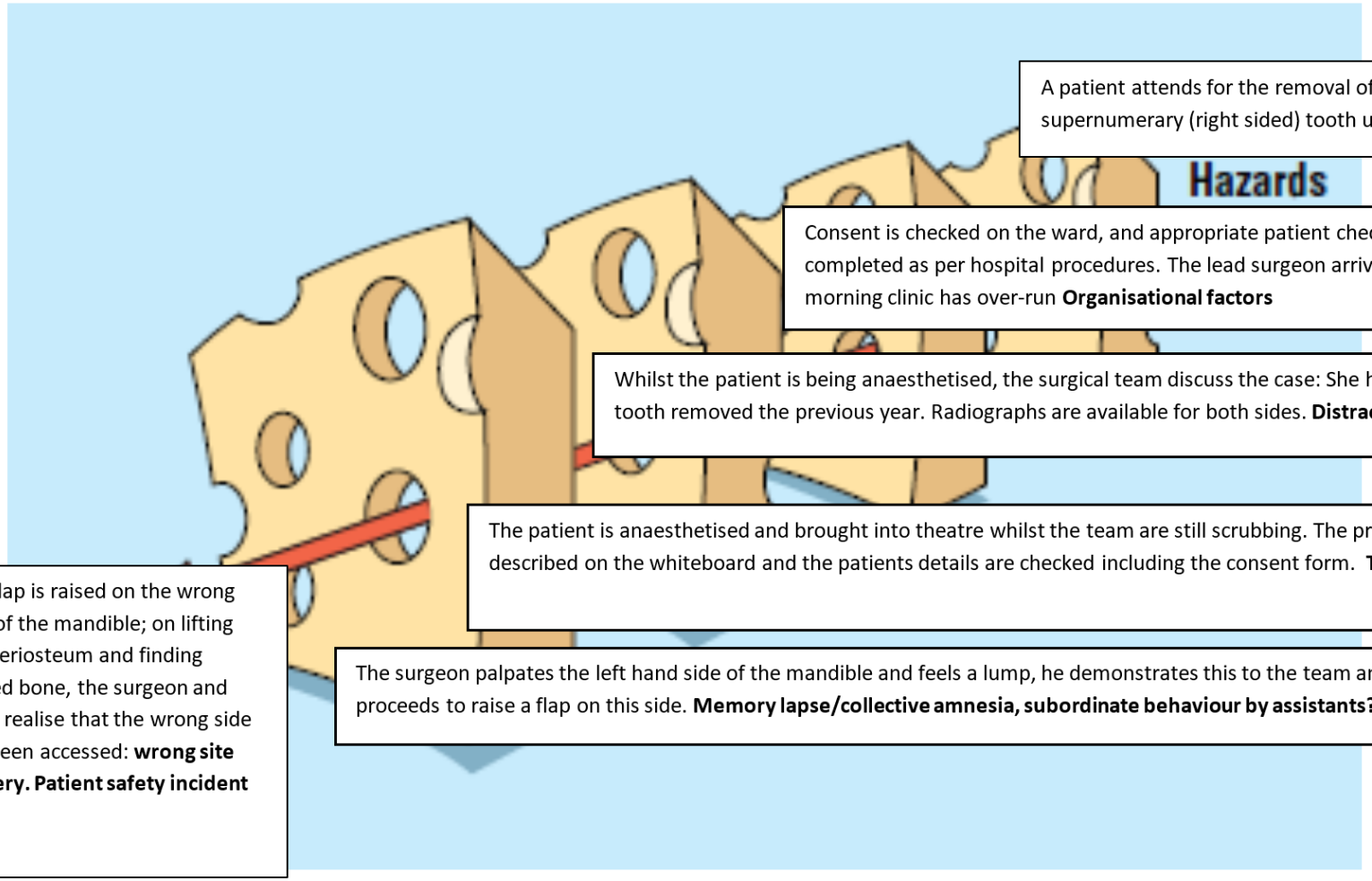
- ✓ Reducing complexity
- ✓ Optimising information processing
- ✓ Automating wisely
- ✓ Mitigating the unwanted effects of change

Patient Factors

Patients are increasingly encouraged to take an active role in their own healthcare.

Patients can act as 'safety buffers', but the responsibility for patient safety still lies with the clinician.

An example of these factors leading to a PSI is shown below:



A patient attends for the removal of a lingually impacted supernumerary (right sided) tooth under GA

Consent is checked on the ward, and appropriate patient checks are completed as per hospital procedures. The lead surgeon arrives late as the morning clinic has over-run **Organisational factors**

Whilst the patient is being anaesthetised, the surgical team discuss the case: She had the contralateral tooth removed the previous year. Radiographs are available for both sides. **Distraction?**

The patient is anaesthetised and brought into theatre whilst the team are still scrubbing. The procedure is correctly described on the whiteboard and the patients details are checked including the consent form. **Tick box mentality?**

The surgeon palpates the left hand side of the mandible and feels a lump, he demonstrates this to the team and proceeds to raise a flap on this side. **Memory lapse/collective amnesia, subordinate behaviour by assistants?**

The flap is raised on the wrong side of the mandible; on lifting the periosteum and finding healed bone, the surgeon and team realise that the wrong side has been accessed: **wrong site surgery. Patient safety incident**

PATIENT SAFETY

EPF European Patients Forum

What is patient safety?

Patient safety is the foremost attribute of quality of care as defined by the **World Health Organisation.**[1]
It is defined as both:

- a goal: a state of being that is free from unnecessary harm.
- a practice: processes and structures that aim to make healthcare safer.

Safety covers every event that may occur in hospital settings but also in any other healthcare settings, like primary health care clinics, nursing homes, pharmacies, patients' homes and in clinical trials such as:

- harm caused as a result of a wrong diagnosis, clinical procedure or decision.
- the side-effects of drugs.
- hazards posed by medical devices or sub-standard products.
- human shortcomings.
- system errors.

WHY IT MATTERS?

1 in 10 patients is harmed while receiving hospital care in developed countries, and **1.4 million people** worldwide suffer from hospital-acquired infections at any given time[2]. Data published in 2006[3] showed that:

23% of Europeans had been directly affected by a medical error

18% had experienced a serious medical error in a hospital

11% had been prescribed the wrong medication

Medical errors and health-care related adverse events occur in 8-12% of hospitalisations[4].

WHAT CAN BE DONE?

Patient safety culture

Adverse events in healthcare settings are often the result of a combination of system failures and human errors. Addressing safety means developing a patient safety

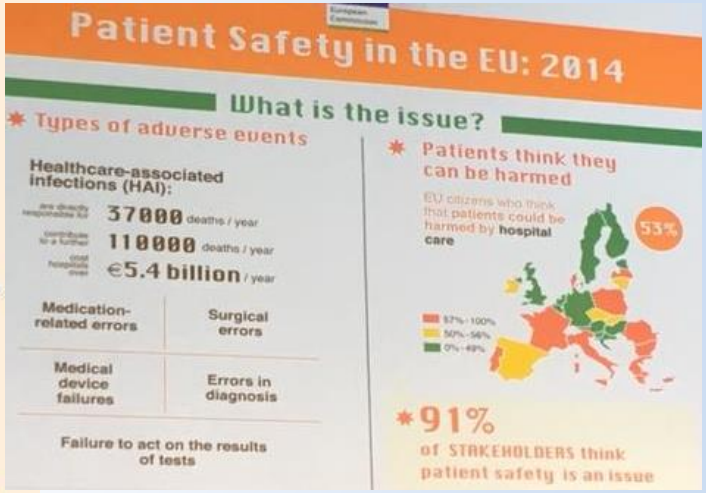
Information to patients

By becoming health literate and actively involved in managing their own condition, patients can help improve their own safety

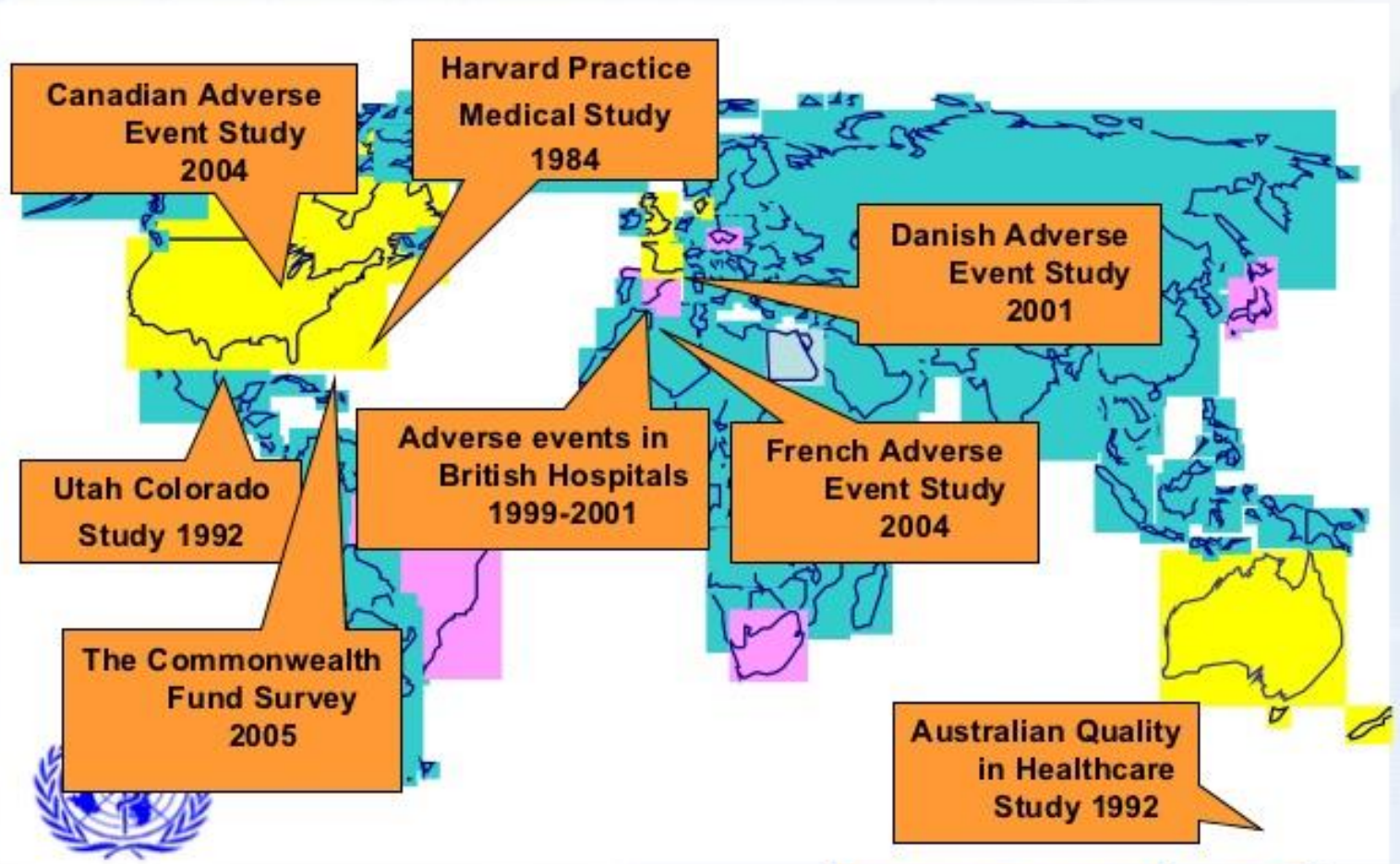
Patient involvement

Patients are a source of information about failures and gaps in the system therefore the involvement of patients, their families, and patient organisations as partners is vital. For this to become a reality, fundamental change in medical culture is necessary. Healthcare professionals and decision-makers need to:

- listen to patients.



