Dealing with an adverse incident

Alison Large, dento-legal adviser at the Dental Defence Union (DDU), explains how to respond to an adverse incident.

Unfortunately, despite the best of intentions of the dental team, it is inevitable that sometimes mistakes will be made in the dental practice. If an adverse event occurs, it is important to provide clear details of the difficulties encountered and consider any steps that can be taken to try and prevent a future occurrence. This gives the dental team an opportunity to learn and develop professionally. Conversely, attempting to cover up mistakes or blame individuals may inflame the situation, fuel mistrust and could lead to escalation.

What is an adverse incident?

An adverse incident can be defined as any event which causes, or has the potential to cause harm to patients, other members of the dental team or members of the public. Examples include:

- Clinical issues, such as the accidental extrusion of sodium hypochlorite during root canal procedure, wrong tooth extraction or a chemical burn when using acid etch
- System failure, such as poor IT security leading to the loss of sensitive patient data
- Administrative lapses, such as failing to send an urgent referral for a patient with a suspicious lesion.

It is important that staff feel comfortable and are trained to identify adverse incidents when they occur. There should be a clear process for raising concerns to a senior nominated individual, such as a line manager or the practice manager as outlined in Standards 8.3 and 8.4 of the GDC's *Standards for the dental team*.[1]

How to respond when something goes wrong

In its guidance on the professional duty of candour,[2] the GDC states that it is important for dental professionals 'to be open and honest with patients when something goes wrong with their treatment or care'. They state that when something goes wrong you must:

- Tell the patient, in a way they can understand and answer any questions
- Apologise
- Offer an appropriate remedy or support to put matters right (if possible)
- Explain the short- and long-term effects of what has happened.

Sometimes, dental professionals believe that apologising is an admission of legal liability which could be used against the individual in the event of a claim. This is not the case.

Although it is important to apologise, it can sometimes feel daunting – below are some tips for a successful verbal apology:

- Start by explaining what has happened. Once there is context, an apology can naturally follow. Don't speculate on reasons for what happened; just inform if further investigation is needed
- Speak as you would in a natural conversation, in the first person. 'I am very sorry that this happened' sounds more sincere and less defensive than 'The practice regrets…'
- Think about body language. Saying the right words while standing over the patient with arms folded may not seem like an apology at all
- Take your time and ensure you won't be interrupted
- Think of a meaningful apology as part of a process of restoring trust and be receptive to the patient's wishes
- You may decide to make a goodwill gesture in the circumstances, but this should never be seen as a substitute for a proper apology.

The apology should be from the most appropriate member of the dental team and should be documented in the patient's records.

The importance of the duty of candour

All practices should have procedures in place for what they need to do following an adverse incident. This legal (statutory) obligation is distinct from the ethical duty of individual dental professionals and applies to healthcare organisations, including general dental practices. The details are set out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended),[3] the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016[4] and the Duty of Candour Procedure (Scotland) Regulations 2018.[5]

From April 2023, the duty of candour also became a legal requirement for all NHS organisations in Wales as outlined in the Duty of Candour Procedure (Wales) Regulations 2023.[6]

It is a misconception that healthcare professionals may inadvertently admit legal liability if they apply the duty of candour. Nevertheless, it is always wise to contact your indemnity organisation for further advice and guidance.

Reflecting on an adverse incident

When a mistake is made, it is imperative that the response is appropriate. A suitable response will hopefully result in those affected feeling properly supported, reassured, and provide an opportunity to learn and improve.

Reflective practice is becoming increasingly significant as part of the GDC's enhanced CPD process and an adverse incident can help identify gaps in learning which you can incorporate in your personal development plan. However, patient identifiable information does not need to be included in a piece of reflective writing.

Undertaking a significant event analysis (SEA) can also help identify areas for development and address problems without placing blame on individual team members. It is useful for analysing more complex cases that have implications for the overall quality of care, rather than one-off mistakes.

The possibility of an adverse incident can never be eliminated entirely but practices can reduce the risk by taking steps to identify and address all significant threats to patient safety. If you have any concerns, contact your dental defence organisation for further advice.

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References

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