Never events and LocSSIPs

Association of Dental Anaesthetists Annual Conference

ADA

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44 Hallam Street, London W1W 6JJ

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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**.
The Key to Quality

Clinical Effectiveness

Patient Safety

Patient Experience
Outline

• Recent history of NHS safety improvement
  – Why is it not reaching dentistry?

• Legislation relating to patient safety in dental practice
  – Duty of candour
  – Notifiable events
    • NSIs, PSIs, Serious events, Never events and Near misses

• Near Misses & Never events
  – What are they? (Never event Consultation)
  – How can they improve patient safety in dentistry?

• Surgical safety in interventional procedures
  – National Safety Standards for Invasive Procedures’ (NatSSIPs) and
  – Local Safety Standards for Invasive Procedures (LocSSIPs)

• Developing patient safety in dentistry: 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
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NHS Patient Safety

- **Francis report** - North Staffordshire 2013
- **Berwick report** 2013
- **Hard Truths** government response - The Journey to Putting Patients First 2013
- **Kings Fund response** 2013
- **NHS patient safety improvements**
  - As of 1 April 2016, Patient Safety is now part of NHS Improvement.
- **NHS patient safety key initiatives** include:
  - Launching a new National Patient Safety Alerting System (NaPSAS)
  - The monthly publishing of data on never events
  - Publishing of key patient safety indicators by hospital on My NHS (NHS Choices)
  - Launching the Patient Safety Collaboratives
  - Developing an initiative with the Health Foundation to recruit a network of ‘5,000 Patient Safety Fellows’

- **Surgical never events taskforce** 2014
- **NatSSIPs** Sept 2015
- **LocSSIPs for dental extraction** November 2016
Never Events surgical taskforce

The main recommendations of the report cover three themes:

• **Standardise** – The development of high-level national standards of operating department practice that will support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures. The report also recommends the establishment of an Independent Surgical Investigation Panel to externally review selected serious incidents;

• **Educate** – Consistency in training and education of all staff in the operating theatres, development of a range of multimedia tools to support implementation of standards and support for surgical safety training including human factors; and

• **Harmonise** – Consistency in reporting and publishing of data on serious incidents, dissemination of learning from serious incidents and concordance with local and national standards taken into account through regulation
NHS commissioning Board set up a task force to look at surgical safety, resulting in the publication "Standardise, educate, harmonise: Commissioning the conditions for safer surgery" (Feb 2014)\textsuperscript{12} is the final report of NHS England’s surgical never events task force, a literature review and survey of 600 practitioners, which was requested to examine the 3 most common never events including;

- **wrong site surgery** (which includes operating on the wrong site, carrying out the wrong procedure, and operating on the wrong patient)
- **wrong prosthesis** (for example, the wrong size components in a replacement hip)
- **retained foreign object** (the most frequently retained foreign object is surgical swabs, but this also includes surgical instruments).

Also to;

- analyse the reasons for the persistence of three never events in surgery
- consider whether the World Health Organisation checklist was helping to reduce them
- to make recommendations about what NHS England, with its responsibilities for commissioning, could do to reduce them further.
What is reaching dentistry?
GDC and CQC Regulatory Standards and training

Continuing Professional Development

Standards for the Dental Team
www.gdc-uk.org

SCOPE OF PRACTICE
GENERAL DENTAL COUNCIL
Standards for the dental team published by the General Dental Council (GDC) in the summer of 2013 makes several statements of relevance with respect to patient safety. Principle one (put patient’s interests first) states in standard 1.5.4 ‘You must record all patient safety incidents and report them promptly to the appropriate national body’. Principle eight (raise concerns of patients at risk) states in standard 8.1 ‘You must always put patients’ safety first’. This brief overview has highlighted some of the strategies that have contributed to improving patient safety. Our challenge now is to continue to broaden our understanding of patient safety issues
But in reality
Progress in dentistry so far is.......
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Duty of candour

• Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 apply to all providers from 1 April 2015.
  – Safe care and treatment Regulation 12
  – Safeguarding service users from abuse and improper treatment Regulation 13
  – Staffing Regulation 18
  – Premises and equipment Regulation 15
  – Good Governance Regulation 17
  – Person-centred care Regulation 9
  – Need for consent Regulation 11
  – Fit and proper persons employed Regulation 19 is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards, are fit and proper to carry out this important role.
  – Duty of candour Regulation 20 is to ensure that providers are open and transparent with people who use services and other ‘relevant persons’ (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

• This statutory duty on organisations supplements the existing professional duty of candour on individuals and it is a legal requirement that NHS health care providers to report notifiable incidents relating to patient care.

