COMMENT

Letters to the editor

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Patient safety

Complication or never event?

Sir, we welcome the review of never events and serious events related to dentistry published in the *BDJ*[1] and support the promotion of a patient-safety culture, particularly in the field of oral surgery, through implementation of surgical safety checklists with the aim of reducing the risk of such events.[2]

We can all agree that we need to protect patients for avoidable harm; however, surgery is an inherently risky business – when do surgical complications become never events? A never event is a specific type of serious incident that must meet all of the following criteria: being wholly preventable; having the potential to cause serious patient harm or death; having occurred in the past and being easily recognisable and clearly definable.[3]

Renton and Sabbah state that 'unplanned retained or displaced tooth roots' constitute retention of foreign objects and, thus, a never event.[1] However, a 'foreign object' is defined as one that is subject to a formal counting/checking process except where the item is intentionally retained, or is known to be missing, and where further action to retrieve may cause more damage.[4] We submit that a retained or displaced root is not a foreign object and that such identifiable surgical risks should be discussed with patients as part of the informed consent process. Moreover, in order to maintain and enhance engagement with surgical safety processes, it is important that we do not cloud the distinction between surgical complications and never events.

A. Dargue, E. Fyfe

1. Renton T, Sabbah W. Review of never and serious events related to dentistry 2005-2014. *Br Dent J* 2016; **221:** 71–79.
2. Fyfe E C C, Fleming C. The WHO surgical safety checklist in a dental teaching hospital department of oral surgery - a model for implementation. *Oral Surg* 2016; **6:** 180–185.
3. NHS England. Revised Never Events Policy and Framework. 27 March 2015. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf (accessed October 2016).
4. NHS England. Never Events List 2015-2016. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf (accessed October 2016).

Professor Tara Renton responds: We welcome the question, by Dargue and Fyfe, regarding whether 'unplanned retained or displaced tooth roots' should be classified as a 'never event' (NE) in our recent publication.[1] By strict definition of NEs, by the serious event policy and framework, we agree that 'unplanned retained or displaced tooth roots' are not categorised as NEs.[2,3] However, our never event analysis highlighted that these events had been incorrectly reported as NEs,[1] and there is a need to clarify notifications regarding the specific surgical complications of 'unplanned retained or displaced tooth roots'.

The intended vital root retention (coronectomy) as part of a treatment plan with the consent of a patient is considered safe practice. However, if a further surgical intervention is required to manage recurrent infection or erupting roots, this, by definition, is moderate patient harm and is a notifiable safety incident (NSI) as stipulated by the CQC definition.[4]

The inadvertent retention or displacement of a vital apex of a root left in situ *after an unintended partial extraction, with subsequent patient notification, with no further intervention required, would also be considered safe practice.*

However, based upon the CQC definition of moderate 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*** *or* ***transfer*** *to another treatment area;'*

if a vital or non-vital unplanned retained or displaced tooth roots occurs, requires additional necessary intervention, this by definition, is moderate patient harm and is a notifiable safety incident (NSI) as stipulated by the by CQC definition.[4] In addition if either 'unplanned retained or displaced tooth roots' occurs and the patient is not informed, this is a matter of proberty, as outlined by GDC standards of Duty of Candour.[5]

In summary, we agree with A. Dargue and E. Fyfe, that in order to maintain and enhance engagement with surgical safety processes, it is important that the distinction between surgical complications, never events and notifiable safety incidents is not clouded. However, the understanding of notifiable events as distinct from never events, and the required reporting standards must be explicit.

1. Renton T, Sabbah W. Review of never and serious events related to dentistry 2005-2014. *Br Dent J* 2016; **221:** 71–79.
2. NHS England. Revised Never Events Policy and Framework. 27 March 2015. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf (accessed October 2016).
3. NHS England. Never Events List 2015-2016. Available online at https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf (accessed October 2016).
4. CQC statutory notifications. Guidance for registered providers and managers of Primary dental care. April 2015. Available online at https://www.cqc.org.uk/sites/default/files/20150331_100501_v6_00_guidance_on_statutory_notifications_ASC_%20IH_PDC_PA_Reg_Persons.pdf (accessed October 2016)
5. Being open and honest with patients when something goes wrong (GDC Duty of candour). Available online at http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Being%20open%20and%20honest%20with%20patients%20when%20something%20goes%20wrong.pdf (accessed October 2016).

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Holistic care

Vulnerable in pregnancy

Sir, I am writing with regard to a recent case which has highlighted the opportunity for the dental team to be involved in true holistic patient care. In this scenario, helping to ensure that a pregnant woman was receiving appropriate antenatal care, thereby serving as a safety net for a vulnerable adult.