Research for Patient Safety

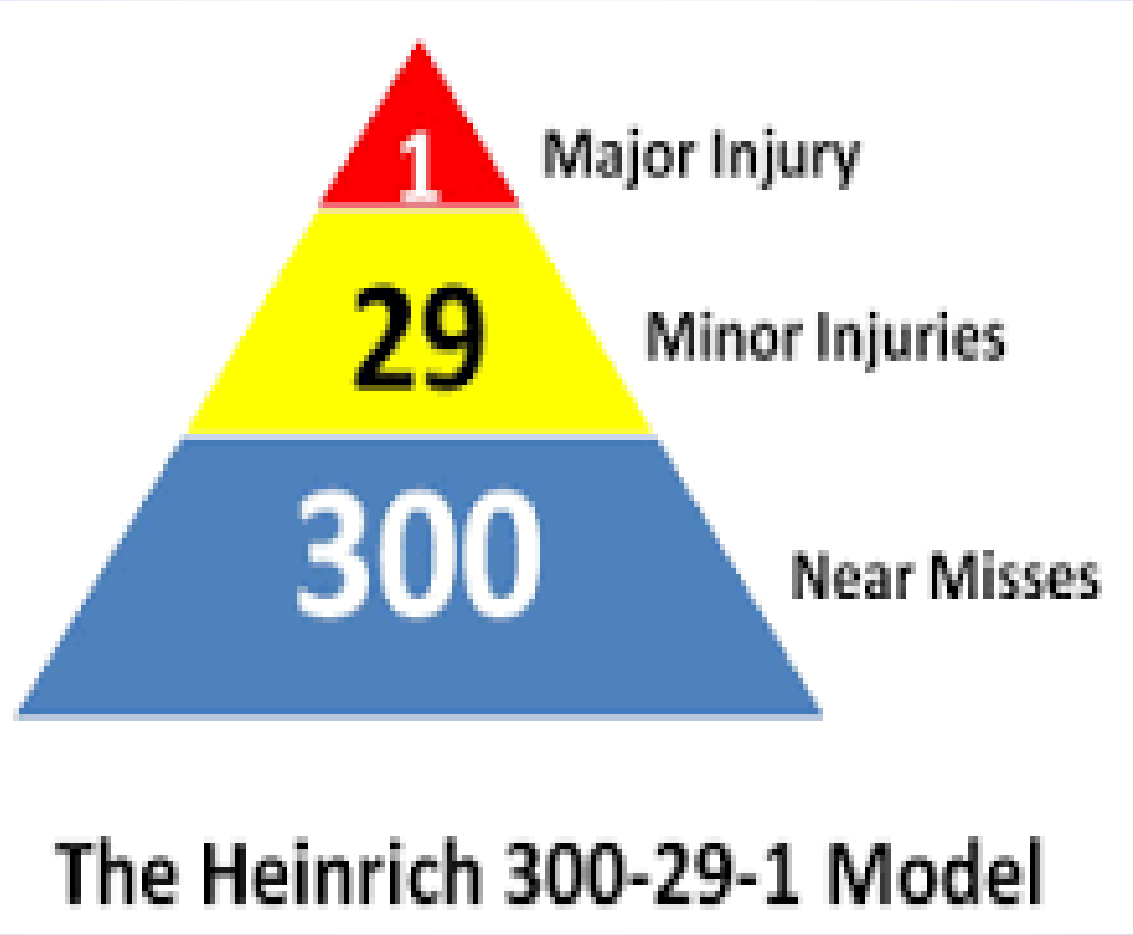


Joint Commission International

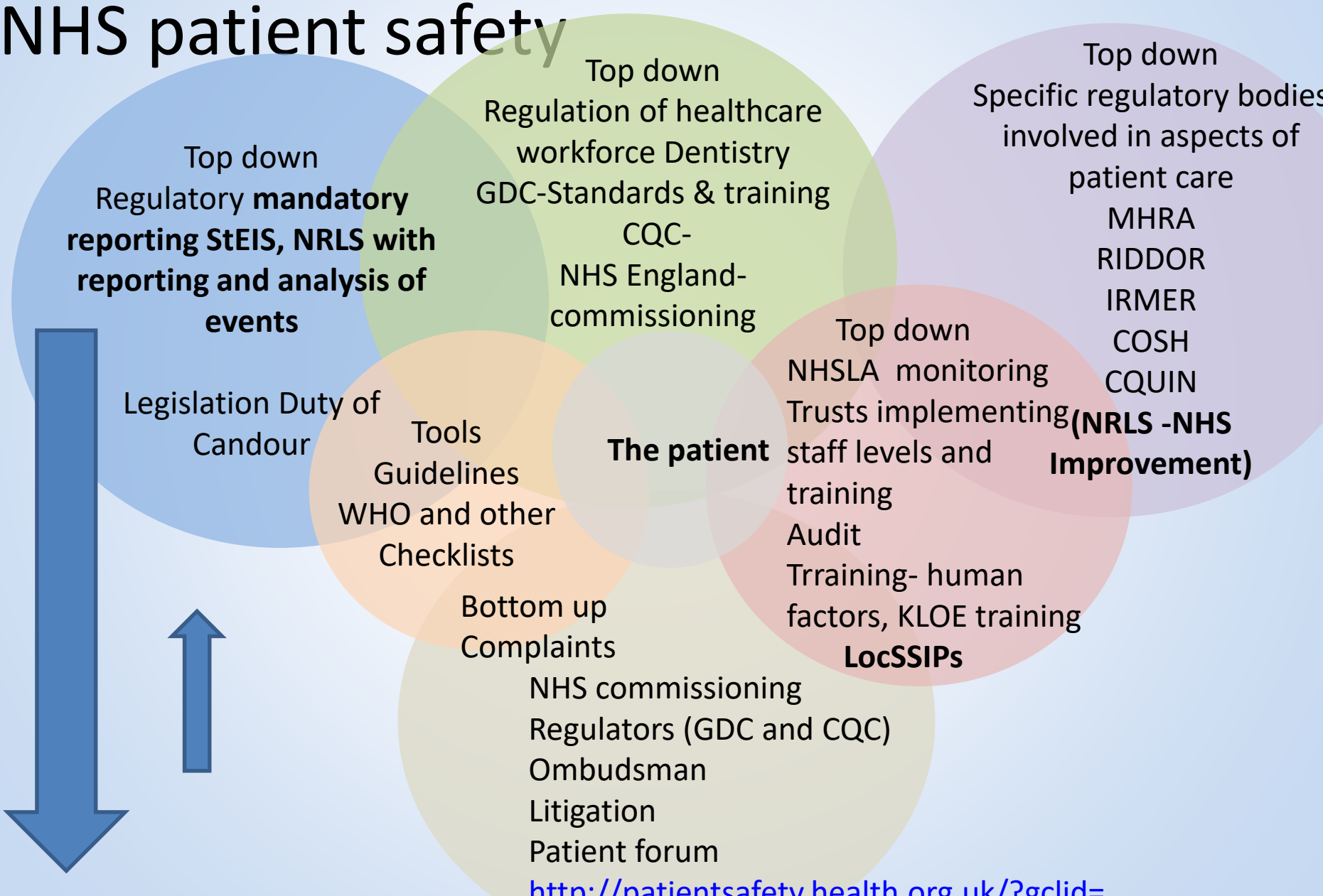
The Joint Commission

© Copyright, Joint Commission Resources

The more near misses the more major events



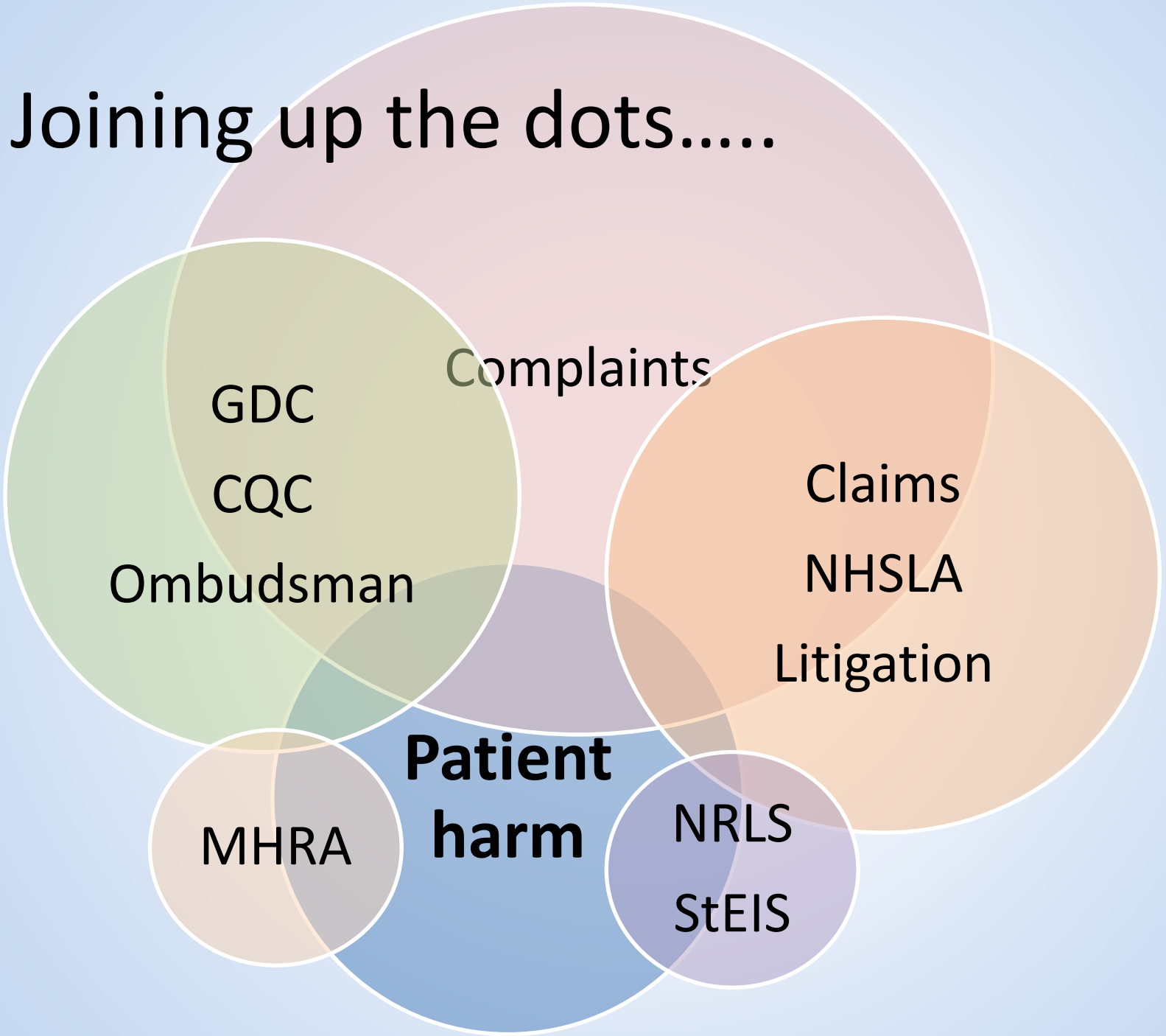
Current structures NHS patient safety



What regulation and legislation apply to dental practice in notifying regulatory bodies regarding Patient Safety relating to dentistry?

- **The Data Protection Act** 1998. In all cases when reporting PSIs, providers must comply with locally agreed and documented Caldicott data protection and information governance requirements **Control of substances hazardous to health COSHH 2002**
- **The Human Rights Act 1998 and the Equality Act 2010**.
- **The Mental Capacity Act 2005**
- **Mental Health Act** monitoring duties as well as our functions under the Health and Social Care Act **2008**.
- **Social Care Act 2008 Code of Practice** on the prevention and control of infections and related guidance, HTM 01-05 and HTM 04-01,
- **Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), Sharps regulations 2013**, HTM 07-01 (healthcare waste)
- **Care Quality Commission (Registration) Regulations 2009**, Regulations 12, 14, 15, 16, 17, 18, 20, 21 and 22 make requirements that the details of certain incidents, events and changes that affect a service or the people using it are notified to CQC.
- **Notification advice related to Social Healthcare act** 2009 for NHS healthcare workers 2013
- **The Health Protection Legislation** (England) Guidance 2010 **RIDDOR (**Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) **The Health and Safety at Work Act 1974** (HSWA) and ensuring that “risks to people’s health and safety from work activities are properly controlled”.
- **‘National Framework for Reporting and Learning from Serious Incidents requiring Investigation’ (2010)** has been replaced by the publication **'Serious Incidents Framework' (2015)** which can be accessed via the following link: http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

Joining up the dots…..



Outline

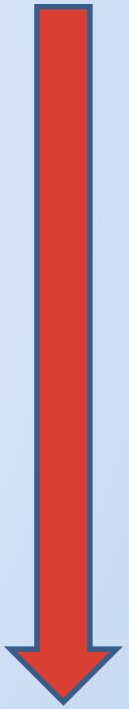
- **Defining quality improvement**
- **Patient safety incidents**
  - Near misses
  - Never events
  - Serious events / notifiable events
- **Events leading to LocSSIPs**
- **LocSSIPs**
  - National Safety Standards for Invasive Procedures' (NatSSIPs) and
  - Local Safety Standards for Invasive Procedures (LocSSIPs)
- **How can we do better?**
  - Identify threats to patient safety by incident reporting
  - Analysing incidents to improve safety
  - Communication and education in patient safety
  - Building a safety culture

Patient safety Incidents (Adverse Events)

Patient safety events (PSIs)

- A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Increasing harm



– **Near Misses (can be no harm)**
  - **which provide the richest opportunity to learn and improve patient safety**
– **Never events NEs (Low, mod rarely severe harm)**
  - **per se not unlawful unlike below**
– **Notifiable safety event (NSI) /Serious untoward events (SUIs) or Serious events (SEs) Serious Incidents (as defined in the Serious Incident Framework) can include but are not limited to patient safety incidents**
  - Moderate, serious harm or death.
  - More 28 days physical or psychological harm (CQC)

http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/serious-incident-reporting-and-learning-framework-sirl/

Definitions of harm

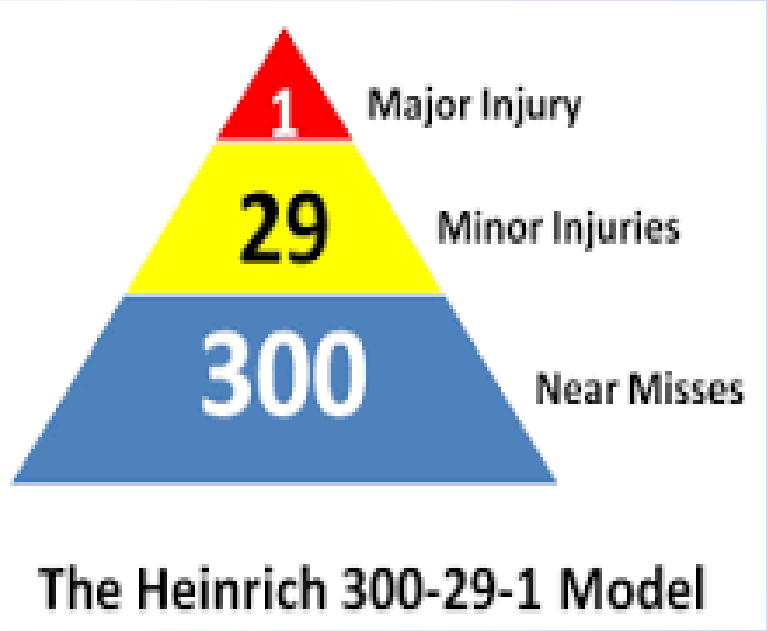
- Low/ moderate /severe
- Moderate harm
  - Requires a moderate increase in treatment
  - Significant but not permanent harm
  - Moderate **increase in treatment** means unplanned return to surgery or a **readmission** prolonged episode f care, **extra time in hospital** or as an outpatient, **cancelling of treatment** of **transfer** to another treatment area

Definitions of harm

- Severe harm
  - Permanent lessening of a bodily sensory motor psychologic or intellectual functions
  - Not related to the natural course of the service user's underlying illness or condition
- Prolonged psychological harm
  - 'psychological harm which..has experienced or is likely to experience, for a continuous period of at least 28 days'

Near Miss- the 'golden nugget' for patient safety improvement

The concept of near miss is taken from a corporate model ''Heinrich's "Safety Triangle", which places near-miss events at the base of the triangle, accidents in the middle and finally fatalities at the top, with the assumption that by eliminating near-miss events alone accidents and fatalities will eventually disappear.



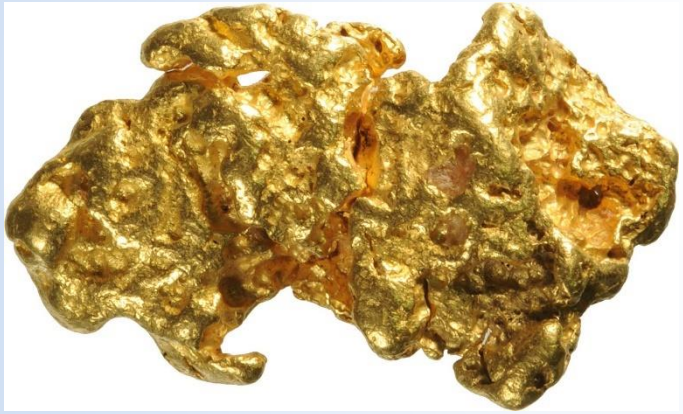
Medical studies have reported that that the near-miss experiences are a wake-up call for systematic risk reducing efforts and the use of checklists in surgery. However evaluation of this model, applied in pharmacology, disputed that attempts in avoiding near misses would obviate fatalities or serious incidents.

Haugen AS, Murugesh S, Haaverstad R, Eide GE, Søfteland E A survey of surgical team members' perceptions of near misses and attitudes towards Time Out protocols. BMC Surg. 2013 Oct 9;13:46. doi: 10.1186/1471-2482-13-46.

Penson RT, Svendsen SS, Chabner BA, Lynch TJ Jr, Levinson W. Medical mistakes: a workshop on personal perspectives. Oncologist. 2001;6(1):92-9.

Gallivan S, Taxis K, Dean Franklin B, Barber N Is the principle of a stable Heinrich ratio a myth? A multimethod analysis. Drug Saf. 2008;31(8):637-42.

Near miss-
No harm =optimal learning opportunity to prevent future events



Tara Renton

Near Misses

Patient safety isn't just about checklists, it is about making clinical teams aware and interested in patient care improvement, thus changing the culture in healthcare, placing patient safety at the very centre of our daily work.

The concept of medical harm has existed since antiquity, as reported by Hippocrates, and defined as *iatrogenesis*, derived from the Greek for *originating from a physician*. Investigators in the Harvard Medical Practice Study defined an adverse event as 'an injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both.' The Institute for Healthcare Improvement uses a similar definition: 'unintended physical injury resulting from, or contributed to, by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death'.

Patient harm arises due to errors. An error refers to any act of commission (doing something wrong) or omission (failing to do the right thing) that exposes patients to a potential harm. Adverse events refer to harm from medical care rather than an underlying disease, subcategories of adverse events include:

- Preventable adverse events: those that occurred due to error or failure to apply an accepted strategy for prevention;
- Ameliorable adverse events: events that, while not preventable, could have been less harmful if care had been different;
- Adverse events due to negligence: those that occurred due to care that falls below the standards expected of clinicians in the community.

It is recognized that recognition and reporting of adverse events in dentistry is poor[1] and, as a result, compromises opportunities to optimize patient care.[2] This may in part be due to poor education,[2] fear of consequences and the complexity of reporting mechanisms for notifiable events.[3] Publication of the Surgical Safety for invasive procedures (**https://www.rcseng.ac.uk/dental-faculties/fds**) Local Safety Standards for Invasive Procedures (LocSSIPs) for dental extractions toolkit provides an update on Never Events in dentistry and is the first step to improve patient safety culture in dentistry. In my review of serious untoward events in dentistry using the NRLS dataset, wrong site surgery, anaphylaxis due to prescription of antibiotics and missed diagnosis of neoplasia were the most common events reported.[1]

Near Misses are the 'golden nuggets' of patient safety, causing no harm to patients but providing opportunities to identify potential issues that, if addressed, can prevent future patient harm, thus improving patient care. Near Misses provide daily opportunities to recognize potential system and process failure that could lead to patient harm. Recognition and rectification of Near Misses prevents patient harm and medical errors.

A Near Miss is *an unsafe situation that is indistinguishable from a preventable adverse event except for the outcome*. A patient is exposed to a hazardous situation, but does not experience harm either through luck or early detection.[4]

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Some examples of near misses

- A patient undergoing root canal treatment in primary dental care practice drinks from one of two white cups on the spittoon. The cup contains sodium hypochrlorite and she spits it out immediately. No harm occurs but obviously this isn't great practice and must be changed to prevent future harm.
- Lack of recognition of oral cancer. Parapharyngeal squamous cell carcinoma is misdiagnosed early on in the presentation, resulting in no harm to the patient but giving rise to a change in patient pathway when a differential diagnosis of glossopharyngeal neuralgia should have been made.
- Prescription of steroids to a patient, with reported history of peptic ulceration, who had recently experienced nerve injury related to dental implants, resulting in near perforation of his peptic ulcer. This could have been avoided if the patient medical history had been checked prior to the prescription.
- A young patient with reported allergy to Penicillin was prescribed Amoxycillin for spreading dental infection, potentially causing Anaphylaxis. The patient's mother identified the problem before the patient took the medication. Medical history checks prior to dispensing medication should ideally be checked by the prescriber and assistant and later by the pharmacist; this did not happen.

These examples illustrate how Near Misses provide opportunities to improve our patient care and minimize harm.

Simple gestures, like keeping a practice or personal log book of Near Misses (and patient safety adverse events/incidents) is essential and provision of evidence that lessons have been learnt from Near Misses or adverse events and showing how practices have been changed which may prevent future events. This demonstrates to peers and the CQC that this shift in concept has been understood. In addition, a patient safety agenda item on monthly practice meetings will avail space and encourage the team to get involved in recognizing, learning from and preventing future events. These simple strategies will demonstrate to the CQC and other stakeholders that the team are intent on changing patient safety culture and improving patient care.

References

1. Renton T, Sabbah W. Review of never and serious events related to dentistry 2005–2014. *Br Dent J* 2016; **221**: 71–79. doi: 10.1038/sj.bdj.2016.526.
2. Renton T, Master S. Never say never: Never Events, NatSSIPs and the need for a new approach in dentistry. *Faculty Dental Journal (FDJ)* October 2016. doi: 10.1308/rcsfdj.2016.141.
3. Renton T, Master S. The complexity of patient safety reporting systems in UK dentistry. *Br Dent J* 2016; **221**: 517–524. doi: 10.1038/sj.bdj.2016.782.
4. Adverse Events, Near Misses, and Errors. AHRQ Patient Safety Network **https://psnet.ahrq.gov/primers/primer/34/adverse-events-near-misses-and-errors**

Notifiable events

- **Statutory** Duty of candour
- **Standards**
  - **Regulatory stipulate mandatory standards applied to dentistry** The Data Protection Act 1998., Control of substances hazardous to health COSHH 2002. The Human Rights Act 1998 and the Equality Act 2010, The Mental Capacity Act 2005, Social Care Act 2008 Code of Practice, Ionising Radiation, Care Quality Commission (Registration) Regulations 2009, Notification advice related to Social Healthcare act 2009 for NHS healthcare workers 2013 and The Health Protection Legislation.
  - **Notifiable events** linked to regulation (MHRA, Public Health, RIDDOR, CQC,) with never events (NRLS NPSA, STEIS, CQUIN).
  - Dental teams may also be regulatory beholden to report criminal (Fraud), mental health (intended suicide), notifiable diseases and COSSH and MHRA events.

What are Never events?