(http://www.cqc.org.uk/sites/default/files/documents/statutory_notifications_for_nhs_bodies_-_provider_guidance_v6.pdf) It is only mandatory to submit reports about the events and incidents to CQC and NPSA shown in Table 1. They include the vast majority of ‘never events’. You should continue to submit reports about other kinds of events under the NRLS’s voluntary arrangements.
• **Duty of candour** (CQC Regulation 20) is to ensure that providers are open and transparent with people who use services and other ‘relevant persons’ (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

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The house of commons Health committee 2011 inserted a contractual duty of candour into all NHS contracts (except primary care) from 1st April 2013

- Reportable incidents of moderate or serious harm or death
- Narrower than ethical duty of candour
- Notifiable safety event (NSI)
The statutory duty

- Applies to health service bodies from 17 November 2014 (until 2022)
- CQC Guidance came out the same day
- Extended to all registered health care persons April 2015
The duty

• The notification must;
  – Be timely
  – Be in person
  – Be true account
  – Set our further enquiries considered appropriate include an apology: An expression of sorrow or regret
  – Be written down
The duty for health service bodies

• A Notifiable serious events (NSIs) for health service bodies
  – Unintended or unexpected incident..that’s, in the reasonable opinion of a health care professional, could result in or appears to have resulted in......
    • Death
    • Severe harm
    • Moderate harm or prolonged psychological harm
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 of 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’
Problem

- A two tier duty
  - One for health service bodies
  - One for primary care and private care providers
- The AvMA document a must read


The CQC has statutory powers to take regulatory action over non-compliance with the duty of candour. These include refusal or removal of registration; warnings; special measures; fines; and, in certain circumstances, criminal prosecution. In May 2015 duty of candour legislation was extended to cover primary care (GPs, dentists, pharmacists), private healthcare providers and adult social care.
For example
Consenting higher risk patients

• There is a case NHSLA admitted that in 2009 it was a breach of duty not to offer a patient with high risk M3M a coronectomy
• Then July 2014 Cochrane review stated that likely that coronectomies reduce the risk of IANI
• But since evidenced to support minimising harm
  – Systematic review 2012 The authors stated that coronectomy could be used in clinical practice, for third molar extractions, with a high risk of nerve injury. The risks of failed coronectomy could be reduced by improving surgical procedures and by monitoring radiographic risk factors.
  – Systematic review 2016 Coronectomy is indicated when the mandibular third molar is in contact with the inferior alveolar nerve and complete removal of the tooth may cause nerve damage.
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Notifiable 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.

- Near Misses (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)

Notifiable events

- **Statutory** Duty of candour
- **Standards**
  - Regulatory stipulate mandatory standards applied to dentistry
  - **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 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 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)** 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/]
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 apply to all providers from 1 April 2015.

- Safe care and treatment Regulation 12
- Safeguarding service users from abuse and improper treatment Regulation 13
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Duty of candour
MHRA Medicines and Healthcare products Regulatory Authority (MHRA) and through the Central Alerting System (CAS).

- Any serious incident involving medication or medical devices (including implants) should be reported to the MHRA. Details on how to do this are at: http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/index.htm

- Adverse drug reactions reported using the Yellow Card Scheme (any drug-related serious event see below) http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/

- Medical history checked

- Appropriate drug prescription (Scottish Dental Clinical Effectiveness Program Guidelines) http://www.sdcep.org.uk/published-guidance/drug-prescribing/

CQUIN

http://www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf NHS Trusts report quarterly on the following:

- The proportion of patients with ‘harm free’ care.
- The number of emergency readmissions within 30 days of hospital discharge.
- The number of revision procedures.
- Hospital stay
- Associated medical complications.
- The number of hospital-acquired infections
- The time taken to achieve restoration of function.
- The extent of return to function.
- Cases of inadequate function or appearance.
### CQC

http://www.cqc.org.uk/content/dentists Collates data on reported serious events and governance and PROMS and PREMS.

Serious harm to patients or death are events that require obligatory reporting to CQC and commissioning body.

Serious events must be reported to the CQC (http://www.cqc.org.uk/content/notifications) within 21 days by provider or registered manager if it is any of the following:

- Fatal.
- Life-threatening – the patient is/was, in the view of the investigator, at immediate risk of death from the adverse event as it occurred.
- Results in an unplanned in-patient hospitalisation, or prolongs an existing hospitalisation.
- Significantly or permanently disabling.
- A congenital anomaly or birth defect.
- Incorrectly administered intravenous antibiotics

### RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013)

The Health Protection Legislation (England) Guidance 2010 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”. Department of Health have published. The Health Protection Legislation (England) Guidance 2010 Notification about certain notifiable infection outbreaks and reporting Health Care Associated Infection (HCAI) serious incidents. Guidance on Health Care Associated Infection Operational Guidance and Standard for Health Protection Units provides information on the notification and management of significant or serious events.
Why is reporting of PSIs so complex in dentistry?
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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 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.

Never events

• Unlike other notifiable event Never events are not ‘per se’ unlawful.
What are Never events?

• 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.

4.2 Never Events are a particular type of serious incident that meet all the following criteria:

4.2.1 They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers\(^2\) are available at a national level, and should have been implemented by all healthcare providers.

