Pav Dental

Wrong Site Surgery Policy

Wrong-site surgery is a rare but serious event that can have substantial consequences for patients and healthcare providers. It occurs when a surgical or invasive procedure is undertaken on the wrong body part, on the wrong patient, or when the wrong procedure is performed. In dentistry, wrong-site surgery is generally associated with an incorrect tooth being extracted.

Wrong tooth extractions were removed from the Never Events list in 2021, meaning dentists no longer have to declare such an incident a never event. However, it is still good practice to try to eliminate the chances of a wrong tooth extraction.

Improving the safety of tooth extraction and other types of dental surgery begins with a highly reliable preparatory procedure. The process by which dentists typically prepare patients for dental extractions in the office setting involves the following steps:

· Confirming the patient's identity

· Review the treatment plan (or, if referred, the referral slip) regarding which tooth should be extracted.

· Review the medical history and record the vital signs (if providing sedation).

· Perform the oral evaluation to assess the surgical site.

· Obtain written informed consent (generally, a pre-printed form with a notation of the tooth to be extracted).

· Administer the local anaesthesia.

· Perform the procedure.

· Give postoperative instructions and dispense prescriptions as required.

· Discharge patient when stable and arrange for follow-up.

Recommendations for Safe Practice

· Using a LocSSIP (Local Safety Standards for Invasive Procedures)

· Develop an educational program for the entire staff on preventing wrong-site tooth extraction.

· Design a more informative referral slip.

· At the initial consultation appointment, inform the patient/parent/guardian verbally and with a hand-held patient mirror which tooth/teeth are to be extracted.

· Confirm that the patient, chart, and x-ray (correctly oriented) are correct and confirm which tooth will be extracted at the surgical appointment.

LocSSIP

A Local Safety Standard for Invasive Procedure (LocSIPP) should be implemented for invasive procedures. To determine if the procedure is invasive or not, you should consider whether the procedure has the potential to lead to patient harm; if the answer is "yes", then the procedure should include the use of the LocSIPP

LocSSIP provides an outline of good practice procedures to minimise errors by using a checklist, and this should include the following:

· Confirmation of procedure and site of procedure

· Confirmation of patient's identity

· Checking the treatment plan and any radiographs available.

LocSSIP guidance can be found here.

Reporting in England

If a wrong tooth is extracted, regardless of whether the error was identified immediately or delayed, full disclosure (under a duty of candour) and possible remedies must be presented to the patient. The practice should also notify the CQC as it would fall under a notifiable safety incident. More information on this and how to report such an incident can be found on the CQC MythBusters page:

https://www.cqc.org.uk/guidance-providers/dentists/dental-mythbuster-11-statutory-notifications-cqc

Case study direct from CQC MythBusters.

Examples of when a notification would and would not be necessary.

Example 4: serious injury or harm

Patient E visits the dental practice for a tooth extraction. The dentist talks patient E through the procedure before treatment and quickly scans the notes to identify the correct tooth. It is only afterwards that the dental nurse sees that a different patient's notes were consulted. The wrong tooth has been removed. The dentist must now refer patient E to another service for remedial treatment.

Is statutory notification to CQC required?

Yes. The injury:

- occurred in the practice while the services were being carried out in the delivery of the regulated activity and
- resulted in changes to the structure of the patient's body.

You must notify the CQC as soon as possible.

For more information on how to notify the CQC, please follow this LINK.

Wales

HIW Duty of Candour Statuary Guidance 2023 - The Duty of Candour Statutory Guidance 2023

Scotland

Recently, the Scottish Government launched a new duty of candour for all health, care, and social work services. This duty outlines how organisations should respond when an unexpected or unintended incident results in death or harm. This includes notifying the person affected and providing an apology and account of what happened. Organisations must also publish and submit an annual report on when the duty has been applied and what learning and improvements have been implemented in response.

NI

Northern Ireland also has its reporting requirements through the Regulation and Quality Improvement Authority.

LINKS/SOURCES

- British Association of Oral Surgeons – Help and Advice for Professionals
- NHS Improvement – Never Events policy and framework
- Scottish Government health policy – Duty of Candour
- Toolkit for LocSSIPs - LocSSIPs

Document Control

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Version	**Status**	**Date**	**Author / Editor**	**Details of Change** (Brief detailed summary of all updates/changes)
0.1	Final	21/07/2023	PG/HD	The policy was updated with guidance for all regulators on reporting and the duty of candour.
0.2	Final	21/8/23	PG	Final checks on the date of going live with a new policy
0.3	Final	21/06/24	PG	General check for updates in guidance**- no updates to add in**, grammar checked and corrected where needed to improve.

The latest approved version of this document supersedes all other versions, upon receipt of the latest approved version all other versions should be destroyed, unless specifically stated that previous version(s) are to remain extant. If in any doubt, please contact the document Author.

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