- **Dental NEs introduced 2012**
- **The revised never events framework of March 2015** reassessed a subset of serious incidents and therefore, this policy should always be read in conjunction with the Serious Incident Framework (http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf March 2013).
- The updated criteria for Never Events are that they a particular type of serious incidents that meet the following criteria;
  - **they are wholly preventable where guidance or safety recommendations provide strong systematic barriers.**
  - **are available at a National Level**
  - **implanted by Healthcare workers**
  - **each Never Event has the potential to cause serious patient harm or death (however serious harm or death is not required)**
  - **There is evidence that it has occurred in the past (ie, it is a known source of risk).**
  - **It can be easily defined, identified and continually measured. This requirement helps minimise disputes around classification and ensures focus on learning and improved patient safety**
  - **it is anticipated that Never Event list will be reviewed annually.**

Serious Incident Framework (http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.

Never events

Never Events are defined by NHS England as being:

- “Serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event”
- Wrong tooth extraction has been clearly designated as a Never Event since April 2015. Wrong tooth extraction continues to top the charts as being the most frequently occurring Never Event based on NHS England’s data.
- The latest figures show that during 2015/16 wrong tooth extraction was reported 33 times by NHS Trusts in England, this was the second most frequent never event for that year.
- During 2016/17, the figure had risen to 42 making **wrong tooth extraction the most frequent never event in England!** We must also note that this figure will not include wrong tooth extractions that occur in primary care dentistry as there is no way of reporting these incidents at the present time.
- **Statutory reporting** Duty of candour

NHS Improvement

Never Events list 2018

January 2018

collaboration trust respect innovation courage compassion

What is a Never Event in dentistry?

The Revised Never Events policy and framework 2018 from NHS England[1] modified the list of Never Events related to dentistry to the following 4 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 /incorrect placement of dental implant**
- **Retained foreign body**
- **Extraction of deciduous teeth under GA**
- **Over sedation using high concentration Midazolam (not allowed in 2017 Conscious sedation Guidelines SDCEP)**

NPSA and NRLS	**http://www.nrls.npsa.nhs.uk and https://report.nrls.nhs.uk/nrlsreporting/ These gather data on:** **• Never events** **Also the Serious Incident Reporting and Learning Framework http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/serious-incident-reporting-and-learning-framework-sirl/**

Jan 2018 updated Never event list

Surgical 1. Wrong site surgery

An invasive procedure performed on the wrong patient or at the wrong site (eg wrong knee, eye, limb, tooth).

- The incident is detected at any time after the start of the procedure. Includes: Interventions that are considered to be surgical but may be done outside a surgical environment – for example, wrong site block (including blocks for pain relief), biopsy, interventional radiology procedure, cardiology procedure, drain insertion and line insertion (eg peripherally inserted central catheter (PICC)/ Hickman lines). This also includes teeth extracted in error that are immediately reimplanted.
- **Excludes:**
- • **removal of wrong primary (milk) teeth unless done under a general anaesthetic**
- • interventions where the wrong site is selected because the patient has unknown/unexpected anatomical abnormalities; these should be documented in the patient's notes
- • wrong level spinal surgery*
- • wrong site surgery due to incorrect laboratory reports/results or incorrect referral letters
- • contraceptive hormone implant in the wrong arm. *Excluded from the current list while NHS Improvement works with the relevant professional organisations to ensure development of robust national barriers to prevent this incident.

Jan 2018 updated Never event list Surgery

- **National safety requirement:**
- • Safer Practice Notice – Wristbands for hospital inpatients improves safety (2005). The key points are summarised in Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list.
- • Safer Practice Notice – Standardising wristbands improves patient safety (2007). The key points are summarised in Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list.
- • Patient Safety Alert – WHO surgical safety checklist (2009). The key points in the alert are summarised in Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list.
- • Safe Anaesthesia Liaison Group – Stop before you block (2011).
- • The Royal College of Radiologists – Standards for providing a 24 hour interventional radiology service (2008).
- • Faculty of Pain Medicine – Safety checklist for interventional pain procedures under local anaesthesia or sedation (2017).
- • Royal College of Surgeons (Faculty of General Dental Practice) – Toolkit for the prevention of wrong tooth extraction (2017).
- • National safety standards for invasive procedures (NatSSIPs) (2015).
- • Patient Safety Alert – Supporting the introduction of the national safety standards for invasive procedures (2015).

Jan 2018 updated Never event list **Wrong implant/prosthesis**

- Placement of an implant/prosthesis different from that specified in the procedural plan, either before or during the procedure. The incident is detected any time after the implant/prosthesis is placed in the patient. Excludes:
- • placed implant/prosthesis is intentionally different from that specified in the surgical plan, based on clinical judgement at the time of the procedure
- • specified implant/prosthesis is placed as planned but later found to be suboptimal
- • implant/prosthesis is different from the one specified due to incorrect preprocedural measurements or incorrect interpretation of the preprocedural data – for example, wrong intraocular lens placed due to wrong biometry or using wrong dataset from correct biometry.

Jan 2018 updated Never event list

Retained foreign object post procedure

- 3. Retention of a foreign object in a patient after a surgical/invasive procedure. ‘Surgical/invasive procedure’ includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside the surgical environment – for example, central line placement in ward areas.

Jan 2018 updated Never event list

Mis-selection of high strength midazolam during conscious sedation

8. Mis-selection refers to when:

- • a patient is given an overdose of midazolam due to the selection of a high strength preparation (5 mg/mL or 2 mg/mL) instead of the 1 mg/mL preparation, in a clinical area performing conscious sedation
- • excludes clinical areas where the use of high strength midazolam is appropriate; these are generally only those performing general anaesthesia, intensive care, palliative care, or areas where its use has been formally risk-assessed in the organisation. Setting: All settings providing NHS-funded care.

National safety requirement:

- • Rapid Response Report – Reducing risk of overdose with midazolam injection in adults (2008). Key points are summarised in Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list.

FDS RCS Faculty Dental Journal October 2016

Tara Renton and Selina Master

Never say never: Never events, NatSSIPs and the need for a new approach in dentistry

by Tara Renton and Selina Master

It is reportedly more perilous to stay in an NHS hospital than to cross the road. A recent survey of 187,337 deaths within 30 days of hospital admission during 1 year revealed that 1.3% of patient deaths were attributable to their hospitalisation. A review of the factors associated with in-hospital death revealed that a person admitted on a Sunday had a 16% increased risk of dying compared with someone admitted on a Wednesday.[1] There is also a human cost when things go wrong and a 'never event' occurs, often with severe consequences for patients, their families and healthcare professionals.[2] This has led to an increased focus on the pressures on staff that contribute to errors.[3] We review the current recommendations for handling never events, and the need for cultural changes to improve and develop patient safety in dentistry.

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Keywords: Never events, wrong site extraction, NatSSIPs

OPINION

FACULTY DENTAL JOURNAL October 2016 - Volume 7 - Issue 4

FAQs

- ***Does the wrong tooth extraction apply to deciduous teeth?*** No - although the strong systemic 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.

Following NEs

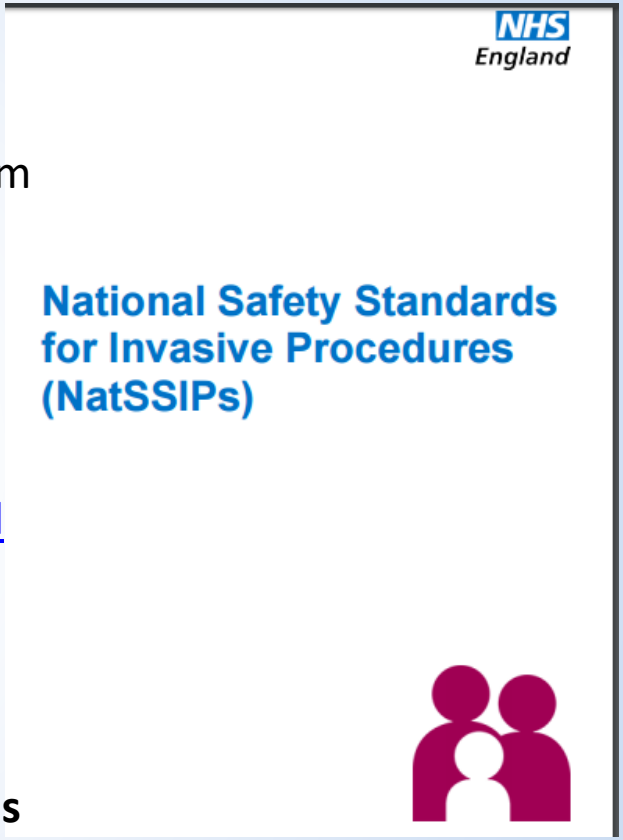
- **Reporting NEs**
- **Investigating NEs –Key lines of enquiry KLOEs**
- **Learning from NEs**
- **Supporting the team after NEs occur**
  - Importantly, we argue in our report that never events are not over when a patient leaves the operating theatre. The task force looked carefully at the support that patients and their loved ones need when never events – and other serious incidents – happen. Professional-ethical duties and the contractual duty of candour mandate that patients are told promptly and honestly when something has gone wrong. But being open is not enough. When things go very wrong patients are entitled to candour, and much more than candour. They also need caring and compassionate support, a credible and independent investigation into what happened, a thoughtful approach to restitution, and proper accountability.
  - Importantly, professionals involved in incidents also need appropriate support. In the NHS, thousands of healthcare professionals will go to work today committed to making people better and, if they can't make them better, giving them comfort. By this evening, some will unintentionally have done their patient harm. The very opposite of what they aimed to do, this can be devastating. How professionals then deal with this awful turn of events affects patients, colleagues, and the systems we design to keep patients safe.
- So professionals need help to manage the situation well, not only for their own benefit, but also to build a safer culture of care.

Outline

- **Defining quality improvement**
- **Patient safety incidents**
  - Near misses
  - Never events
  - Serious events / notifiable events
- **Events leading to LocSSIPs**
- **LocSSIPs**
  - National Safety Standards for Invasive Procedures' (NatSSIPs) and
  - Local Safety Standards for Invasive Procedures (LocSSIPs)
- **How can we do better?**
  - Identify threats to patient safety by incident reporting
  - Analysing incidents to improve safety
  - Communication and education in patient safety
  - Building a safety culture

National Safety Standards for Invasive Procedures' (NatSSIPs) Local Safety Standards for Invasive Procedures (LocSSIPs)

A key initiative by NHS Improvements in 2015
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**. T

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)**

What are invasive procedures?

The National Institute for Health and Care Excellence (NICE) defines an “interventional 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.

Local Safety Standards for Invasive Procedures Tool kit

- Main document explanation and pathway for dental extraction
- Appendices
  - Reference to development of LocSSIPs
  - How, who to and when to report Never events
  - Example of how to manage a never event
  - How to demonstrate learning from near miss or never event and proposed log of learning for portfolio
  - FAQs

LocSSIPs Group Participant List 20160429

SPEC/ORG	NAME
FGDP	Mick Horton, Dean
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NHS England, Office of CDO	Janet Clarke
ADH Clinical Directors	Avril MacPherson
Dental Dean	Callum Youngson
Manchester Patient Safety Group	Edmund Bailey
ABAOMS	Justin Durham
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BSHDT (Dental Therapists and Hygienists)	Invited
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Nurse Manager and Governance Lead for Dental Hospital	Lesley Davies
CQC	John Milne & Sampana Banga
Lay Member	Sue Parroy
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HEE	Elizabeth Jones HEE
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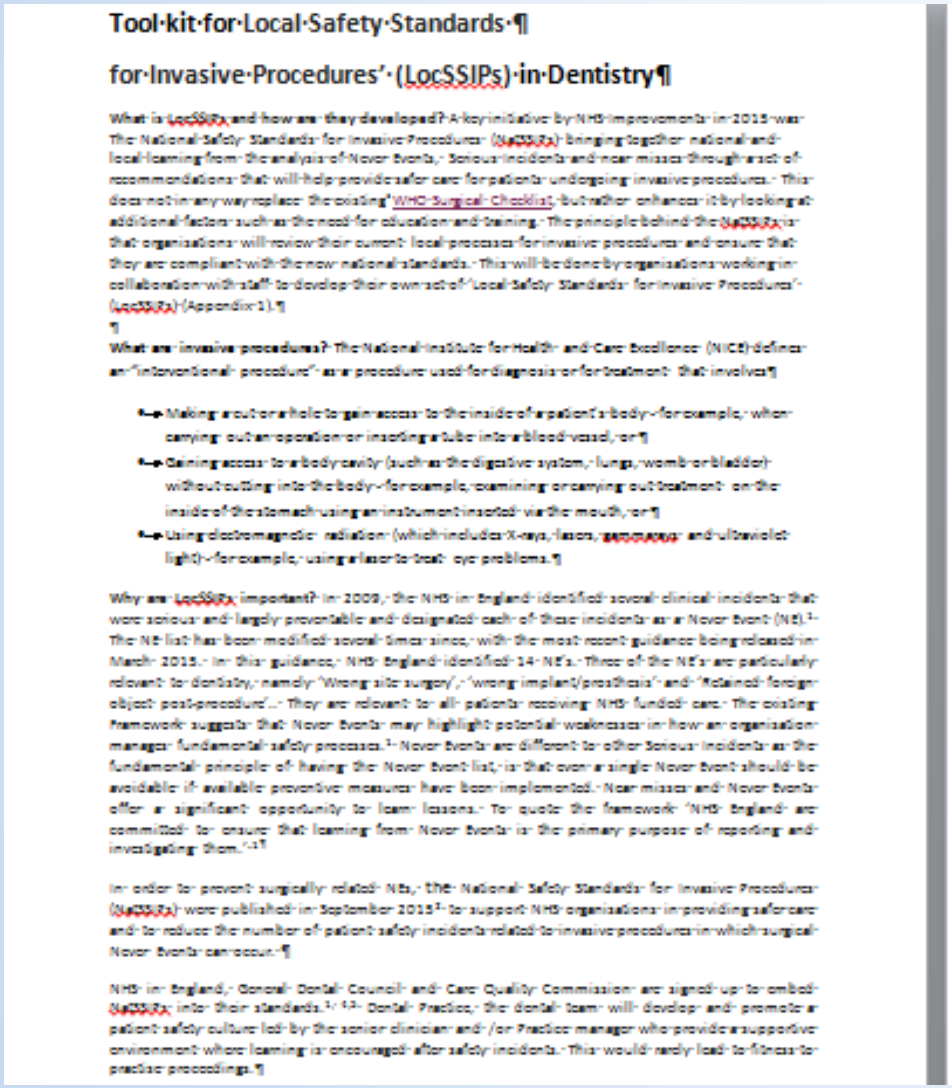
Local Safety Standards for Invasive Procedures



Tool·kit·for·Local·Safety·Standards·¶

for·Invasive·Procedures'·(LocSSIPs)·in·Dentistry¶

What is LocSSIPs and how are they developed? A key initiative by NHS Improvement 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).¶

¶

What are invasive procedures? The National Institute for Health and Care Excellence (NICE) defines an "interventional 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.¶

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).[1] The NE list has been modified several times since, with the most recent guidance being released in March 2015. In this guidance, NHS England identified 14 NE's. Three of the NE's 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.[1] 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.'[1]¶

In order to prevent surgically related NEs, the National Safety Standards for Invasive Procedures (NatSSIPs) were published in September 2015[2] to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur.¶

NHS in England, General Dental Council and Care Quality Commission are signed up to embed NatSSIPs into their standards.[3, 4,5] Dental Practice, the dental team will 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. This would rarely lead to fitness to practice proceedings.¶

Dentistry provides one of the NHS' highest volume 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 which 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 it occurs in. With simple routine good practice it should be possible in the majority of cases to minimise wrong site surgery in dentistry.¶

How are LocSSIPs applied? The example Dental extraction LocSSIPs 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 2 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 tooth is outside the GDC core Scope of Practice for dental nurses however utilising an empowered dental nurse as an assisting member of staff in all stages of the pathway where necessary, will engender the correct team mind-set and approach to improving patient safety. ¶

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 (flow chart in Appendix 2) facilitating a national perspective to provide support where there are issues and to evolve patient safety. An example of how to report a never event is provided in Appendix 2 and an example of how to manage a never event is provided (Appendix 3) ¶

How do I learn from near miss and never events? Appendix 4 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 Website FGDP website and BOA website links) website.¶

What else do I need to know? Frequently asked questions about never events in dentistry are provided in Appendix 5.¶

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

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. ¶

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

GDC??? ¶

GDC??¶

This process has highlighted needs for improvement including necessary infrastructure for simplified reporting and analysis of data to inform improvement in dental care, necessary training for the dental team and improved responsiveness maximising patient safety when undergoing invasive procedures by the dental team. This work will continue and evolve. ¶

The Pathway LocSSIPS for dental extraction

Pre-patient
Procedural verification & justification

Patient present Check:
Patient Name / DoB/ Address

Consent Verbal / Written
Procedure verification with patient & clinical team member, notes, radiographs, any other relevant clinical material
Confirm planned implant or device

PAUSE or last look

Recheck treatment plan, countdown to tooth, correct arch and side with DCP or colleague)
Treat as prescribed