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\(^2\) As compiled by NHS England patient safety experts and health professionals and referenced in the Never Event list, these include: physical barriers (e.g. special equipment that makes it impossible to connect medications via the wrong route); time and place barriers (e.g. withdrawal of concentrated medication from settings to prevent accidental selection) or systems of double or triple checking only where supported by visual or computerised warnings, standardised procedures, or memory/communication aids. As all human action is vulnerable to human error, particularly where there is a risk of staff becoming overloaded, processes that rely solely on one staff member checking the actions of another or referring to written policies are not strong barriers.
4.2.2 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.

4.2.3 There is evidence that the category of Never Event has occurred in the past, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.

4.2.4 Occurrence of the Never Event is easily recognised and clearly defined – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.

4.3 It is anticipated the Never Event list will be reviewed annually by NHS England.
**What is a Never Event in dentistry?**

The Revised Never Events policy and framework 2015 from NHS England\(^1\) modified the list of Never Events related to dentistry to the following 3 incidents:

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

- **Wrong implant /incorrect placement of dental implant**

- **Retained foreign body**

**NPSA and NRLS**

http://www.nrls.npsa.nhs.uk and https://report.nrls.nhs.uk/nrlsreporting/ These gather data on:

- Wrong site surgery
- Wrong implant or wrong site
- Retained foreign object
- Wrong site block

Also the Serious Incident Reporting and Learning Framework

1. Wrong site surgery

A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, wrong tooth or wrong organ); the incident is detected at any time after the start of the procedure.

- Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block (unless being undertaken as a pain control procedure), biopsy, interventional radiology procedures, cardiology procedures, drain insertion and line insertion e.g. PICC/ Hickman lines.

- Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient’s anatomy. This should be documented in the patient’s notes.

- Excludes incidents where the wrong site surgery is due to incorrect laboratory reports/results or incorrect referral letters.

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- *How to Guide to the five steps to safer surgery*, 2010, available at [http://www.nrsl.npsa.nhs.uk/resources/?EntryId45=92901](http://www.nrsl.npsa.nhs.uk/resources/?EntryId45=92901)
- *Safe Anaesthesia Liaison Group – Stop before you block 2011* [https://www.rcoa.ac.uk/sites/default/files/CSQ-PS-sbvb-supporting.pdf](https://www.rcoa.ac.uk/sites/default/files/CSQ-PS-sbvb-supporting.pdf)
- *Standards for providing a 24 hour interventional radiology service, 2008*, The Royal College of Radiologists. Available at [http://www.rcr.ac.uk/docs/radiology/pdf/Stand_24hr_IR_provision.pdf](http://www.rcr.ac.uk/docs/radiology/pdf/Stand_24hr_IR_provision.pdf)
2. Wrong implant/prosthesis

Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in the patient is other than that specified in the surgical plan either prior to or during the procedure and the incident is detected at any time after the implant/prosthesis is placed in the patient.

- Excludes where the implant/prosthesis placed in the patient is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure
- Excludes where the implant/prosthesis placed in the patient is intentionally planned and placed but later found to be suboptimal.

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- How to Guide to the five steps to safer surgery’, 2010, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901)
3. Retained foreign object post-procedure

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 of the surgical environment e.g. central line placement in ward areas.

‘Foreign object’ includes any items that should be subject to a formal counting/checking process at the commencement of the procedure and a counting/checking process before the procedure is completed (such as swabs, needles, instruments and guide wires) except where:

- Items are inserted any time before the procedure that are not subject to the formal counting/checking process, with the intention of removing them during the procedure and they are not removed.
- Items are inserted during the procedure that are subject to the counting/checking process, but are intentionally retained after completion of the procedure, with removal planned for a later time or date and clearly recorded in the patient's notes.
- Items are known to be missing prior to the completion of the procedure and may be within the patient (e.g. screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention.

See the **Appendix A on page 11** for examples of correct application of this never event definition.

**Settings:** All patients receiving NHS funded care.

**Guidance:**
- *How to Guide to the five steps to safer surgery*, 2010, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901)
- *Reducing the risk of retained throat packs after surgery*, 2009, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59853](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59853)
- *Reducing the risk of retained swabs after vaginal birth and perineal suturing*, 2010, available at [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=74113](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=74113)
- *Risk of harm from retained guide wires following central venous access*, 2011, available at [http://www.nrls.npsa.nhs.uk/resources/?entryid45=132829](http://www.nrls.npsa.nhs.uk/resources/?entryid45=132829)
4. Mis – selection of a strong potassium containing solution

5. Wrong route administration of medication

6. Overdose of Insulin due to abbreviations or incorrect device

7. Overdose of methotrexate for non-cancer treatment

8. Mis – selection of high strength midazolam during conscious sedation

9. Failure to install functional collapsible shower or curtain

10. Falls from poorly restricted windows

11. Chest or neck entrapment in bedrails

12. Transfusion or transplantation of ABO-incompatible blood

13. Misplaced naso- or oro-gastric tubes

14. Scalding of patients
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
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.
FAQs

- *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.
FAQs

• *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.
FAQs and more........

