NEVER EVENTS IN DENTISTRY

By **Ridah Hasan**

Mismatched blood transfusions. Foreign bodies left in a patient post-surgery. Hip replacement on the wrong side. Scalding a patient. Extraction of the wrong tooth.

All these things have one thing in common; they are all never events.

Never events are defined as patient safety incidents that are wholly preventable where guidelines or safety recommendations are available and have been implemented by healthcare providers.¹

An example of a never event in dentistry is the extraction of the wrong tooth. Although prior to June 2019, administering local anaesthesia at the wrong site was deemed a never event, the British Dental Association (BDA) successfully campaigned against this, and dental professionals no longer have to report such occurrences.²

NHS Improvement are a public body who oversee those who provide NHS-funded services. They are responsible for keeping patients safe and making sure the care the NHS provides is of a high quality. This includes preventing and monitoring never events.

Failure to report a never event is seen as a safety failing by NHS Improvement. In their Never Event Framework, NHS Improvement quoted Sir Liam Donaldson: 'to err is human, to cover up is unforgivable, and to fail to learn is inexcusable'.¹ A quote which is relevant to many aspects of life but particularly important when dealing with never events.

As a dental student, you may be understandably afraid of the repercussions of extracting the wrong tooth. What will the patient think? What will my tutor say? What if word gets around to other students? Will I have to forfeit my dental studies?

If you become involved in a never event, it is crucial that you stop what you are doing, inform your supervising tutor. You may get a telling off by your tutor, but you've done the right thing by reporting the incident. What follows depends on different dental hospitals. Usually, the tutor would have a chat with the patient to explain what has happened and if possible, what treatment can be carried out to best rectify the situation. The hospital may also require a DATIX form to be completed – this is a patient safety organisation to which incidents are reported.

In recognition of the possibility of wrong tooth extraction, the British Association of Oral Surgeons (BAOS) have developed a document which details the correct protocol to avoid a wrong site extraction. The Exemplar Wrong Site Extraction paper⁴ is part of a toolkit⁵ which includes a useful patient pathway that highlights the three Rs – Reposition, Recheck, Reaffirm – when carrying out an extraction. Here are some ways to prevent never events.

Make sure your tooth notation is clear

Tooth notations can confuse clinicians so make sure to write the UR6 as upper right first molar so that it isn't mistaken for another tooth.

Ask the patient why they are there

It's important that you are taking out the right tooth. Confirm this by checking the notes but also by asking the patient to point at the tooth. This will help confirm the notes are correct and informed consent can be gained from the patient.

Write down the procedure

In the Oral Surgery department at my

university, each dental chair has a whiteboard behind it on which we have to clearly right the patient's name, the procedure to be carried out and any relevant medical history. Even if you don't have this, write it on a piece of paper – clear for you, your nurse and your tutor. This will help make sure you're all on the same page and can keep checking that the correct tooth is being extracted.

Check. Double check. Triple check

Ensure you have the correct patient, correct arch, the correct side and count to make sure you have the correct tooth.

This may be tricky if it is difficult to differentiate the teeth. For example, there may be a missing 6 and the 7 and 8 may have closed its space. The previous dentist may have notated the current 8 as the 7 because of where it is located. This is why asking the patient to point at the tooth is useful.

There has been a massive rise in medical negligence claims to the NHS in the UK – the NHS had to pay out more than £1.6 billion to claimants in 2017/2018.³ Taking extra care at the start of the appointment and following a surgical checklist can prevent a never event from happening – saving the patient and yourself from a lot of stress and grief.

In the case of a never event, understand that mistakes can happen and use it as an opportunity to learn.

References

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<https://doi.org/10.1038/s41406-020-0112-3>