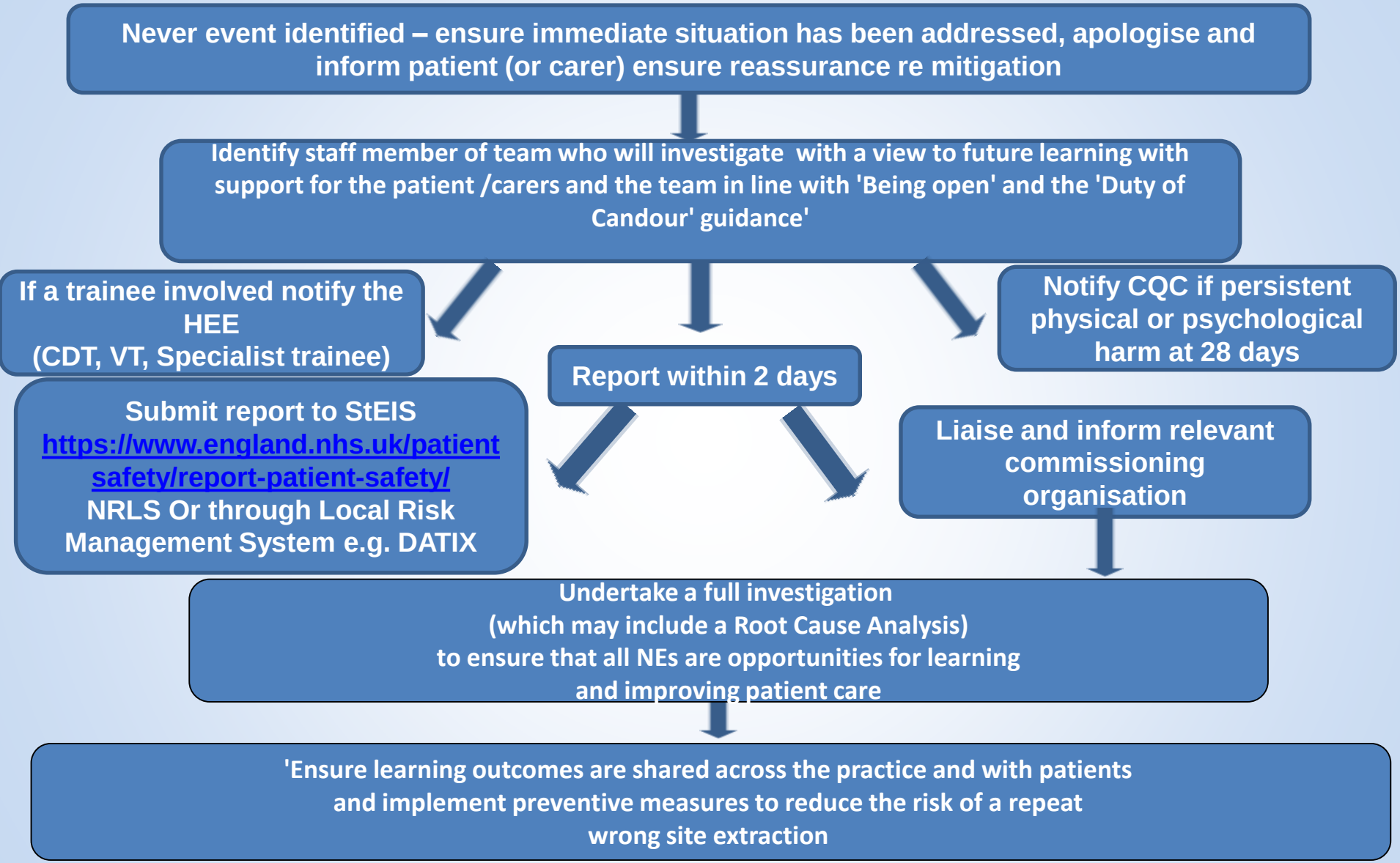
Check for no lost or retained objects (implants, screws, bur heads, tooth fragments)

Debrief to confirm if process could be improved or not'

[PDF]LocSSIPs Toolkit Dental extraction
https://www.rcseng.ac.uk/-/media/files/rcs/fds/.../locssips-toolkit-dental-extraction.pdf?.

(LocSSIPs) for wrong site extraction in Dentistry This toolk
www.baos.org.uk/resources/LocSSIPsToolkitDentalextraction.pdf

Dental Never Events – reporting NEs to NRLS



Abbreviations: **CQC**, Care Quality Commission; **NE**, never event; **WSE**, wrong site extraction, **NRLS** National Reporting and Learning System **StEIS** The Strategic Executive Information System captures all Serious Incidents. Serious Incidents (as defined in the Serious Incident Framework) can include but are not limited to patient safety incidents.

Reporting

- NHS Dental reporting primary care system being developed currently directly to NRLS

- CQC reporting of;
  - **Abuse or allegations of abuse**
  - **Serious injuries -** physical or psychological damage to service user > 28 days
  - **Applications to deprive a person of their liberty**
  - **Events that prevent or threaten to prevent the registered person from carrying on an activity safely and to an appropriate standard**
  - **Deaths of service users**
  - **Incidents reported to or investigated by the police**
  - **Unauthorised absences mental health act**

EXEMPLAR

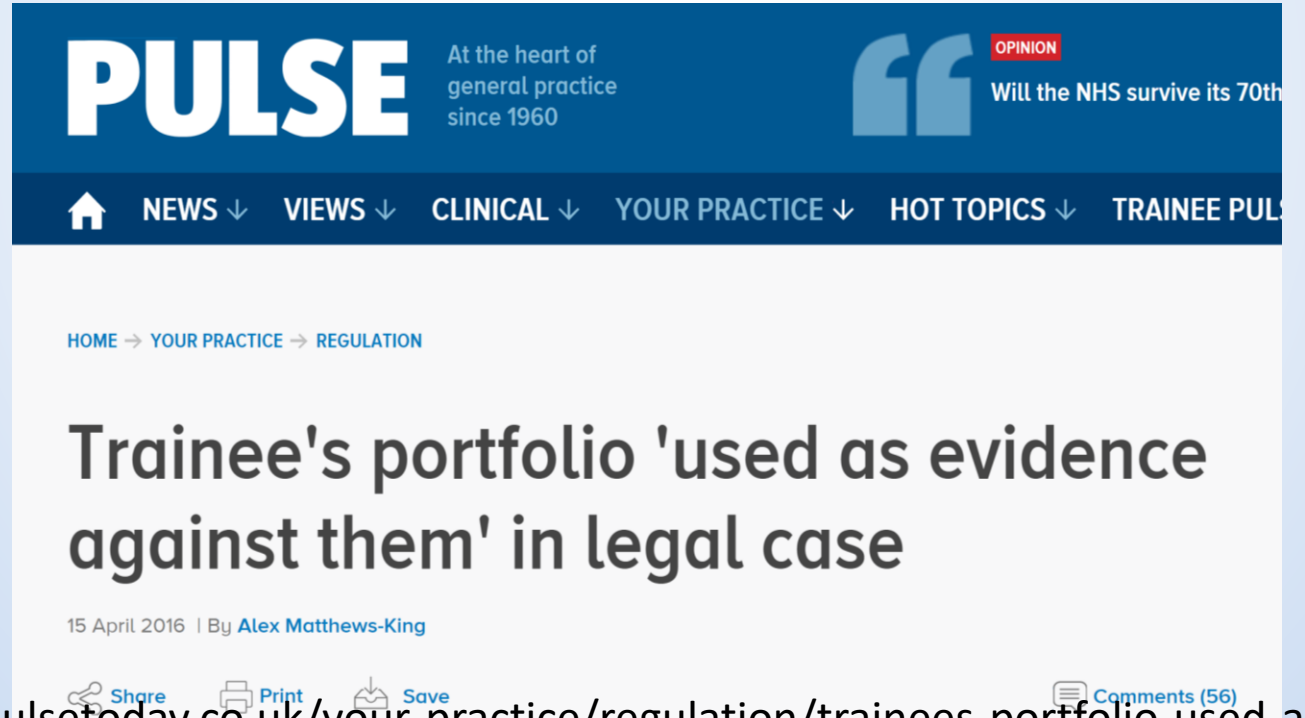
Scenario A 13 year old boy is referred back to his own GDP for Orthodontic extractions. The Specialist Orthodontist requests extraction of maxillary first premolars and mandibular second premolars as part of the Orthodontic treatment plan.	**History:** a) Medical History: Nil relevant b) Dental History: Phobic – previous experience of difficult deciduous extractions c) Social History: Attends with Mother who is also dental phobic	**Risk Factors:** 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. b) Dentist is working with a bank nurse who is unfamiliar with the clinic and team and regular processes and systems for the practice. c) It has been a busy day and they are running late. d) There is only a printed DPT available. 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. 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. 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. h) The practice does not routinely use a WHO surgical check list.

The Pathway LocSSIPS learning log

Patient Identifier:
Age & sex of patient:
Medical/Dental and relevant Social History:
Brief summary of Never Event, including: • **Risk Factors**
Effect of never event on patient: • **How will the outcome be managed?** • **How involved has the patient/carer been in the consequences?** • **Has the patient/carer been continually involved in the learning process?** • **Have I apologised? (Duty of Candour)** • **How effective and appropriate do you feel was your communication? Have you reflected on your engagement with the patient?**
How did the clinical team manage the never event? • **What went well?** • **What was the impact on the team?**
What has been learnt from the never event? • **Mitigation of risk factors** • **What will be done differently next time?**
How has the learning been shared amongst the team/service?
How will it influence your future approach to similar cases?

Reflective learning

- **Importance of reflective learning recorded in your logs <u>DO not mention patient or staff names</u>**
- **Reflective ARCP learing log used against trainee**



http://www.pulsetoday.co.uk/your-practice/regulation/trainees-portfolio-used-as-evidence-against-them-in-legal-case/20031605.fullarticle

- Letter from HEE

Health Education England

BY EMAIL

To:
All East of England Trainees

East of England Office
Directorate of
Education & Quality
Victoria House
Capital Park, Fulbourn
Cambridge, CB21 5XB

20 April 2016

Dear Trainees,

RE: Position Statement on Trainees' Written Reflections

I am writing to you as the Postgraduate Dean and Responsible Officer for postgraduate medical trainees to clarify the position with regard to trainees' written reflections. I am aware that there have been some confusing messages about this recently.

The General Medical Council make it clear in Good Medical Practice that reflection is the key to effective continuing professional development, and is a skill that must be developed and practised by all doctors (http://www.gmc-uk.org/education/continuing_professional_development.asp).

All aspects of a doctor's professional work, including interactions with colleagues and patients, must be reflected upon. It is equally important that all doctors are open to reflect on critical incidents and complaints. Trainees must continue to do this in discussion with their supervisors and provide evidence of this activity at ARCP. This is no different to the expectation that all consultants, non-training grade doctors and GPs reflect for their annual appraisal and that without this evidence no doctor can revalidate.

Recently, a trainee released a written reflection to a legal agency, when requested, which was subsequently used as evidence against the trainee in court. This has resulted in questions about whether trainees should still provide reflection about incidents in their portfolios.

Health Education England - East of England is clear that all doctors have to provide written reflections for their ARCP and appraisal, and so doctors in training must continue to write reflections, especially when there are things that do not go well. This is an essential part of training and is needed to progress through a postgraduate training programme.

However, it is important that doctors in training should be mindful that their reflections are carefully written and focus on the learning gained from such events. In order to comply with Information Governance, there must be no patient identifiable information contained within written reflections.

Although the law will continue to challenge us, we need to continue to maintain our Professional approach, including reflection for learning. We would encourage doctors in training to continue to

Additional Resources

- All documentation will be available from NatSSIPs, FDS RCS, FGDP and BDA websites
- Examples of good practice will be available

Preventing wrong tooth extraction: experience in development and implementation of an outpatient safety checklist

IN BRIEF

- Provides a model surgical safety checklist for use in an outpatient oral surgery setting.
- Discusses how patient safety incidents can be analysed and audit used to monitor use of an outpatient checklist.
- Demonstrates how communication and teamwork can be improved to ensure safe management of patients.

PRACTICE

A. Saksena,*[1] M. N. Pemberton,[1] A. Shaw,[1] S. Dickson[1] and M. P. Ashley[1]

Extraction of the wrong tooth or teeth is a serious and avoidable clinical error causing harm to the patient. All NHS Trusts in England are required to use a surgical safety checklist in operating theatres to prevent incorrect site surgery and ensure safe management of patients. However, the majority of patients have dental extractions and other oral surgical procedures undertaken on an outpatient basis and these patients are also at risk of having an incorrect site surgical procedure such as a wrong tooth extraction. We describe our experience in developing, introducing and refining a surgical safety checklist for outpatient oral surgery along with the key strategic actions needed to ensure effective cultural change and optimum patient safety in the outpatient setting.

BACKGROUND AND OUR EXPERIENCE

The Dental Division of Central Manchester University Hospitals NHS Foundation Trust undertakes extractions for approximately 3,500 patients over 5,000 treatment appointments per year, for single or multiple tooth extractions, with the majority of teeth being extracted under local anaesthesia and sedation at the University Dental Hospital of Manchester or Manchester Royal Infirmary. The patient will be seen by a number of different administrative, clinical and nursing staff in their journey from referral to consultation, treatment and at discharge. The oral surgery/oral and maxillofacial teams over this period has consisted of up to seven substantive and honorary consultants, up to five registrars, 12 foundation year 2 trainees, four career development trainees, up to 15 full- and the majority of extractions are carried out by an operator who has not been involved in the treatment planning for the patient.

This phenomenon of having an operator who is different to the treatment planner has previously been identified as increasing the risk of wrong tooth extraction.[1] In a paper from Israel analysing medical malpractice claims for wrong tooth extraction, most errors occurred during the extraction due to confusion and miscommunication between clinicians within and between clinics.[2]

Another paper analysing wrong tooth extractions in a hospital in Korea found the most frequent cause of wrong tooth extraction to be cognitive failure and miscommunication.[3] The authors further identified risk factors of wrong site surgery to be multiple condemned teeth, partially erupted teeth mimicking third molars, and teeth with gross decay.

number of wrong tooth extraction claims despite risk management seminars and online educational courses.

In England, under the Clinical Negligence Scheme for Trusts, the NHSLA recorded 64 claims (settled and outstanding) for wrong tooth extractions by NHS Trusts in England equating to damage costs of £219,919 and a total cost of £572,000 in the period 2007–2012.

Interestingly five of the incidents occurred between 2010 and 2011 in the operating theatre despite mandatory use of the World Health Organisation (WHO) checklist in operating theatres (personal communication).

It is clear that the sequence of events leading to patient harm are multifactorial and have been broadly classified into active failures such as human error, mistakes and violations and latent failures resulting from organisational and workplace conditions

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

Time out before you take out: best practice storyboard for chairside exodontia

1) **Before the list** - ensure list is appropriately treatment planned
   a) Before your theatre session check the clinical notes for all patients to **ensure all paper work is present and correct** including:
      I. Relevant radiographs
      II. Appropriate treatment plan
      III. Consent form correctly completed
      IV. Consent form agrees with both clinical records and treatment plan.
   b) Cross-check extraction plan against radiograph ensuring it makes clinical sense to remove the tooth treatment planned.

   c) If any confusion or concern, **discuss and clarify with another appropriate member of staff**. Following this if confusion or concern persists then postpone treatment and liaise with the referrer.

2) **Confirmation with patient (or parent) prior to entering theatre**
   All theatre WHO checklist processes should be completed in tandem from this point
   a) Use clinical notes, radiographs, consent form and referral letter if appropriate to confirm with the patient/parent the exact teeth for removal.
   b) Ask if the patient has any questions before proceeding to theatre.

3) **Pre Operatively**
   a) Ensure the most recent, appropriate radiograph is **on display**. Check it is for the correct patient, and the correct way round.
   b) Once treatment plan confirmed write out the teeth for extraction clearly onto visible display board.

   c) Ensure you and your assistant cross-reference the teeth on display board to the teeth on consent form and the treatment plan in notes.

   d) Ensure the confirmed consent form is **visible and accessible**.

4) **Peri-operatively**
   a) Once the patient is anaesthetised - count the teeth out loud from anterior to posterior to identify tooth for delivery.
   b) Confirm with your assistant that they agree this count is correct.

   c) Gently place elevators or forceps on tooth identified in step 4b above, **PAUSE AT THIS POINT** to confirm with your assistant that you are both happy that this is the correct tooth for extraction before proceeding.
   d) Proceed to extract the correct tooth.
   e) Complete the same process for each tooth being delivered.

Additional safety notes

Good practice for multi quadrant surgery is to **start posteriorly and move anteriorly** and follow the order to ensure no teeth are missed - 1. LRQ 2. URQ 3. LLQ 4. ULQ

Cases to take special precautions in:

Orthodontic extractions - always confirm against **ALL** correspondence (checking for any misfiles) that correct teeth are listed in the treatment plan and on the consent form. In addition confirm with orthodontist's clinical notes (if NDH orthodontic patient).

Cases where teeth are missing/may have drifted position - A good example are last standing molars. Always refer to these as last standing molars as opposed to trying to identify as wisdom tooth or second molar tooth.

Cases where access is difficult - visualising individual teeth may be difficult.

Produced by Potts.co.uk

E Beecroft and J Durham Sept 2014. *Adapted with thanks from King's College Dental Institute's guidance*

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

S.T.O.P. before you block

Site-check and mark
with notes, patient & colleague or supervisor

Time **O**ut
with colleague or supervisor observing

Perform

Produced by Potts.co.uk

Based on Royal College of Anaesthetists' STOP before you block campaign. J.Durha

What else can we do?

Based on both practical experience and research evidence, the main methods for mitigation of these errors are:

- **Learning from mistakes / near misses**– including investigation and root cause analysis
- **Engaging the clinical team when developing Correct Site Surgery Policies**
- **Utilising the LocSSIPs** template and guidelines from NHS England/RCS England
- **Developing a Correct Site Surgery checklist** that is appropriate for your clinical environment
- **Providing training for staff** on the use of the Checklist
- Ensuring that the Checklist is being used correctly **through active audits of the processes involved**
- **Supporting the clinical team** throughout the process and not taking punitive action when incidents do occur.

Thank you
Questions please

[PDF]LocSSIPs Toolkit Dental extraction
https://www.rcseng.ac.uk/-/media/files/rcs/fds/.../locssips-toolkit-dental-extraction.pdf?.