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

**Does wrong site surgery apply to giving a block on the incorrect site?** YES, if it is undertaken as part of a planned surgical intervention as there are strong systemic barriers that are available at a national level to prevent them from happening.

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

**What about incidents where an instrument component, fragment, or the whole instrument is retained inside the patient and its location is known to the surgeons?** YES, if it requires removal on a separate occasion. NO, if it is more harmful to re-operate as long as the patient is notified and the risks of leaving it are not greater than removing it. This requirement does not apply to parts of instruments used in orthograde root therapy retained in the root canal as this procedure is not currently regarded as a surgical intervention for the purpose of Never Event reporting.
Following NEs

- Reporting NEs
- Investigating NEs - 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.
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
  How to report Serious events
Why is reporting of PSIs so complex in dentistry?
Outline

• Recent history of NHS safety improvement
  – Why is it not reaching dentistry?

• Legislation relating to patient safety in dental practice
  – Duty of candour
  – Notifiable events
    • NSIs, PSIs, Serious events, Never events and Near misses

• Near Misses & Never events
  – What are they? (Never event Consultation)
  – How can they improve patient safety in dentistry?

• Surgical safety in interventional procedures
  – National Safety Standards for Invasive Procedures’ (NatSSIPs) and
  – Local Safety Standards for Invasive Procedures (LocSSIPs)

• Building a culture of patient safety improvement in dentistry
• **Never Events data**
  – The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Since the **NRLS was set up in 2003**, over four million incident reports have been submitted.
  – **From 1 April 2010** it became mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission. All incidents resulting in death or severe harm should be reported to the NRLS (which is then forwarded to CQC).

• **Surgical Never Events task force**
  – NHS England commissioned a Surgical Never Events taskforce to examine and clarify the reasons for the persistence of these patient safety incidents, and to produce a report making recommendations on how their occurrence can be minimised. This report was published in **February 2014**.

• **National Safety Standards for Invasive Procedures (NatSSIPs)**
  – One of the recommendations of the Surgical Never Events Taskforce report was to develop a set of high-level national standards of operating department practice.
  – The National Safety Standards for Invasive Procedures (NatSSIPs) were published in **September 2015** to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in all clinical areas.
  – Development of LocSSIPs

• **Revised Never Events Policy and Framework**
  – A revised Never Events Policy and Framework was published on **27 March 2015**.
  – **August 2016** Never event consultation.
NatsSSIPs and 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
<table>
<thead>
<tr>
<th>SPEC/ORG</th>
<th>NAME</th>
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<tbody>
<tr>
<td>FGDP</td>
<td>Mick Horton, Dean</td>
</tr>
<tr>
<td>SCD</td>
<td>Vanita Brookes</td>
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<td>Paed</td>
<td>Stephen Fayle</td>
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<tr>
<td>FDS</td>
<td>Tara Renton</td>
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<tr>
<td>FDS</td>
<td>Selina Masters</td>
</tr>
<tr>
<td>Dental Hospital Association</td>
<td>Mike Pemberton</td>
</tr>
<tr>
<td>DMFR</td>
<td>Jane Luker (email only)</td>
</tr>
<tr>
<td>Manchester Patient Safety Group</td>
<td>Alka Saksena</td>
</tr>
<tr>
<td>NHS England, Office of CDO</td>
<td>Janet Clarke</td>
</tr>
<tr>
<td>ADH Clinical Directors</td>
<td>Avril MacPherson</td>
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<tr>
<td>Dental Dean</td>
<td>Callum Youngson</td>
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<tr>
<td>Manchester Patient Safety Group</td>
<td>Edmund Bailey</td>
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<td>ABAOMS</td>
<td>Justin Durham</td>
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<tr>
<td>National Examining Board for Dental Nurses</td>
<td>Pam Daley</td>
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<td>BSHDT (Dental Therapists and Hygienists)</td>
<td>Invited</td>
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<tr>
<td>NHS Lead for NatSSIPS</td>
<td>Fran Watts</td>
</tr>
<tr>
<td>Nurse Manager and Governance Lead for Dental Hospital</td>
<td>Lesley Davies</td>
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<tr>
<td>CQC</td>
<td>John Milne &amp; Sampana Baner</td>
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<tr>
<td>Lay Member</td>
<td>Sue Parroy</td>
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<tr>
<td>OMFS, Deputy Lead BAOMS Dental Alveolar Specialist Interest Group</td>
<td>Max Chauhan</td>
</tr>
<tr>
<td>Dental Indemnity</td>
<td>Bryan Harvey (MDU)</td>
</tr>
<tr>
<td>BAOS</td>
<td>Mike Murphy</td>
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<tr>
<td>NHS Improvement</td>
<td>Joan Russell</td>
</tr>
<tr>
<td>GDC</td>
<td>Jessica Rothnie GDC Standards Policy Manager</td>
</tr>
<tr>
<td>BDA</td>
<td>Martin Woodrow Director of Member Services Invite David Cottam Deputy Chair of the BDA's General Dental Practice Committee <a href="mailto:davidcottam@blueyonder.co.uk">davidcottam@blueyonder.co.uk</a> attending final meeting</td>
</tr>
<tr>
<td>HEE</td>
<td>Elizabeth Jones HEE</td>
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<tr>
<td>PHE</td>
<td>John Morris</td>
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</table>
Local Safety Standards for Invasive Procedures
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’
**Dental Never Events - recommended action**