(LocSSIPs) for wrong site extraction in Dentistry This toolk
www.baos.org.uk/resources/LocSSIPsToolkitDentalextraction.pdf

Outline

- **Defining quality improvement**
- **Patient safety incidents**
  - Near misses
  - Never events
  - Serious events / notifiable events
- **Events leading to LocSSIPs**
- **LocSSIPs**
  - National Safety Standards for Invasive Procedures' (NatSSIPs) and
  - Local Safety Standards for Invasive Procedures (LocSSIPs)
- **How can we do better?**
  - Identify threats to patient safety by incident reporting
  - Analysing incidents to improve safety
  - Communication and education in patient safety
  - Building a safety culture

Problems how can we do better?

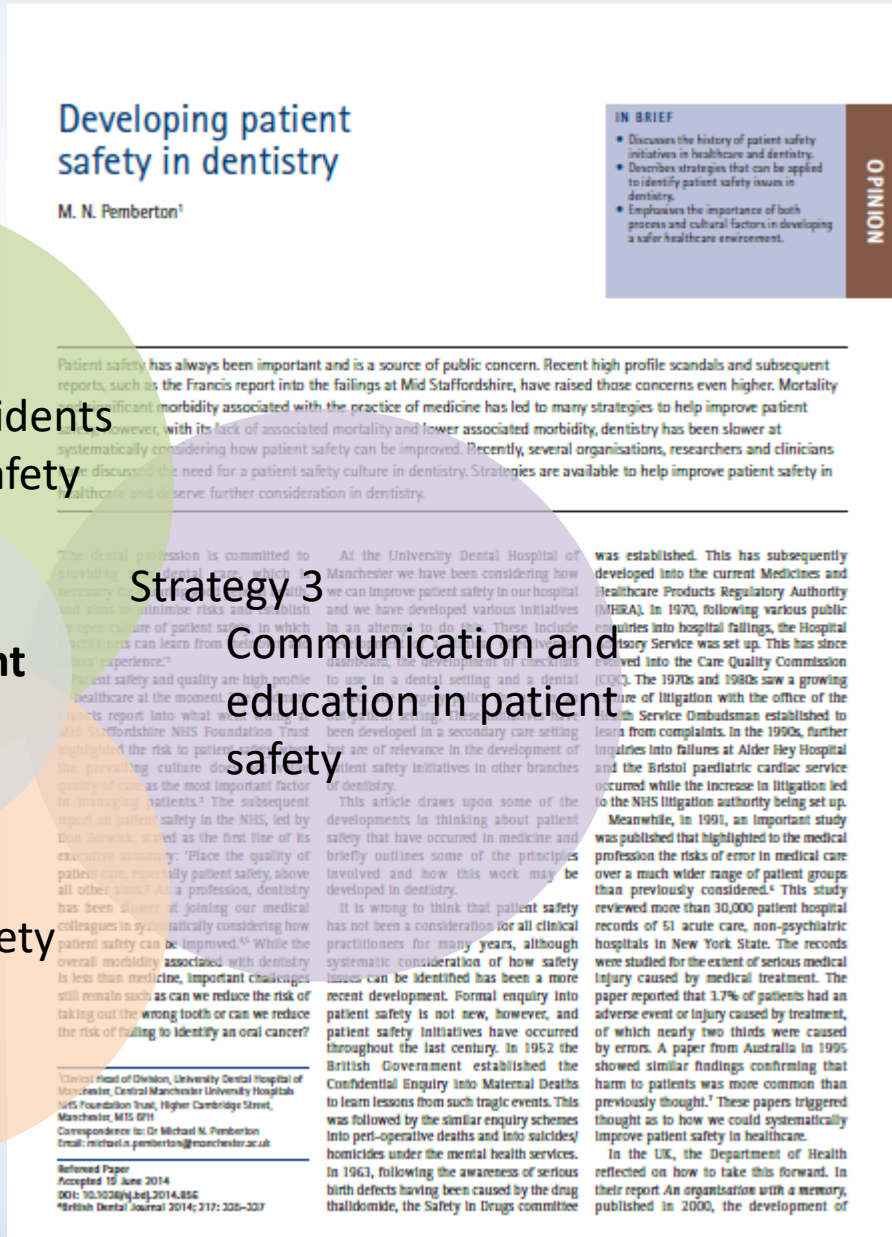
Strategy 1
Identify threats to patient safety by incident reporting

Strategy 2
Analysing incidents to improve safety

The patient

Strategy 3
Communication and education in patient safety

Strategy 4
Building a safety culture



Developing patient safety in dentistry

M. N. Pemberton[1]

IN BRIEF
- Discusses the history of patient safety initiatives in healthcare and dentistry.
- Describes strategies that can be applied to identify patient safety issues in dentistry.
- Emphasises the importance of both process and cultural factors in developing a safer healthcare environment.

OPINION

Patient safety has always been important and is a source of public concern. Recent high profile scandals and subsequent reports, such as the Francis report into the failings at Mid Staffordshire, have raised those concerns even higher. Mortality and significant morbidity associated with the practice of medicine has led to many strategies to help improve patient safety. However, with its lack of associated mortality and lower associated morbidity, dentistry has been slower at systematically considering how patient safety can be improved. Recently, several organisations, researchers and clinicians have discussed the need for a patient safety culture in dentistry. Strategies are available to help improve patient safety in healthcare and deserve further consideration in dentistry.

was established. This has subsequently developed into the current Medicines and Healthcare Products Regulatory Authority (MHRA). In 1970, following various public inquiries into hospital failings, the Hospital Advisory Service was set up. This has since evolved into the Care Quality Commission (CQC). The 1970s and 1980s saw a growing culture of litigation with the office of the Health Service Ombudsman established to learn from complaints. In the 1990s, further inquiries into failures at Alder Hey Hospital and the Bristol paediatric cardiac service occurred while the increase in litigation led to the NHS litigation authority being set up.

Meanwhile, in 1991, an important study was published that highlighted to the medical profession the risks of error in medical care over a much wider range of patient groups than previously considered.[6] This study reviewed more than 30,000 patient hospital records of 51 acute care, non-psychiatric hospitals in New York State. The records were studied for the extent of serious medical injury caused by medical treatment. The paper reported that 3.7% of patients had an adverse event or injury caused by treatment, of which nearly two thirds were caused by errors. A paper from Australia in 1995 showed similar findings confirming that harm to patients was more common than previously thought.[7] These papers triggered thought as to how we could systematically improve patient safety in healthcare.

In the UK, the Department of Health reflected on how to take this forward. In their report *An organisation with a memory*, published in 2000, the development of

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Refereed Paper
Accepted 19 June 2014
DOI: 10.1038/sj.bdj.2014.656
©British Dental Journal 2014; 217: 335–337

Unlike USA and Finland

- Patients and dentists have had no say in what criteria are set and how best to report them
- Should we use PROMS and PREMS to assess quality of care?
- Why not include Pain as AE?
- Make the reported items relevant to dentists so that they can see and engage in improved quality of care
- Simplify reporting!!
- Anonymise reporting?

Strategy 1

Identify threats to patient safety by incident reporting

British Association Oral Surgery

PROMS (quality)

How did we do? An investigation into the suitability of questionnaires (PREMS and PROMS) in three primary cai surgery practices.

Gerrard, G., Jones, R., Hierons, R. J.

Abstract

With the expansion of oral surgery services into the primary care sector there is a need t the quality of the care provided. The Guide for Commissioning Oral Surgery and Oral proposed a set of questions to be used as Patient Related Experience and Outcome (PREMS and PROMS). The British Association of Oral Surgeons (BAOS) primary care gro includes the authors) were tasked by the Chief Dental Officer for England to test the su these PREMS and PROMS. This investigation sought to determine the fitness of these que use in primary care oral surgery practices. The authors then proposed and implemented an series of questions that they felt would be more practical as generic templates for or services.

Introduction

Primary care oral surgery services (PCOS) expanded following the Medical Education Engla of Oral Surgery Services and Training in 2010. This review concluded that "there is co support for the expansion and extension of oral surgery services in the primary care support local delivery of services".[1]

This expansion in the number of providers mean that robust methods for quality assu essential to ensure optimal patient care. The Guide for Commissioning Oral Surgery Medicine[2] (published in 2015) provides a framework for commissioning these services in a and coherent way.

A section of this document is concerned with Quality and Outcome Key Assessment Are which are Patient Reported Experience Measures (PREMS) and Patient Reported Outcome (PROMS). The document recommended a standard set of PREMS and PROMS for Or practice which will be used as part of a broad range of performance metrics for quality and contract management. Whilst PREMS focus on the humanity of care, such as invol decision making and being treated with kindness and compassion, PROMS seek to functional status, health related quality of life and patients' views of their symptoms. I they were first used nationwide to measure outcomes of mastectomy and breast reconstr have since been introduced for many elective surgical procedures including hip replacements, groin hernia repair and varicose vein surgery[3]. The use of these measures t the performance of different providers has been controversial, given potential bias from format, case-mix, late or non-responders, socio-economic deprivation and ethnicity[4,5].

The British Association of Oral Surgeons (BAOS) was tasked by the Chief Dental Officer for I look at these generic PREMS and PROMS with a view to ascertaining their fitness for purpose. The BAOS primary care group (which includes the authors) planned to evaluate these in three different Primary Care practices. A second trial was then carried out with a set of amended PREMS and

Figure 3: Round 1 PROMS questions

Question	Response	Details
Did you need to seek advice or assistance hours/ days after the procedure?	Yes/No/Unsure	List for data recorder (not shared with the patient unless clarification or prompts needed) Interested in: • Uncontrolled bleeding (%) • Inadequate pain relief that needed further medication (e.g. dry socket? Typically 5% of cases) • Infection that needed further treatment (%) • Damage to other teeth/fillings (%) • Nerve injury altered sensation (Typically 1% of cases) fifth or trigeminal • TMD
Have you had to have additional surgery subsequent to this treatment?	Yes/No/Unsure	If yes, what is the problem? • Fractured jaw • Unintentional root retention • Bone infection • Nerve injury – A) Lingual B) ID nerve (lip) C) Mental nerve (chin) D) Other (facial nerve palsy)
Time taken to achieve restoration of normal activities or appearance	Yes/No/Unsure	Days Weeks Months
Did you find these questions easy to understand?	Yes/No/Unsure	
For the person recording the answers, any other comments made by the patient please record here.	----------	

Consult patients and clinicians to improve buy in and improve quality of care
Should we Include Pain as adverse event?

- US
- Finland
- Ask clinicians and patients they will say YES!

Pain: When poorly managed, is the most common cause for complaints and litigation

Kalenderian E et al have demonstrated that poorly managed perioperative pain is the leading adverse event in routine US dental care. **Patients are most frightened of poorly managed pain and injections**

In **Finland a national overview assessing patient complaints about their dental care also report that poorly managed pain was the leading adverse event.**

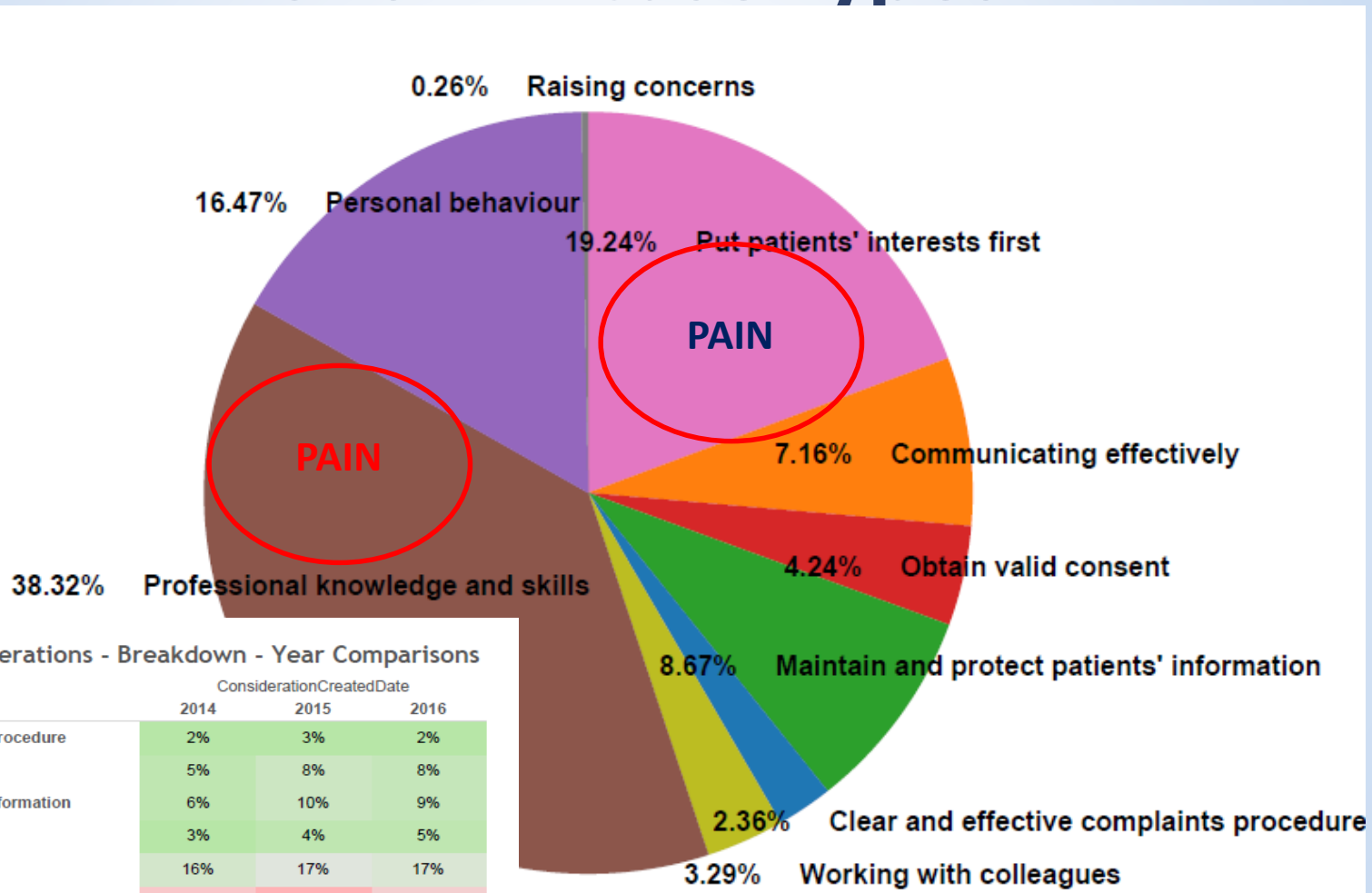
This makes sense, if a patient has an unpleasant experience at the dentist, with either unexpected pain or severe pain during a dental procedure, this may set the basis for the patients to question the quality of other aspects of their care. Thus, patient expectations must be managed, not just in the short term for post-surgical inflammatory pain, but in the context of chronic neuropathic pain if there is risk of nerve injury.

Pixabay royalty free images

KING'S College LONDON

Kalenderian E, Obadan-Udoh E, Maramaldi P, Etolue J, Yansane A, Stewart D, White J, Vaderhobli R, Kent K, Hebballi NB, Delattre V, Kahn M, Tokede O, Ramoni RB, Walji MF Classifying Adverse Events in the Dental Office.J Patient Saf. 2017 Jun 30. doi: 10.1097/PTS.0000000000000407. [Epub ahead of print] Maramaldi P, Walji MF, White J, Etolue J, Kahn M, Vaderhobli R, Kwatra J, Delattre VF, Hebballi NB, Stewart D, Kent K, Yansane A, Ramoni RB, **Kalenderian E**. How dental team members describe adverse events. J Am Dent Assoc. 2016 Oct;147(10):803-11. doi: 10.1016/j.adaj.2016.04.015. Epub 2016 Jun 3 **Hiivala N**, Mussalo-Rauhamaa H, Tefke HL, Murtomaa H. An analysis of dental patient safety incidents in a patient complaint and healthcare supervisory database in Finland. Acta Odontol Scand. 2016;74(2):81-9. doi: 10.3109/00016357.2015.1042040. Epub 2015 May 13. **Hiivala N**, Mussalo-Rauhamaa H, Murtomaa H. Can patients detect hazardous dental practice? A patient complaint study. Int J Health Care Qual Assur. 2015;28(3):274-87.

2016 FtP case types



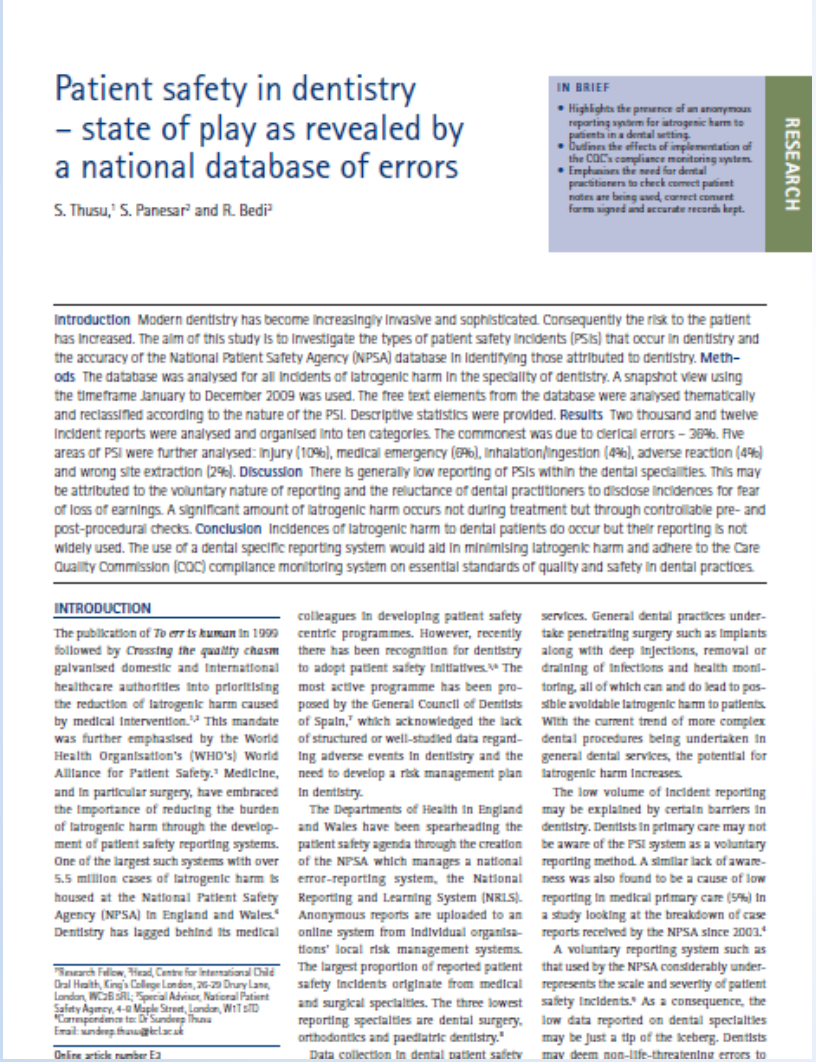
New Standards Considerations - Breakdown - Year Comparisons

Consideration Group	ConsiderationCreatedDate 2014	2015	2016
Clear and effective complaints procedure	2%	3%	2%
Communicating effectively	5%	8%	8%
Maintain and protect patients' information	6%	10%	9%
Obtain valid consent	3%	4%	5%
Personal behaviour	16%	17%	17%
Professional knowledge and skills	43%	38%	34%
Put patients' interests first	21%	18%	20%
Raising concerns	0%	0%	0%
Working with colleagues	3%	3%	4%

- We cannot analyse and learn from what is not reported!