Never event identified – ensure immediate situation has been addressed, apologise and inform patient (or carer) ensure reassurance re mitigation

Identify staff member of team who will investigate with a view to future learning with support for the patient/carers and the team in line with 'Being open' and the 'Duty of Candour' guidance'

If a trainee involved notify the HEE (CDT, VT, Specialist trainee)


Report within 2 days

Notify CQC if persistent physical or psychological harm at 28 days

Liaise and inform relevant commissioning organisation

Undertake a full investigation (which may include a Root Cause Analysis) to ensure that all NEs are opportunities for learning and improving patient care

'Ensure learning outcomes are shared across the practice and with patients and implement preventive measures to reduce the risk of a repeat wrong site extraction

**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.
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
- 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.cqc.org.uk/content/notifications)
- Notification guidance
  - Events causing Moderate – severe harm (psychological and or physical damage persisting beyond 28 days)
  - Death
  - Abuse or allegation of abuse
  - Criminal
  - Any change to provider content statement of purpose has changed Address, lead staff etc
ensure the following:

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

6.2 Commissioners of NHS funded care: NHS England

NHS England are committed to ensuring that learning from Never Events is the primary purpose of reporting and investigating them.

NHS England’s role in relation to Never Events is twofold:
**EXEMPLAR**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>History:</th>
<th>Risk Factors:</th>
</tr>
</thead>
</table>
| 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. | 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 | 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. |
### 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?
Additional Resources

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

• Recent history of NHS safety improvement
  – Why is it not reaching dentistry?
• Legislation relating to patient safety in dental practice
  – Duty of candour
  – Notifiable events
    • NSIs, PSIs, Serious events, Never events and Near misses
• Near Misses & Never events
  – What are they? (Never event Consultation)
  – How can they improve patient safety in dentistry?
• Surgical safety in interventional procedures
  – National Safety Standards for Invasive Procedures’ (NatSSIPs) and
  – Local Safety Standards for Invasive Procedures (LocSSIPs)
• Building a culture of patient safety improvement in dentistry
Actions to improve culture of patient safety in dentistry

- **Increase overall PS awareness, compliance and learning 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)
FDS RCS PS study day 3rd March 2017
launch of LocSSIPs

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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</thead>
<tbody>
<tr>
<td>0845-0915</td>
<td>Registration and coffee</td>
</tr>
<tr>
<td>0915-0925</td>
<td>Welcome Faculty of Dental Surgery</td>
</tr>
<tr>
<td>0925-0930</td>
<td>Introduction Dr Jane Luker and Professor Tara Renton Course Convenors</td>
</tr>
<tr>
<td>0930-1015</td>
<td>CDO office (England) approach to dental patient safety Dr Janet Clarke</td>
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<td></td>
<td>Deputy Chief Dental Officer NHS England</td>
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<tr>
<td>1015-1040</td>
<td>What is the role of the CQC in patient safety in dentistry? How can it be improved? Mr Clive Fern Clinical Dental Advisor, Care Quality Commission</td>
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<tr>
<td>1040-1110</td>
<td>Coffee break</td>
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<tr>
<td>1110-1125</td>
<td>Developing a patient safety culture Dr Mike Pemberton Consultant Oral Medicine, University of Manchester</td>
</tr>
<tr>
<td>1135-1200</td>
<td>The human factor: setting the scene Mr Trevor Dale CEO Atrainability</td>
</tr>
<tr>
<td>1200-1225</td>
<td>Whole systems approach to reducing wrong site surgery Ms Alka Sakarika Consultant Oral Surgeon, University of Manchester</td>
</tr>
<tr>
<td>1225-1240</td>
<td>Q&amp;A and discussion</td>
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<tr>
<td>1240-1340</td>
<td>Lunch with and trade display</td>
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<tr>
<td>1510-1640</td>
<td>Coffee break</td>
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<tr>
<td>1640-1700</td>
<td>Questions/ discussion/concluding remarks Professor Tara Renton and Dr Jane Luker</td>
</tr>
</tbody>
</table>
Thank you
Outline