Strategy 2
Analysing incidents to improve safety

Under reporting AEs in dentistry



Patient safety in dentistry – state of play as revealed by a national database of errors

S. Thusu,[1] S. Panesar[2] and R. Bedi[3]

IN BRIEF

- Highlights the presence of an anonymous reporting system for iatrogenic harm to patients in a dental setting.
- Outlines the effects of implementation of the CQC's compliance monitoring system.
- Emphasises the need for dental practitioners to check correct patient notes are being used, correct consent forms signed and accurate records kept.

RESEARCH

Introduction Modern dentistry has become increasingly invasive and sophisticated. Consequently the risk to the patient has increased. The aim of this study is to investigate the types of patient safety incidents (PSIs) that occur in dentistry and the accuracy of the National Patient Safety Agency (NPSA) database in identifying those attributed to dentistry. **Methods** The database was analysed for all incidents of iatrogenic harm in the speciality of dentistry. A snapshot view using the timeframe January to December 2009 was used. The free text elements from the database were analysed thematically and reclassified according to the nature of the PSI. Descriptive statistics were provided. **Results** Two thousand and twelve incident reports were analysed and organised into ten categories. The commonest was due to clerical errors – 36%. Five areas of PSI were further analysed: injury (10%), medical emergency (6%), inhalation/ingestion (4%), adverse reaction (4%) and wrong site extraction (2%). **Discussion** There is generally low reporting of PSIs within the dental specialities. This may be attributed to the voluntary nature of reporting and the reluctance of dental practitioners to disclose incidences for fear of loss of earnings. A significant amount of iatrogenic harm occurs not during treatment but through controllable pre- and post-procedural checks. **Conclusion** Incidences of iatrogenic harm to dental patients do occur but their reporting is not widely used. The use of a dental specific reporting system would aid in minimising iatrogenic harm and adhere to the Care Quality Commission (CQC) compliance monitoring system on essential standards of quality and safety in dental practices.

INTRODUCTION

The publication of *To err is human* in 1999 followed by *Crossing the quality chasm* galvanised domestic and international healthcare authorities into prioritising the reduction of iatrogenic harm caused by medical intervention.[1,2] This mandate was further emphasised by the World Health Organisation's (WHO's) World Alliance for Patient Safety.[3] Medicine, and in particular surgery, have embraced the importance of reducing the burden of iatrogenic harm through the development of patient safety reporting systems. One of the largest such systems with over 5.5 million cases of iatrogenic harm is housed at the National Patient Safety Agency (NPSA) in England and Wales.[4] Dentistry has lagged behind its medical colleagues in developing patient safety centric programmes. However, recently there has been recognition for dentistry to adopt patient safety initiatives.[5,6] The most active programme has been proposed by the General Council of Dentists of Spain,[7] which acknowledged the lack of structured or well-studied data regarding adverse events in dentistry and the need to develop a risk management plan in dentistry.

The Departments of Health in England and Wales have been spearheading the patient safety agenda through the creation of the NPSA which manages a national error-reporting system, the National Reporting and Learning System (NRLS). Anonymous reports are uploaded to an online system from individual organisations' local risk management systems. The largest proportion of reported patient safety incidents originate from medical and surgical specialities. The three lowest reporting specialities are dental surgery, orthodontics and paediatric dentistry.[8]

Data collection in dental patient safety services. General dental practices undertake penetrating surgery such as implants along with deep injections, removal or draining of infections and health monitoring, all of which can and do lead to possible avoidable iatrogenic harm to patients. With the current trend of more complex dental procedures being undertaken in general dental services, the potential for iatrogenic harm increases.

The low volume of incident reporting may be explained by certain barriers in dentistry. Dentists in primary care may not be aware of the PSI system as a voluntary reporting method. A similar lack of awareness was also found to be a cause of low reporting in medical primary care (5%) in a study looking at the breakdown of case reports received by the NPSA since 2003.[4]

A voluntary reporting system such as that used by the NPSA considerably underrepresents the scale and severity of patient safety incidents.[9] As a consequence, the low data reported on dental specialties may be just a tip of the iceberg. Dentists may deem non-life-threatening errors to

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Online article number E3

Thusu S, Panesar S, Bedi R. Patient safety in dentistry - state of play as revealed by a national database of errors. Br Dent J. 2012 Aug;213(3):E3. doi: 10.1038/sj.bdj.2012.669.

Between January 2005 and June 2006, 59,802 medication incidents were reported to the NRLS. Just over 80 per cent of the medication incidents reported to the NRLS occurred in a hospital, although most prescribing and dispensing happens in the community. Reporting among trusts is variable and just under one-third of trusts (mainly primary care organisations) reported no medication incidents at all over six months. All trusts could report more incidents.

Under reporting AEs in primary dental care

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Original Articles

Patient safety in dental care: A challenging quality issue? An exploratory cohort study

November 2013, Vol. 71, No. 6 , Pages 1588-1593 (doi:10.3109/00016357.2013.777471)

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Abstract

Objective. Little is known about patient safety in primary oral healthcare. The aim of this study was to describe and analyze patient safety incidents in primary oral health care. ***Materials and methods.*** A random sample of 1000 patient records from 20 dental practices was reviewed retrospectively over 60 months. All adverse events (AEs) were noted: unintended events happening during treatment that resulted or could have resulted in harm to the patient. ***Results.*** A total of 46 (95% CI = 33–59) AEs was identified, of which 18 (95% CI = 10–26) were considered preventable. From these, 15 related to treatment, 10 to diagnostics and one to communication. ***Conclusions.*** The low incidence of AEs and absence of major harm to patients suggests that primary oral care is safe for patients. However, the low quality of record keeping may imply underestimation.

http://informahealthcare.com/doi/abs/10.3109/00016357.2013.777471

Review 10 years

National reporting and learning system (NRLS) and Strategic Executive Information System (StEIS) databases

Renton T
Sabbah W BDJ 2016

Review of never and serious events related to dentistry 2005–2014

T. Renton[1] and W. Sabbah*[2]

In brief

Identifies where, when and why patient safety is compromised.	Identifies limitations of the reporting system of iatrogenic incidents.	Provides recommendations to avoid limitations of incident reporting system.	Provides recommendations to avoid patients compromising incidents.

Aims To review never and serious events related to dentistry between 2005-2014 in England. **Methods** Data from the National Reporting and Learning System (NRLS), with agreed data protection and intelligence governance, was used – snapshot view using the timeframe January 2005 to May 2014. The Strategic Executive Information System (STEIS) database was reported separately for 2012–2013 and 2013–2014. The free text elements from the database were analysed thematically and reclassified according to the nature of the patient safety incident (PSI). **Results** From the NRLS dataset, 32,263 patient safety events were reported between 1 January 2005 and 30 May 2014. Never events (NEs) from STEIS files were all wrong site extractions (WSS), reported separately for 2012-2013 and 2013-2014. The total number was 43.36 of the 43 PSIs were WSS involving: multiple extractions and bimodal age distribution (very young or over 60 years). Forty-seven percent of never events resulted in no harm, 20% low harm, 7% moderate harm, less than 1% severe harm and 23 deaths over this period (five of which were not related to dentistry). Serious harm and death risk factors included: care in an acute trust ward, peri oncological, reconstructive surgery (OMFS), patient age over 67 years with concurrent medical complexity (ischaemic heart disease). Sixty percent of PSIs occurred in OS/OMFS in acute trust inpatients and 20% in primary care. From STEIS 2012-2013, 21 WSS were reported of which 50% occurred in oral surgery (OS) or oral and maxillofacial surgery (OMFS). The reported sites were 45% in operating theatre and 42% in dental surgery. **Conclusion** Incidences of iatrogenic harm to dental patients do occur but their reporting is not widely carried out. Improved awareness and training, simplifying the reporting systems improved non-punitive support by regulators would allow the improvement of patient safety in dental practice.

Introduction

Preventable patient safety events (PSIs) can and do occur, sometimes with severe consequences for patients and to the distress of the health-care professionals involved.[1] For example, the perception of error, stress and teamwork in the healthcare field is rather worrying in that 79% of surgeons and 49% of anaesthetists do not seem to have the perception of fatigue while working.[2] Other studies also showed (perhaps without surprise) that 50% of medical staff find it difficult to discuss mistakes and 33% do not even think that they are capable of making mistakes.[3]

In order to try to identify where, when and why patient safety is compromised and to learn from these events, two major NHS safety databases were established ten years ago to which practitioners and managers report patient safety incidents (PSIs). Some of which are never events listed on the STEIS database, which records never events irrespective of the degree of harm caused to the patients (many have no harm related to the event but fulfil the criteria for never events). The second database is the NRLS which records all reported incident for (DATIX or other systems) recording adverse events. Some of these may be never events but most are not. The level of harm (none, low, moderate, severe and death) are recorded alongside these events with related data including speciality, site, hospital trust and free text. Uptake of reporting and learning from near misses and never events has been encouraged within NHS trusts by use of mandatory training, mandatory use of checklists and financial incentives for evidence for improving patient safety.

The concept of a near miss is taken from a corporate model – Heinrichs 'Safety Triangle', which places near-miss events at the base of the triangle, accidents in the middle and finally fatalities at the top, with the assumption that by eliminating near-miss events, accidents and fatalities will eventually disappear. James Reason developed the 'Swiss Cheese' model of system failure in business whereby holes in the cheese slices line up to allow significant system failure to

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DOI: 10.1038/sj.bdj.2016.526
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Summary

- Gross under reporting- Incidences of iatrogenic harm to dental patients do occur but their reporting is not widely used.
  - Only 19 trusts (155 acute trusts (including 100 foundation trusts)
  - 8 community dental bodies (78 in UK)
  - 10300 dental practices (3 reports)
  - No IG Aes
  - Only 3 NSIs
- Incorrect reporting- Several data errors were identified
- The analysis confirms that there is a limited capacity to learn from the data set as many relevant points both generic and specialty specific are missing

Care Quality Commission CQC clearly state

- An offence not to notify
- An offence not to notify in the way prescribed
- Defence ‘took all reasonable steps and exercised all due diligence’
- Fine of up to £2500

Reporting

- Notifiable event notification must be made by all services registered under the Health and Social Care Act (HSCA).
- This includes all **NHS Trusts, independent healthcare, adult social care, primary dental care and independent ambulance providers.**
- The way in which notifications are made will depend on their nature and the type of service. The process differs slightly for NHS Trusts than for other providers
- For NHS Trusts, the requirement to report incidents is typically met by reporting incidents to the **National Reporting and Learning System (NRLS)** and to **StEIS** the Strategic Executive Information System captures all Serious Incidents.
- Please refer to the CQC's notification guidance which outlines how each type of notification needs to be made: http://www.cqc.org.uk/content/notifications

  http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/serious-incident-reporting-and-learning-framework-sirl/

  How to report Serious events

  https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/01/how-to-guide-ss-at-incident-reporting.pdf

So why is reporting of PSIs so complex in dentistry?

It needs simplification!

Author query: Please provide a working link for references 6 and 15. We are unable to find these documents online. The original links seem to lead to an error page.
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Please clarify refs 20 and 24 - the links are not accessible to readers and for ref 20 it is unclear from the description what the document is referring to.
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The complexity of patient safety reporting systems in UK dentistry

T. Renton*[1] and S. Master[2]

In brief

Provides an update on existing systems and procedures in relation to patient safety in dentistry in the UK.	Highlights the existence of conflicting advice which further complicates an overly burdensome process.	Suggests solutions to address the problems surrounding patient safety development in dentistry.

Since the *'Francis Report'*, UK regulation focusing on patient safety has significantly changed. Healthcare workers are increasingly involved in NHS England patient safety initiatives aimed at improving reporting and learning from patient safety incidents (PSIs). Unfortunately, dentistry remains 'isolated' from these main events and continues to have a poor record for reporting and learning from PSIs and other events, thus limiting improvement of patient safety in dentistry. The reasons for this situation are complex. This paper provides a review of the complexities of the existing systems and procedures in relation to patient safety in dentistry. It highlights the conflicting advice which is available and which further complicates an overly burdensome process. Recommendations are made to address these problems with systems and procedures supporting patient safety development in dentistry.

Introduction

Patients expect to be treated safely when seeking healthcare. 'Safe' means that patients are protected from abuse and avoidable harm. A patient safety incident (PSI) is defined as any unintended event caused by healthcare that either resulted in, or could have led to patient harm. PSIs have been shown to cause harm in 3% to 17% of hospital inpatients.[1,2]

When patient harm occurs in relation to healthcare it can be devastating, not just for the patient and their extended family and social network, but also for the treating clinician and their team. The CQC estimates that there are approximately 11,000 incidents of severe harm and up to 100,000 incidents of serious harm occurring each year within the NHS. Indeed, preventable adverse events could be costing 'approximately £1 billion' per year.[3]

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©British Dental Journal 2016; 221: xxx-xxx

We now recognise that by embracing a systems approach and a supported open culture, prevention of future adverse events is possible, as already demonstrated within the aviation industry.

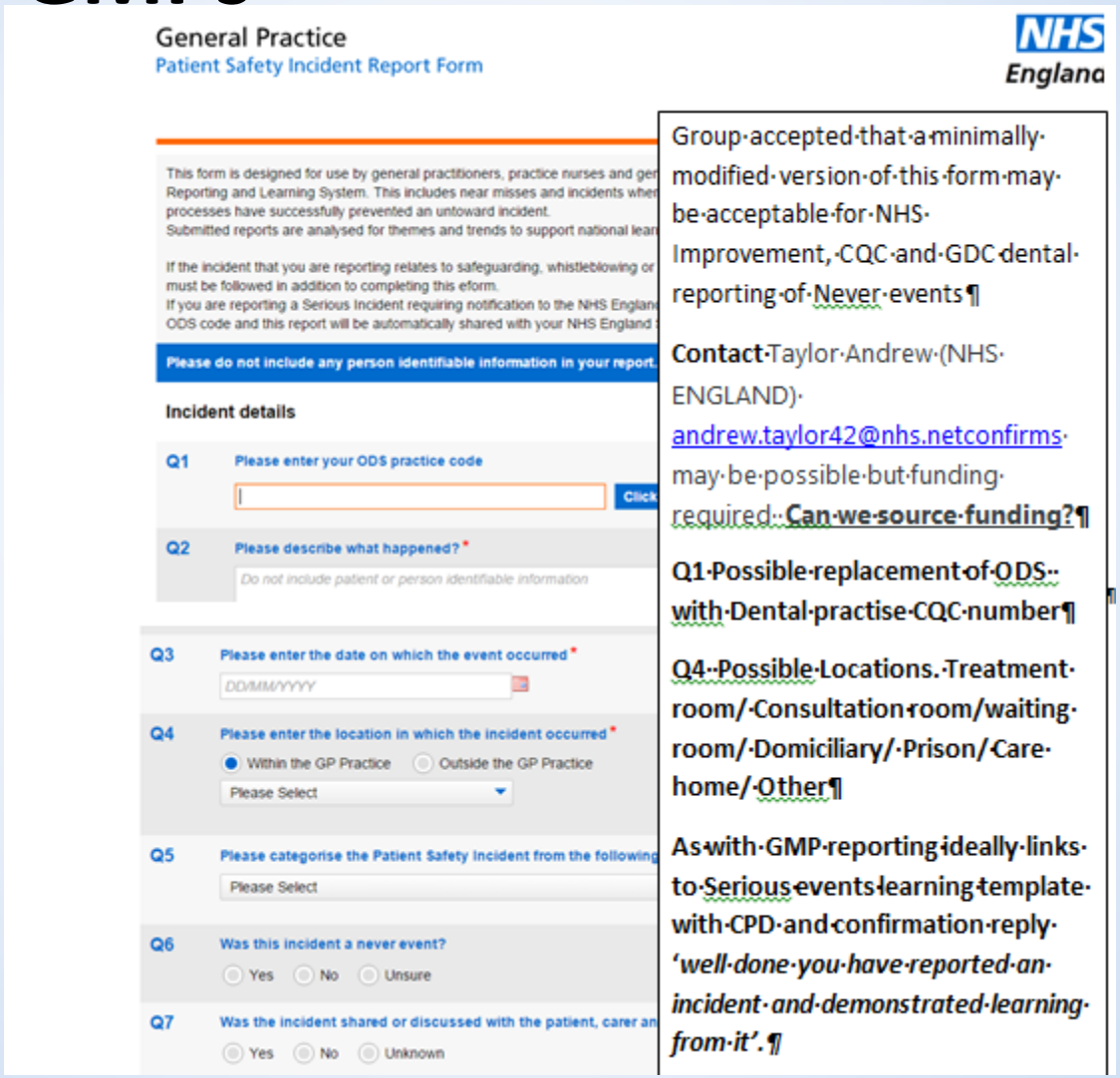
Significant changes in healthcare regulation in the UK have taken place over the last 10 years. While some have arisen due to the changes in political leadership, many regulatory changes have been in response to alarming adverse events within NHS patient care. The most recent response to the events in the Mid Staffordshire NHS Trust, the *'Francis Report'* (2012),[4] recommended significant changes in amending our culture (whistleblowing without consequences) in recognising potential weaknesses in our healthcare systems, and has resulted in the implementation of improved regulation and new systems to ensure patient safety is prioritised.