• Recent history of NHS safety improvement
  – Why is it not reaching dentistry?
• Legislation relating to patient safety in dental practice
  – Duty of candour
  – Notifiable events
    • NSIs, PSIs, Serious events, Never events and Near misses
• Near Misses & Never events
  – What are they? (Never event Consultation)
  – How can they improve patient safety in dentistry?
• Surgical safety in interventional procedures
  – National Safety Standards for Invasive Procedures’ (NatSSIPs) and
  – Local Safety Standards for Invasive Procedures (LocSSIPs)
• Developing patient safety in dentistry: 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
Developing patient safety in dentistry

- **Strategy 1**
  - Identify threats to patient safety by incident reporting

- **Strategy 2**
  - Analysing incidents to improve safety

- **Strategy 3**
  - Communication and education in patient safety

- **Strategy 4**
  - Building a safety culture

Strategy 1
Identify threats to patient safety by incident reporting

Strategy 2
Analysing incidents to improve safety
Patient safety resource centre

Helping you make the right change

Patient safety information sources - measuring and understanding safety

- **STAFF**
  - reporting & learning
  - interviews
  - walkarounds
  - climate/culture
  - observation

- **PATIENTS**
  - reporting
  - complaints
  - comments
  - surveys

**UNDERSTANDING SAFETY** (qualitative)

**MEASURING SAFETY** (quantitative)

**METRICS**
- adverse event rate
- never event rate
- sentinel event rate
- routine data

Overlap?
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.

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.
Review 10 years National reporting and learning system (NRLS) and Strategic Executive Information System (StEIS) databases

Renton T Sabbah W BDJ 2016


T. Renton1 and W. Sabbah*1

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 (WSEs), reported separately for 2012-2013 and 2013-2014. The total number was 43.36 of the 43 PSEs were WSE 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 3% 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-implantological, reconstructive surgery (OMMS), patient age over 67 years with concurrent medical complexity (choreaemic heart disease). Sixty percent of PSEs occurred in OSM/OMS in acute trust inpatients and 20% in primary care. From StEIS 2012-2013, 21 WSE 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-punitivesupport by regulators would allow the improvement of patient safety in dental practice.

Introduction

Preventable patient safety events (PSEs) can and do occur, sometimes with severe consequences for patients and to the distress of the healthcare professionals involved. For example, the perception of error, stress and teamwork in the healthcare field in rather worrying in that 20% of surgeons and 40% of anaesthetics do not seem to have the perception of fatigue while working. 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.

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 fulfill 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 specialty, 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 – 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, accidents and fatalities will eventually disappear. James Reason developed the Swiss Cheese model of system failure in business whereby holes in the cheese slice line up to allow significant system failure. 
10 years Strategic Executive Information System StEIS database

- Patient safety events were reported between 1st January 2005 and 30th May 2014.
- NE from StEIS files were all wrong site extraction, reported separately for 2012-2103 and 2013-2104, total number is 43.
- 32,263 reported events
  - 47% of which were no harm, 20% low harm, 7% moderate harm, Less than 1% severe harm
  - 23 deaths over this period. (5 -20% not related to dentistry)
  - 60% OS/OMFS were acute trust inpatients and 20% primary care.
  - 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% dental surgery.
- WSS most common event (n=36)
  - Multiple extractions, bimodal age distribution (very young or over 60 years)
- Serious harm and death Risk factors
  - Acute trust ward, peri oncological, reconstructive surgery (OMFS), age over 67 years, concurrent medical complexity (Ischaemic heart disease
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
Why is reporting of PSIs so complex in dentistry?
Simplified single anonymised reporting system for GMPs

http://www.npsa.nhs.uk/
Dental Never Events – reporting NEs to NRLS

Never event identified – ensure immediate situation has been addressed, apologise and inform patient (or carer) ensure reassurance re mitigation

Identify staff member of team who will investigate with a view to future learning with support for the patient /carers and the team in line with 'Being open' and the 'Duty of Candour' guidance

If a trainee involved notify the HEE (CDT, VT, Specialist trainee) If UG involved Notify Dean

Submit report to StEIS https://www.england.nhs.uk/patient safety/report-patient-safety/ NRLS Or through Local Risk Management System e.g. DATIX

Report within 2 days

Notify CQC if persistent physical or psychological harm at 28 days

Liaise and inform relevant commissioning organisation

Undertake a full investigation (which may include a Root Cause Analysis) to ensure that all NEs are opportunities for learning and improving patient care

'Ensure learning outcomes are shared across the practice and with patients and implement preventive measures to reduce the risk of a repeat wrong site extraction

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.
Strategy 3
Communication and education in patient safety
Recent publications

Manchester Dental School have explored various strategies to improve patient safety in relation to dentistry including WSS:

- **Human factors** are discussed and related risks alongside lack of awareness and under reporting in primary care.
- **Surgical safety checklist** for outpatient oral surgery along with the
- **Key strategic actions** needed to ensure **Effective cultural change** to optimise patient safety in the outpatient setting WSS could be prevented.
- **Better analysis of patient safety** incidents can be better analysed and audited by monitoring the use of an outpatient checklist.
- **Mandatory training in communication and teamwork** explicitly around patient safety can ensure safe management of patients.
- **Introduction of a patient safety dashboard assessing**;
  - WSS;
  - use of benzodiazepine antagonist;
  - compliance (NICE; Trust Policies; consent procedures; surgical checklist; mandatory training) was introduced for the dental institute.
  - Additional patient safety dashboard incidents included; TMD patients presenting with trismus; incorrect placement of dental implant; nerve injury; accuracy of letters requesting extraction for orthodontics; failure of biopsy management.
  - **Each metric is a potential learning opportunity to improve performance.**
Systematic review of patient safety interventions in dentistry

Edmund Bailey¹”, Martin Tickle¹, Stephen Campbell¹ and Lucy O’Malley²

Abstract

Background: The concept of patient safety in dentistry is in its infancy, with little knowledge of the effectiveness of tools or interventions developed to improve patient safety or to minimise adverse events.

Methods: The aim of this qualitative systematic review was to search the academic and grey literature for tools or interventions used in dental care settings to maintain or improve patient safety. Outcome measures were: patient safety, patient satisfaction, patient acceptance, professional acceptability, efficiency. Quality assessments were performed on the included studies based on CASP criteria undertaken to discover whether any of the tools had been trialled or verified by the authors.

Results: Following abstract screening, and initial qualitative synthesis, nine studies were included with 31 being excluded following initial analysis. Tools identified included: auditing systems (3), the use of electronic notes (1) and trigger tools (1). Grey literature identified any further appropriate studies. In terms of study design, there were observational studies (5 studies), epidemiological studies (3) and prospective cluster randomised trials. The quality of the studies varied and none of their outcomes were verified by other research.

Conclusions

This systematic review finds that the only interventions in dentistry that reduce or minimise adverse events are surgical safety checklists.

It should be clear from reading this review that research into patient safety in dentistry is in its infancy, as it is in other aspects of ambulatory healthcare [68]. Healthcare quality is made up of multiple domains including safety, effectiveness, patient-centredness, timeliness, efficiency, and equity [81]. It is important that tools developed to improve patient safety are adapted and customised for different healthcare settings so that they are appropriate to the patients and staff in those areas. We must be aware that not all tools and techniques found in other industries, such as aviation, are appropriate for transfer to healthcare settings [12].

All of the papers included in this review mention both the need for further research into patient safety in dentistry and the importance of educating practitioners in how to improve patient safety. This review echoes these calls for further research; we have demonstrated that a systematic approach to the investigation of patient safety in dentistry is required. The profession, in collaboration with patients, needs to develop a common understanding of the concept; we need to understand the epidemiology of patient safety in dentistry in different contexts.
Training needs in dentistry

**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.**
The findings of this review identified one ITS study for a non-medical procedure conducted in a dental outpatient setting. 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. 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 cautiously.
FDS RCS PS study day 3rd March 2017
launch of LocSSIPs

Programme
0845-0915 Registration and coffee
0915-0925 Welcome
Faculty of Dental Surgery
0925-0930 Introduction:
Dr Jane Luker and Professor Tara Renton
Course Convenors
0930-1015 CDO office (England) approach to dental patient safety
Dr Janet Clarke
Deputy Chief Dental Officer NHS England
1015-1040 What is the role of the CQC in patient safety in dentistry?
How can it be improved?
Mr Clive Fern
Clinical Dental Advisor, Care Quality Commission
1040-1110 Coffee break
1110-1135 Developing a patient safety culture
Dr Mike Pemberton
Consultant Oral Medicine, University of Manchester
1135-1200 The human factor: setting the scene
Mr Trevor Dale
CEO Atrainability
1200-1225 Whole systems approach to reducing wrong site surgery
Ms Alka Salvesen
Consultant Oral Surgeon, University of Manchester
1225-1240 Q&As and discussion
1240-1340 Lunch with and trade display
1340-1510 Afternoon workshops: parallel sessions
1. What is a never event/ notifiable event? – Dr Jane Luker
2. How do you manage it?/root cause analysis – Dr Selina Master
3. Systems/culture – Dr Mike Pemberton
4. Tools – Ms Alka Salvesen
5. NatSSIPs – Professor Tara Renton
1510-1640 Coffee break
1640-1700 Questions/ discussion/ concluding remarks
Professor Tara Renton and Dr Jane Luker
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)
Dental Procedures and risk of NEs

UG training

If you relate to the current NHS activity, then training is not currently reflected in UG teaching

Improved training required for extraction competency and joint decision making
Total volume of activity of NHS dental service - 79,563,980 procedures

Fig 1 Total volume of activity of the NHS dental service
# 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
Strategy 4
Building a safety culture
Putting patients first in dentistry

Report of a seminar held in London on 8 February 2012 to explore lay representation in dentistry
Litigation related to NHS Oral Surgery

• Litigation claims are increasing in medicine but we know of little detailed analysis of those published concerning oral and maxillofacial surgery (OMFS) despite information being freely available from the NHS Litigation Authority (NHSLA) under the Freedom of Information Act.