In the Government's initial response to the Francis Inquiry, published in March 2013, we accepted the need to introduce a statutory 'duty of candour' for health and care providers. This contractual duty of candour was imposed on all NHS and non-NHS providers of services to NHS patients in the UK to 'provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurs. A 'reportable patient safety incident' is one which could have or did result in moderate or severe harm or death. The Francis Inquiry also noted that observance of the duty should be policed by the Care Quality Commission (CQC).[5-7]

The Report[4] made a number of recommendations about the duty of candour that can be summarised as follows:

- Healthcare providers should be under a statutory duty of candour:
  - To inform the patient, or other duly authorised person
  - To inform their employer as soon as practicable, when they believe or suspect that treatment or care it provided has caused death or serious injury to that patient, and thereafter, provide such information and explanation as the patient reasonably may request
- It should be a criminal offence for any registered medical practitioner, or nurse or allied health professional or director of an authorised or registered healthcare organisation to knowingly obstruct another in the performance of these statutory duties,

Simplified single anonymised reporting system for GMPs



Group·accepted·that·a·minimally·modified·version·of·this·form·may·be·acceptable·for·NHS·Improvement,·CQC·and·GDC·dental·reporting·of·Never·events¶

Contact·Taylor·Andrew·(NHS·ENGLAND)·andrew.taylor42@nhs.netconfirms·may·be·possible·but·funding·required··**Can·we·source·funding?**¶

Q1·Possible·replacement·of·ODS··with·Dental·practise·CQC·number¶

Q4··Possible·Locations.·Treatment·room/·Consultation·room/waiting·room/·Domiciliary/·Prison/·Care·home/·Other¶

As·with·GMP·reporting·ideally·links·to·Serious·events·learning·template·with·CPD·and·confirmation·reply·*'well·done·you·have·reported·an·incident·and·demonstrated·learning·from·it'*.¶

Reassessment of learning -Audit

TITLE	**Improving patient safety in a UK dental hospital: long-term use of clinical audit**
AUTHOR(S)	Ashley, M. P.; Pemberton, M. N.; Saksena, A.; Shaw, A.; Dickson, S.
PUB. DATE	October 2014
SOURCE	British Dental Journal;10/10/2014, Vol. 217 Issue 7, p369
SOURCE TYPE	Academic Journal
DOC. TYPE	Article
ABSTRACT	The improvement of patient safety has been a long-term aim of healthcare organisations and following recent negative events within the UK, the focus on safety has rightly increased. For over twenty years, clinical audit has been the tool most frequently used to measure safety-related aspects of healthcare and when done so correctly, can lead to sustained improvements. This paper explains how clinical audit is used as a safety improvement tool in an English dental hospital and gives several examples of projects that have resulted in long-term improvements in secondary dental care.
ACCESSION #	98774702

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Strategy 3

Communication and education in patient safety

- Mandatory training now includes
- LocSSIPs and human factors

Strategy 4

Building a safety culture

- We need to establish and embed daily awareness of potential patient safety improvement into daily practise
- Mandatory training
- Make more relevant to dentistry
- No more regulation!

Training needs in dentistry

Dent Update. 2015 Apr;42(3):206-9.

The Francis Report--Why it Matters to the Dental Team.

Bagg J, Welbury R.

Abstract

The Francis Report into the deaths at Mid-Staffordshire NHS Trust highlighted the problems facing the NHS when patients, families, clinicians and nurses are not heard, and where the management, leadership and ensuing culture are focused on the system's business, not patient care. This paper, the first in a series based on the implications of the Francis Report, provides the background and context for the subsequent 'perspective' articles from a range of relevant stakeholders and care-providers. The overriding message is that in all areas of healthcare, dentistry included, the quality of patient care, especially patient safety, must be placed above all other aims. Clinical Relevance: The overriding importance of patient-centredness and quality of care, above all other aims, is the key message of clinical relevance from the Francis Report.

Dent Update. 2015 Apr;42(3):215-8.

The Francis Report--Implications for the Education and Training of Dental Professionals.

Bissell V, Felix DH.

Abstract

This paper explores the implications of the Francis Report for education of the dental team. It considers selection of candidates for training, issues relating to the curriculum itself, including assessment and the importance of listening to trainees. The overriding importance of the 'informal' or 'hidden' curriculum, through which students and trainees observe their teachers and develop a sense of the professional and ethical culture within an educational institution, is stressed. Clinical relevance: **Sound education, rooted in the recognized ethical principles highlighted in the Francis Report, is essential to the delivery of a dental work force that will deliver care according to the fundamental standards laid down by the GDC.**

Cochrane Database Syst Rev. 2012 Sep 12;9:CD009404. doi: 10.1002/14651858.CD009404.pub2.

Interventions for reducing wrong-site surgery and invasive procedures.

Mahar P[1], Wasiak J, Batty L, Fowler S, Cleland H, Gruen RL.

⊕ Author information

Update in

Interventions for reducing wrong-site surgery and invasive clinical procedures. [Cochrane Database Syst Rev. 2015]

Abstract

BACKGROUND: Specific clinical interventions are needed to reduce wrong-site surgery, which is a rare but potentially disastrous clinical error. Risk factors contributing to wrong-site surgery are variable and complex. The introduction of organisational and professional clinical strategies may have a role in minimising wrong-site surgery.

OBJECTIVES: To evaluate the effectiveness of organisational and professional interventions for reducing wrong-site surgery (including wrong-site, wrong-side, wrong-procedure and wrong-patient surgery), including non-surgical invasive procedures such as regional blocks, dermatological, obstetric and dental procedures and emergency surgical procedures not undertaken within the operating theatre.

SEARCH METHODS: We searched the following electronic databases: the Cochrane Effective Practice and Organisation of Care (EPOC) Group Specialised Register (June 2011), the Cochrane Central Register of Controlled Trials (The Cochrane Library 2011, Issue 6), MEDLINE (1948-June 2011), EMBASE (1947-June 2011), CINAHL (1980-June 2011), Dissertations and Theses (1861-June 2011), African Index Medicus, Latin American and Caribbean Health Sciences database, Virtual Health Library, Pan American Health Organization Database and the World Health Organization Library Information System. A grey literature search was conducted. Database searches were conducted June 2011.

SELECTION CRITERIA: We included randomised controlled trials (RCTs), non-randomised controlled trials, controlled before-after studies (CBAs) with at least two intervention and control sites, and interrupted-time-series (ITS) studies where the intervention time was clearly defined and there were at least three data points before and three after the intervention. Studies evaluated the effectiveness of organisational and professional interventions for reducing wrong-site surgery, including wrong site, wrong side and wrong procedure. Participants included all healthcare professionals providing care to surgical patients; studies where patients were involved to avoid the incorrect procedures or studies with interventions addressed to healthcare managers, administrators, stakeholders or health insurers.

DATA COLLECTION AND ANALYSIS: Two review authors independently assessed the quality and abstracted data of all eligible studies using a standardised data extraction form, modified from the Cochrane EPOC checklists. We contacted study authors for additional information.

MAIN RESULTS: We included one study in this review. One ITS study evaluated a targeted educational intervention aiming at reducing the incidence of wrong-site tooth extractions. The intervention included examination of previous cases of wrong-site tooth extractions, educational

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The findings of this review identified one ITS study for a non-medical procedure conducted in a dental outpatient setting**. <u>The study suggested that the use of a specific educational intervention, in the above-mentioned context, which targets junior dental staff using a training session that included cases of wrong-site surgery, presentation of clinical guidelines and feedback by the instructor, was associated with a reduction in the incidence of wrong-site tooth extractions.</u>** Given the nature of the intervention in a very specific population, application of these results to a broader population undergoing other forms of surgery or invasive procedures should be undertaken cautiousl

Development of necessary mandatory training

- HEE involved in LocSSIPs agree further development is required

- Joint conversations with GDC, CQC, NHS England and NHS improvement (patient safety)

Fundamental key steps to improving patient safety in dentistry

- What are the patient safety issues in your particular area?
  - Level of harm
  - What regulation?
  - What language?
    - Adverse events?
    - Patient safety incidents?
    - Notifiable events?
    - Near misses?
- Identification
  - Education of healthcare work force and patients
  - Criteria for events and related regulation
- Reporting
  - Reporting systems
  - Mandatory / elective reporting
  - Open disclosure / Duty of candour
- Prevention -by shared learning and regulation
  - Healthcare regulation
  - Guidelines
  - Rolling annual audit- Learn from events and prevent them in the future
  - Dissemination

- Embed daily awareness of potential patient safety improvement into daily practise
- Use PROMS and PREMS to assess quality of care?
- Include Pain as AE?
- Anonymous and simplified reporting system for dentistry
- Shared open learning culture in local practice to national practise

Freemantle N, Richardson M, Wood J, et al. Weekend hospitalization and additional risk of death: An analysis of inpatient data. Journal of the Royal Society of Medicine. Published online on February 2 2012
Haugen AS[1], Murugesh S, Haaverstad R, Eide GE, Søfteland E A survey of surgical team members' perceptions of near misses and attitudes towards Time Out protocols. BMC Surg. 2013 Oct 9;13:46. doi: 10.1186/1471-2482-13-46.
Penson RT[1], Svendsen SS, Chabner BA, Lynch TJ Jr, Levinson W. Medical mistakes: a workshop on personal perspectives. Oncologist. 2001;6(1):92-9.
Gallivan S[1], Taxis K, Dean Franklin B, Barber N. Is the principle of a stable Heinrich ratio a myth? A multimethod analysis. Drug Saf. 2008;31(8):637-42.
Prof Don Berwick, who led a system-wide review of safety in the NHS (2012)[3]
http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals
Lord Darzi report. 2008 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf
Serious Incident Framework (http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf March 2013
2012/13 NRLS event review http://www.nrls.npsa.nhs.uk/resources/type/data-reports/
Serious Incident Reporting Framework http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/
The Foundation Trust network response to the Never events framework consultation 2014 *"Standardise, educate, harmonise: Commissioning the conditions for safer surgery" (Feb 2014)*
NPSA Incident Decision Tree http://www.suspension-nhs.org/Resources/Safety%20-%20IDT%20%28info%20and%20advice%20on%20use%29.pdf
Thusu S, Panesar S, Bedi R. Patient safety in dentistry - state of play as revealed by a national database of errors. Br Dent J. 2012 Aug;213(3):E3. doi 10.1038/sj.bdj.2012.669.
Rattan R, Tiernan J. Risk management in general. Dental Practice. London: Quintessence, 2004.
Hiivala, Mussalo-Rauhamaa H, Murtmaa H. Patient safety incidents reported by Finnish dentists; results from an internet-based survey. Acta Odontol Scand 2013;71:1370-1377
Perea-Perez B, Santiago-Saez A, Garcia-Marin F, Labajo-Gonzalez E, Villa-Vigil A. Patient safety in dentistry:dental care risk management plan. Med Oral Patol Oral Cir Bucal 2011;e805-809.
Saksena A, Pemberton MN, Shaw A, Dickson S, Ashley MP. Preventing wrong tooth extraction: experience in development and implementation of an outpatient safety checklist. Br Dent J. 2014 Oct;217(7):357-62. doi: 10.1038/sj.bdj.2014.860. Erratum in: Br Dent J. 2014 Nov;217(10):585.
Pemberton MN, Ashley MP, Shaw A, Dickson S, Saksena A. Measuring **patient safety** in a UK dental hospital: development of a dental clinical effectiveness dashboard. Br Dent J. 2014 Oct;217(7):375-8. doi: 10.1038/sj.bdj.2014.859.
Ashley MP, Pemberton MN, Saksena A, Shaw A, Dickson S. Improving **patient safety** in a UK dental hospital: long-term use of clinical audit. Br Dent J. 2014 Oct;217(7):369-73. doi: 10.1038/sj.bdj.2014.861.
Bailey E, Tickle M, Campbell S. **Patient safety** in primary care **dentistry**: where are we now? Br Dent J. 2014 Oct;217(7):339-44. doi: 10.1038/sj.bdj.2014.857.
Pemberton MN. Developing **patient safety** in **dentistry**. Br Dent J. 2014 Oct;217(7):335-7. doi: 10.1038/sj.bdj.2014.856.

NHSLA recommendations for monitoring of support for staff involved in incidents ***not reaching dentistry***

- *Being open:* ***Saying sorry*** *when things go wrong* (2009)
- *Being open:* ***Supporting information*** (2009)
- ***Patient Safety Alert****. Being Open: Communicating with patients, their families and carers following a patient safety incident* (2009)
- ***Duty of Candour*** *The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm (2014).*

National Patient Safety Agency (NPSA) website provides further information and resources in relation to managing patient safety incidents: www.npsa.nhs.uk

Potential to improve PS in dentistry

- Significant under reporting PSIs (AEs, NEs)
- No standard tools for dentistry and no access to EPR
- Lack of routine Patient safety reporting mechanism (no EPR) /assessment (NPSA, GDC, CQC, MHRA)
- Lack of regulator engagement/ training
- Specific indicators for dentistry missing?
  - Delayed /referral – red flags
  - Over radiation
  - Antibiotic use
  - Alerts- no access to electronic patient records
  - Holistic medical care health screening and advice
  - Mental health
  - Liaison social care

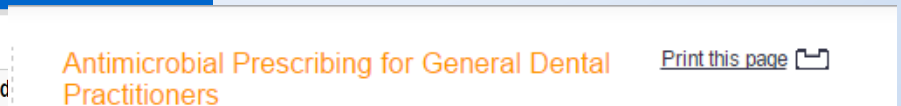
Current common events in dentistry

NEs in dentistry

- WSS
- Nerve injury
- Burnt lip
- Retained fractured instrument
- Reversal Midazolam sedation

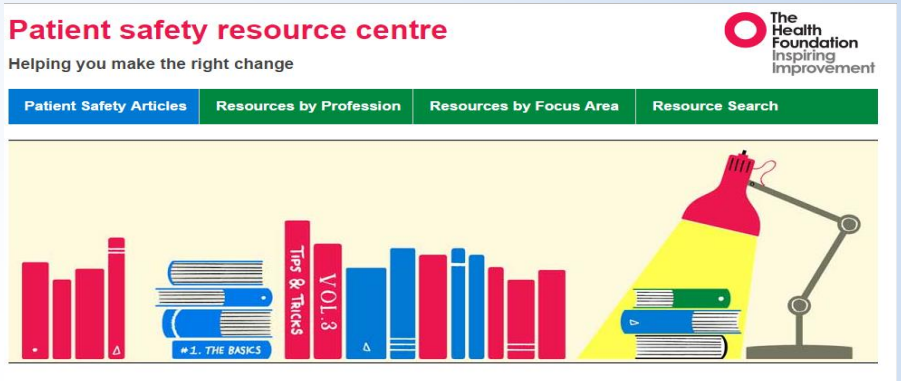
AEs in dentistry

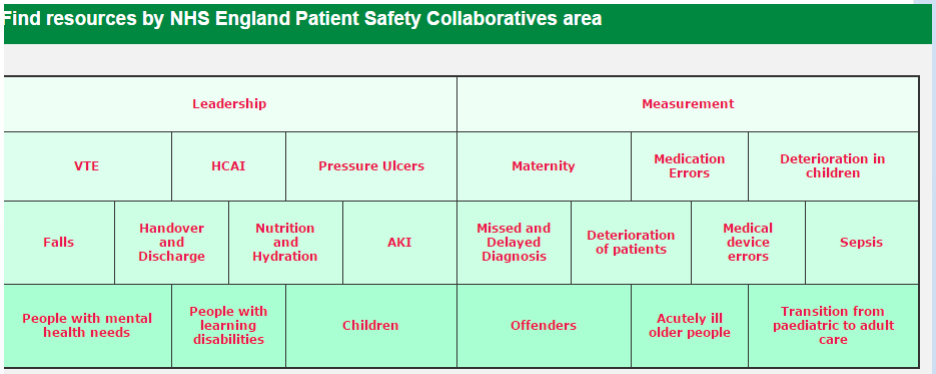
- Anaphylaxis
- Haemorrhage
- MRONJ
- Delayed diagnosis
- Death (2-3 per year)
- Tissue injury
  - Sodium hypochlorite
  - CaOH



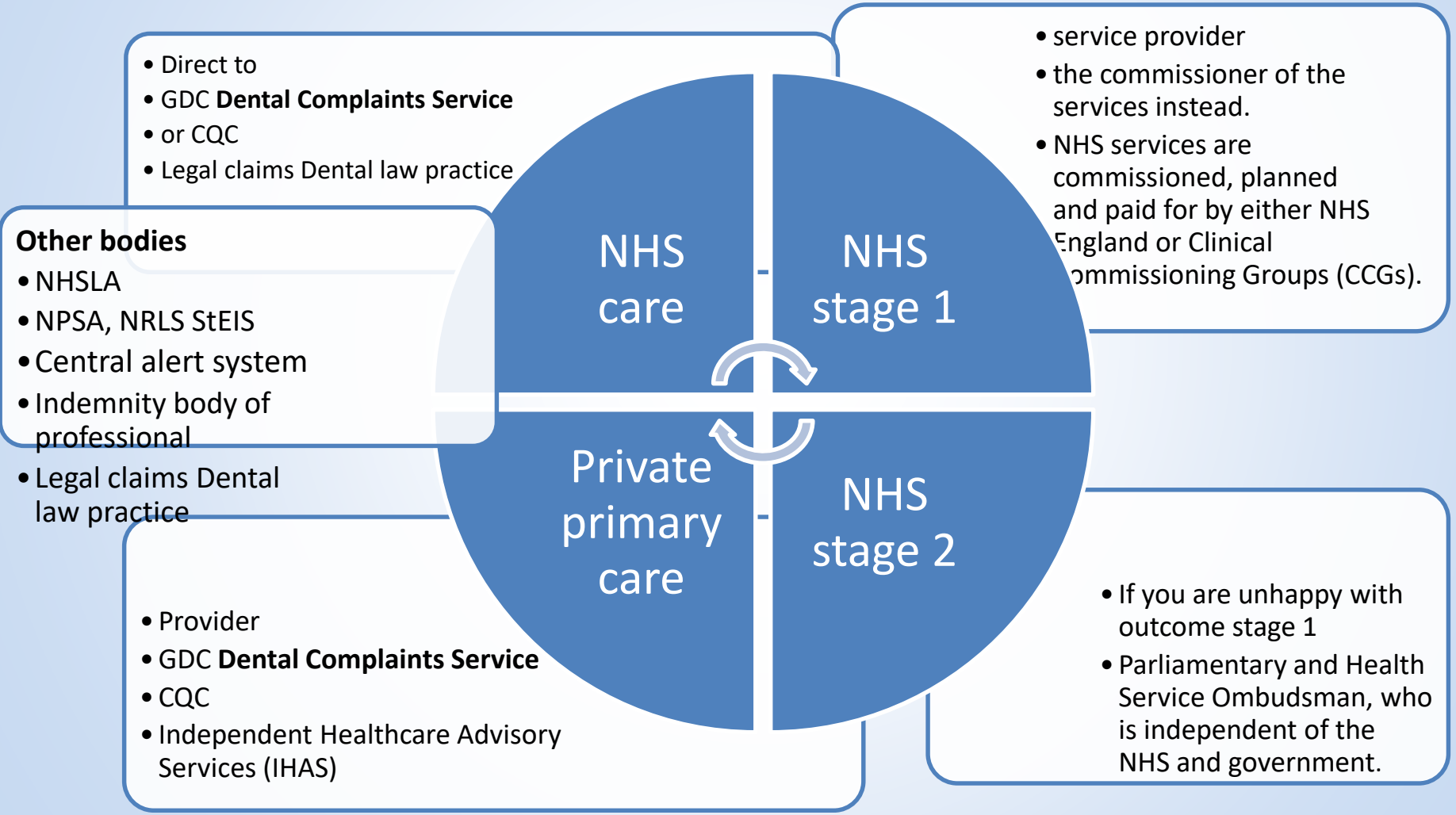
NHS Measures of patient safety

- Never events
  - NLRS
- Adverse events
  - MHRA
  - Implanted devices
  - Other
- Sentinel event rate
  - StEIS
- Complaints
  - NHS commissioning
  - Regulators (GDC and CQC)
  - Ombudsman
- Other
  - NHSLA monitoring Trusts implementing staff levels and training
  - Audit
  - Litigation
  - Patient forum http://patientsafety.health.org.uk/?gclid=CLmb9Pr-kMcCFS3MtAodH4YCtg
    - Dentistry not mentioned!





Complex & non centralised pathways for complaints, AEs and NEs occurring in dental care



Most common complaint is due to poorly managed pain

2012 NPSA transfer to Commissioning board Special Health Care authority

Dentistry commissioned by separate National board

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Keywords

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About us
Reporting incidents
Alerts and tools
Patient safety data

The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.

>> More about the NPSA

Patient Safety Incident Data

latest publication:
Patient Safety Incident Reports for Organisations in England and Wales

Public Health England

Oral Surgery Pathway and Commissioning Guide Update

BAOS Edinburgh
September 2014

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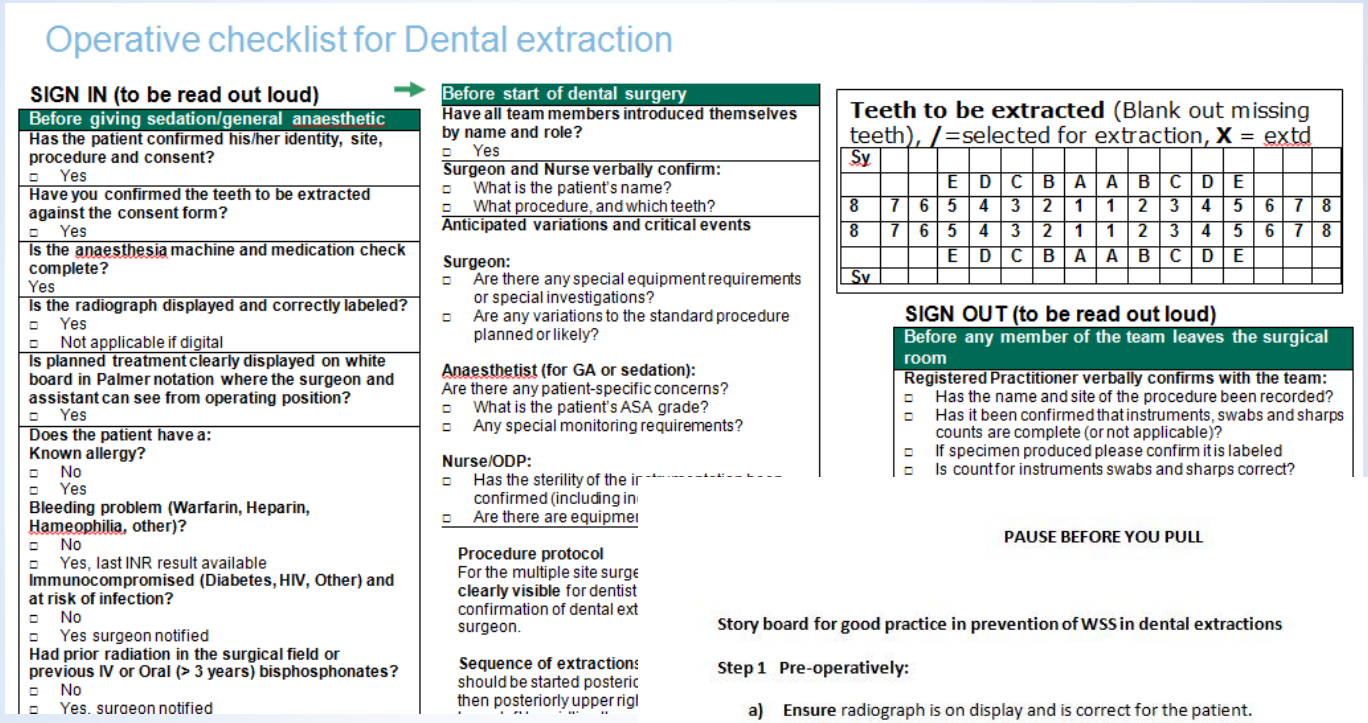
NHS England

Commissioning Guides for dental specialties - introduction

Commissioning Guide for Oral Surgery & Oral Medicine

Standard Tools -early dissemination/ shared good practice



Operative checklist for Dental extraction

SIGN IN (to be read out loud)

Before giving sedation/general anaesthetic

Has the patient confirmed his/her identity, site, procedure and consent?
- ☐ Yes

Have you confirmed the teeth to be extracted against the consent form?
- ☐ Yes

Is the anaesthesia machine and medication check complete?
Yes

Is the radiograph displayed and correctly labeled?
- ☐ Yes
- ☐ Not applicable if digital

Is planned treatment clearly displayed on white board in Palmer notation where the surgeon and assistant can see from operating position?
- ☐ Yes

Does the patient have a:
Known allergy?
- ☐ No
- ☐ Yes

Bleeding problem (Warfarin, Heparin, Hameophilia, other)?
- ☐ No
- ☐ Yes, last INR result available

Immunocompromised (Diabetes, HIV, Other) and at risk of infection?
- ☐ No
- ☐ Yes surgeon notified

Had prior radiation in the surgical field or previous IV or Oral (> 3 years) bisphosphonates?
- ☐ No
- ☐ Yes, surgeon notified

Before start of dental surgery

Have all team members introduced themselves by name and role?
- ☐ Yes

Surgeon and Nurse verbally confirm:
- ☐ What is the patient's name?
- ☐ What procedure, and which teeth?

Anticipated variations and critical events

Surgeon:
- ☐ Are there any special equipment requirements or special investigations?
- ☐ Are any variations to the standard procedure planned or likely?

Anaesthetist (for GA or sedation):
Are there any patient-specific concerns?
- ☐ What is the patient's ASA grade?
- ☐ Any special monitoring requirements?

Nurse/ODP:
- ☐ Has the sterility of the in… confirmed (including in…
- ☐ Are there are equipmer…

Procedure protocol
For the multiple site surge…
clearly visible for dentist…
confirmation of dental ext…
surgeon.

Sequence of extractions
should be started posteric…
then posteriorly upper rig…

Teeth to be extracted (Blank out missing teeth), **/**=selected for extraction, **X** = extd

Sy															
			E	D	C	B	A	A	B	C	D	E			
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
			E	D	C	B	A	A	B	C	D	E			
Sy															

SIGN OUT (to be read out loud)

Before any member of the team leaves the surgical room

Registered Practitioner verbally confirms with the team:
- ☐ Has the name and site of the procedure been recorded?
- ☐ Has it been confirmed that instruments, swabs and sharps counts are complete (or not applicable)?
- ☐ If specimen produced please confirm it is labeled
- ☐ Is count for instruments swabs and sharps correct?

PAUSE BEFORE YOU PULL

Story board for good practice in prevention of WSS in dental extractions

Step 1 Pre-operatively:

a) **Ensure** radiograph is on display and is correct for the patient.
b) Double check extraction plan against radiograph.
c) If any confusion/concerns, seek confirmation from another appropriate member of staff and/or liaise with referring dentist

Step 2 Pre-operatively:

- Dentalised checklists
- Story boards

Actions to improve culture of patient safety in dentistry

- **Increase overall awareness and compliance PS in dentistry**
  - Set up FGDP and FDS committee to promote patient engagement, study days, QA for CPD and training and dissemination of good practice
  - Encourage use of standard tools
  - Identify meaningful key PS indicators for dentistry to facilitate PS improvement
- **Improve supportive structures** for those involved in AEs and NEs
- **Unify regulator PSIs recommendations for dentistry** (NHS commissioning board, GDC and CQC);
  - Key indicators and standards for dentistry to improve analysis for monitoring and measuring improvements to increase opportunity to improve patient safety
  - Alignment to rest of health care to achieve key factors
  - Embed mandatory team training in patient safety in dental UG and PG training to improve reporting rates
  - Encourage Training CPD and QA driven by Royal Colleges
  - Unify tools , Palmer notation, Checklist, Dashboards
- Provide a **clear single repository/ pathway** for appropriate complaints, AEs and NEs for dentistry (GDC/CQC/NHS/NHSLA/)
- **Unify regulator categorising complaints** and dealing with and recording complaints (NHS Eng, GDC and CQC)
  - Encourage mediation / Resolution centre for complaints for dentistry (similar to Australian Dent Association and Irish DA models)

Mail - Renton, Tara - Outl | WHO | Patient Safety Curr

www.who.int/patientsafety/education/curriculum/Curriculum_Tools/en/

Apps | Resources | Login | King's Colleg... | Trigeminal Foundati... | orofacial pain | Electronics, Cars, Fas... | Armani Jeans Classi... | The Onion - Americ... | Finance for women |... | Other bookmarks

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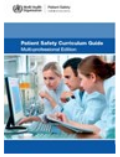
Patient safety

- Patient safety
- Research
- Campaigns
- Education & training
- Implementing change
- Patient engagement
- Information centre
- News and events

Patient Safety Curriculum Guide

Multi-professional Patient Safety Curriculum Guide



The Patient Safety Curriculum Guide provides teaching and information tools to support patient safety learning. The Curriculum Guide comprises two parts. Part A is a teachers' guide designed to introduce patient safety concepts to educators. It relates to building capacity for patient safety education, programme planning and design of the courses. Part B provides all-inclusive, ready-to-teach, topic-based patient safety courses that can be used as a whole, or on a per topic basis. There are 11 patient safety topics, each designed to feature a variety of ideas and methods for patient safety learning.

Universities are encouraged to start with Part A which provides comprehensive advice on how to introduce and build patient safety courses.

Multi-professional Patient Safety Curriculum Guide launch

Link to form where the Multi-professional Patient Safety Curriculum Guide is

Handouts: Patient safety topics

Teaching slides

Share | Print

Tools and resources

1. Multi-professional Patient Safety Curriculum Guide
2. Handouts: Patient safety topics
3. Teaching slides
4. Information notes
5. Promotional Materials

05:14
09/09/2015

Debate around should dental extractions wrong site surgery (WSS) be a never event?

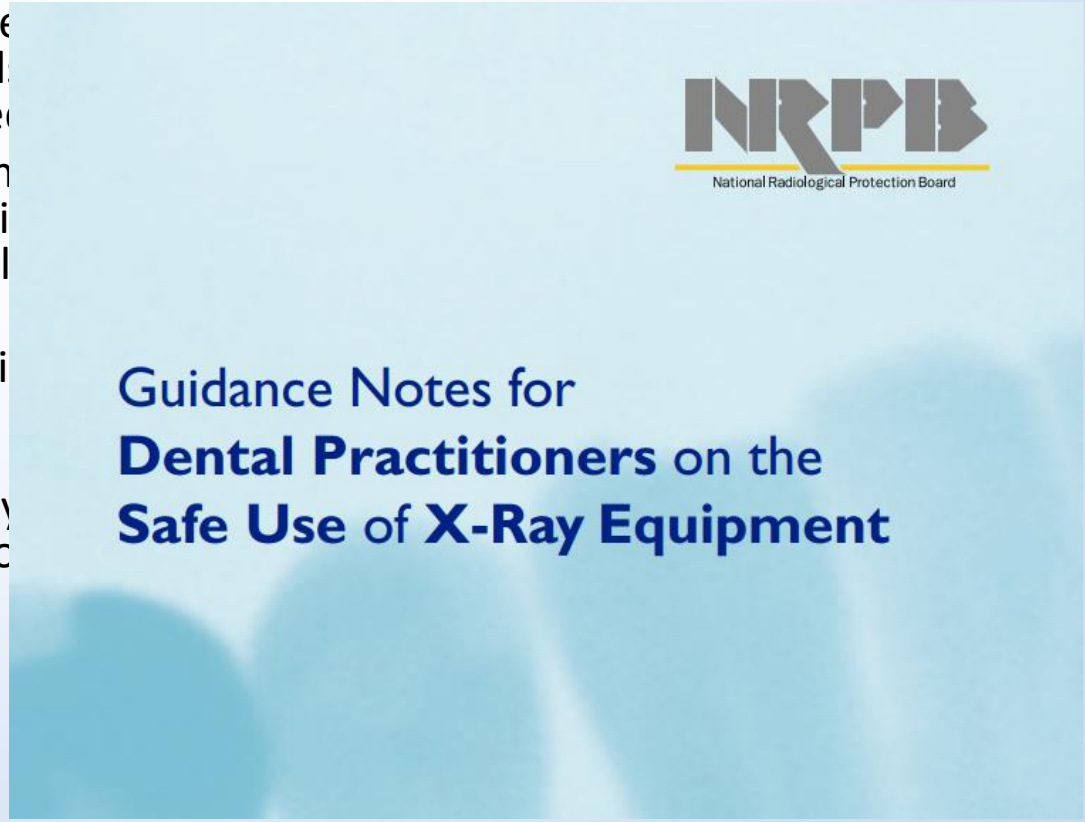
Many suggest that due to the inability to mark the surgical site and the 4 quadrant, with deciduous and permanent dentitions, dental extractions correct site surgery is more complex and challenging than other surgeries.

So does Dental WSS fit the criteria for a Never Event?

- they are wholly preventable where guidance or safety recommendations provide strong systematic barriers and are available at a National Level (YES)
- implanted by Healthcare workers (YES)
- there is evidence that it has occurred in the past (ie, it is a known source of risk). (YES)
- It can be easily defined, identified and continually measured. This requirement helps minimise disputes around classification and ensures focus on learning and improved patient safety (YES)
- WSS involving teenagers may result in loss of teeth that may necessary prolonged and **expensive corrective treatment** (orthodontics, implants etc).
  - it is anticipated that Never Event list will be reviewed annually

GDC 2015
Mandatory training for Dentists

- Standard 1.4
- You must take a holistic and preventative approach to patient care which is appropriate to the individual patient
- 1.4.1 A holistic approach means you must take account of patients' overall he psychological and social need health needs and their desire
- 1.4.2 You must provide patien is in their best interests, provi health advice and following cl relevant to their situation.
- You may need to balance thei with their desired outcomes. outcome is not achievable or interests of their oral health, y risks, benefits and likely outcc make a decision.



In US health expenditure

US Expenditures 2008
Diagnostic Conditions

- Oral Health $102 Billion (ADA)
- Heart Conditions $ 96 Billion (AHRQ)
- Trauma-related disorders $ 74 Billion
- Cancer $ 72 Billion
- Mental Disorders $ 72 Billion
- COPD, Asthma $ 54 Billion
- The total national expenditures for oral health care are expected to increase to $167.9B in 2020. (CMS. National Health Expenditure Projections)