• We obtained information from the NHSLA on clinical and non-clinical negligence claims in OMFS from April 1995 to August 2010, and analysed the data with outcomes and a further breakdown of subspecialty.

• During the period 318 claims relating to OMFS were registered. As expected, because of the high volume of patients treated, the highest number of claims related to dentoalveolar surgery and minor oral surgery.

• The total amount paid out was in excess of £5 million, and the highest claim (more than £300,000) during the period was for misdiagnosis of an oral cancer.

• Litigation in OMFS is increasing, as is the number of cases that necessitate compensation by the NHSLA. We discuss the trends and implications.

Dental Defence Union - patient safety recommendations

Checklist

• Does your practice have a **quality assurance system** in place?
• Can you demonstrate that you participate in **regular clinical audits** and review the delivery of healthcare to ensure patient safety and best practice?
• Do you hold **significant event audits to learn from things** that have gone wrong and highlight examples of good practice?
• Does your **practice have policies** in place to ensure it meets its legal obligations e.g. infection control, IRMER, data protection, anti-discrimination and child protection?
• Do staff have the opportunity to contribute ideas and raise concerns?
• Do you discuss and act on the findings of patient satisfaction surveys in your practice?
• **Have your training needs been reviewed recently?** What about those of any employees and/or team members?
GDC and CQC alignment with NHS improvement
A considerable mismatch between current NHS regulatory PS standards and implementation of mandatory training in dentistry

What do patients expect?

- No harm
  - Correct diagnosis
  - Continued wellbeing
    - Recognition existing of medical conditions
    - Prevention worsening of existing medical conditions
  - Correct prescription of treatment
    - Radiology
    - Anaesthesia
    - Sedation
    - Analgesic and pain management
    - Antibiotics
    - Never events
      - WSS
      - Anaphylaxis
      - Death
      - Readmission or re treatment
      - Damage, lip burns, nerve injury

- Existing GDC recommended training related standards (in blue)
  - Oral cancer
  - Well being lack of applied to IHD, DM, Obesity, mental health or social care. Counselling for alcohol abuse, smoking
  - CPR
  - Prescription
    - IRMER plus new CBCT training
    - RCS standards anaesthesia 2010
    - Intercollegiate sedation 2015
    - Analgesia and antibiotics
      - SDCEP prescribing guidelines 2011
      - FGDP RCS Antibiotic guidelines
    - AEs and NEs
      - MHRA reporting
      - StEIS, NRLS reporting (no systems or training in place in primary care)

- Consent
- Continued care
- Patient centred

-- Consent
-- Home check recommended by oral surgery commissioning pathway
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)
Never event consultation
Closes October 28th

Dear colleague,

Re: NHS Improvement consultation on Never Events Policy and Framework

I am writing to invite you and your organisation to participate in a consultation launched today to gather opinions and feedback on the current Never Events Policy and Framework. This is with a view to amending the framework for 2017/18 and considering the NHS’s overall approach to Never Events in England.

The Never Events Policy and Framework is designed to provide healthcare workers, clinicians, managers, boards and accountable officers with clarity around their responsibilities and clarity on the principles of Never Events. In particular, it is designed to be clear about what they are expected to do in terms of preventing Never Events and how they must respond to them if they should occur, including clarity around incident reporting.

A Never Event may highlight potential weaknesses in how an organisation manages fundamental safety processes. Never Events differ from other serious incidents in that even a single Never Event should be interpreted as a strong signal that an organisation’s systems for implementing existing safety advice/alerts might not be robust. However, it is apparent that there can be too much focus on the numbers of Never Events, or on very specific improvement actions related to one sub-type of Never Event.

8 September 2016
Thank you
Questions please
Recommendations

• Standardise
  – Single reporting mechanism NaTSIPPS palmer notation, recognised difficulty of site marking (Use e form for primary care including all statutory reporting / may come with new NRLS work)
  – Training WHO patient safety curriculum, FT training Jane Luker, CQC & GDC core mandatory training
  – Tools
    • Checklists, Audit, commissioning, outcomes
    • Data set (new NRLS work on updating data collection and analysis)
  – Alignment of dentistry PS with overall NHS (GDC & CQC)
  – Encourage reporting with Improved support for clinicians

• Educate
  – Standard mandatory training-WHO patient safety curriculum, FT training Jane Luker, CQC & GDC core mandatory training
  – Other initiatives ADH annual conference

• Harmonise
  – Engage all regulators (CQC, GDC and NHS England)
  – Engage all stakeholders
    • BDA, FDS RCS, FGDP, Specialist societies, Indemnity bodies
  – Align Commissioning with integrated PS initiatives
    • Outcomes FFT, Quality standards


Prof Don Berwick, who led a system-wide review of safety in the NHS (2012)

http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals


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)


