#PatientSafety #GHNHSFT
#GlosOralSurg #J2O #GHTFest19

Gloucestershire Hospitals
NHS Foundation Trust

Development of Outpatient 'LocSSIPs' for the Oral & Maxillofacial Department—the Gloucestershire Experience

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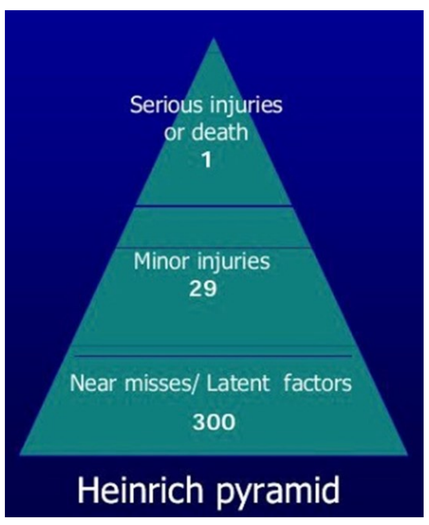
1) Background

- ***"Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous" - Sir Cyril Chantler 1998***
- Medical error may be the 3rd largest cause of death in the US
- Medical error can result in a significant and long-lasting impact on emotional & physical health and long-lasting loss of trust in healthcare (1)
- 'Wrong tooth extraction' = 6-9% of **all** 'Never Events' in the UK (2)
- 'Wrong tooth extraction' = 20-25% of **all** 'Wrong-site Never Events' in the UK (2)

2) How can we make patient care safer?

A direct relation exists between

- 'Major Incidents / Never Events' & 'Minor Incidents / Near-Misses'
- For every 1'Never Event' there will be 300 'Near-Misses'
- If we record, analyse & learn from the 'Near-Misses' we can hopefully prevent the 'Never Events'



'Safe systems should be designed considering "Human Factors" to reduce error towards zero' (3)

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'System process analysis should be undertaken with a view to mitigating human factors by 'Standardising, educating & harmonising' patient care episodes (4)

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'Near-Misses' offer learning opportunities in the absence of actual harm

3) Reducing Error - 'Safety Standards'

2009 World Health Organisation (WHO): Introduction of 'Surgical Safety Checklist'

- Reduction in mortality and in-patient complication rates observed
- Now standard in all UK operating theatres
- Proven to reduce error in both surgery & dentistry (5)

But also need

- Right culture & strong leadership in patient safety
- Standardised processes and evaluation & sharing of lessons learnt
- Empowered team & staff feedback

2015 NHS England publishes **'NatSSIPs'** guidance to address these very issues

- **Nat**ional **S**afety **S**tandards for **I**nvasive **P**rocedure**s**
- Based on 'Francis' & 'Berwick' Reports
- Aim to reduce patient safety incidents by enhancing the WHO process
- Based on analysis of 'Never Events', 'Serious Incidents' & 'Near-Misses'
- Covers all 'invasive procedures' out with the operating theatre

⇒ **Local speciality teams to develop Local Safety Standard *(LocSSIP)* based on audit, checklists & error reporting**

4) We developed a 'Local Safety Standard'

⇒ Standardised documentation

Pre & post-list team safety briefing & patient specific surgical safety checklist

⇒ Patient Safety Incident Trigger List (in addition to existing Datix system)

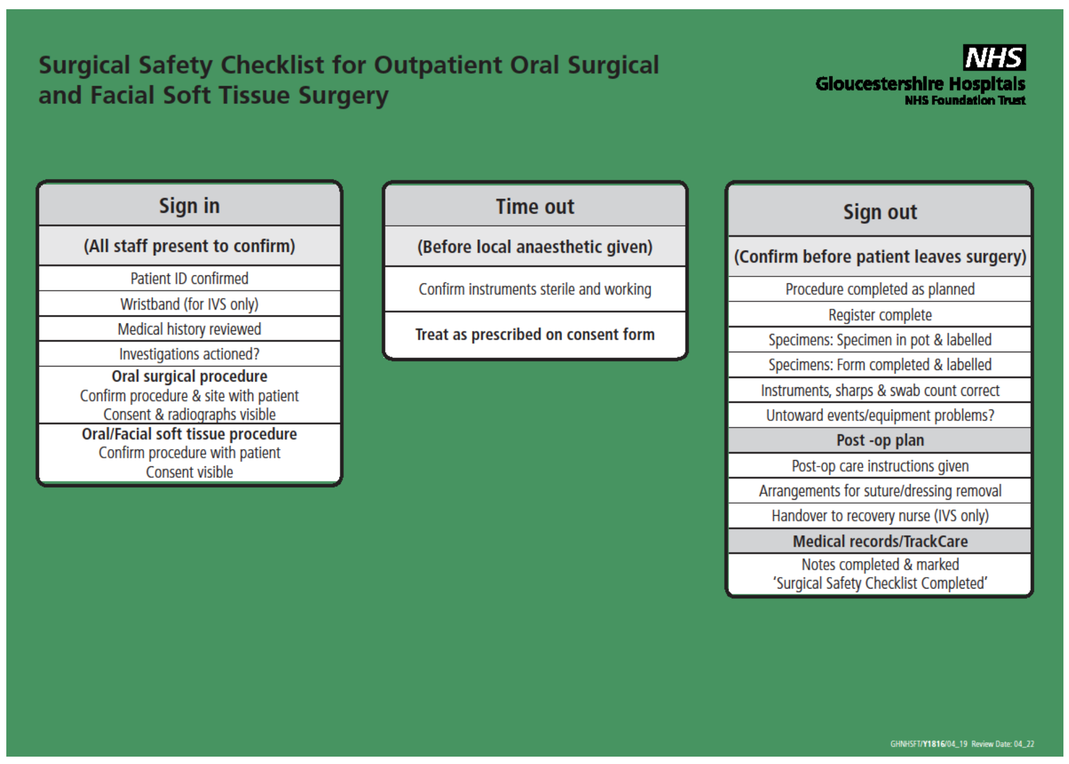
Bespoke data collection form accessible to all OMFS team on 'SharePoint'

⇒ Workforce / List Management Policy

Safe staffing levels & standardised booking process established

⇒ Change of practice staff survey performed

5) OMFS Surgical Safety Checklist



Surgical Safety Checklist for Outpatient Oral Surgical and Facial Soft Tissue Surgery

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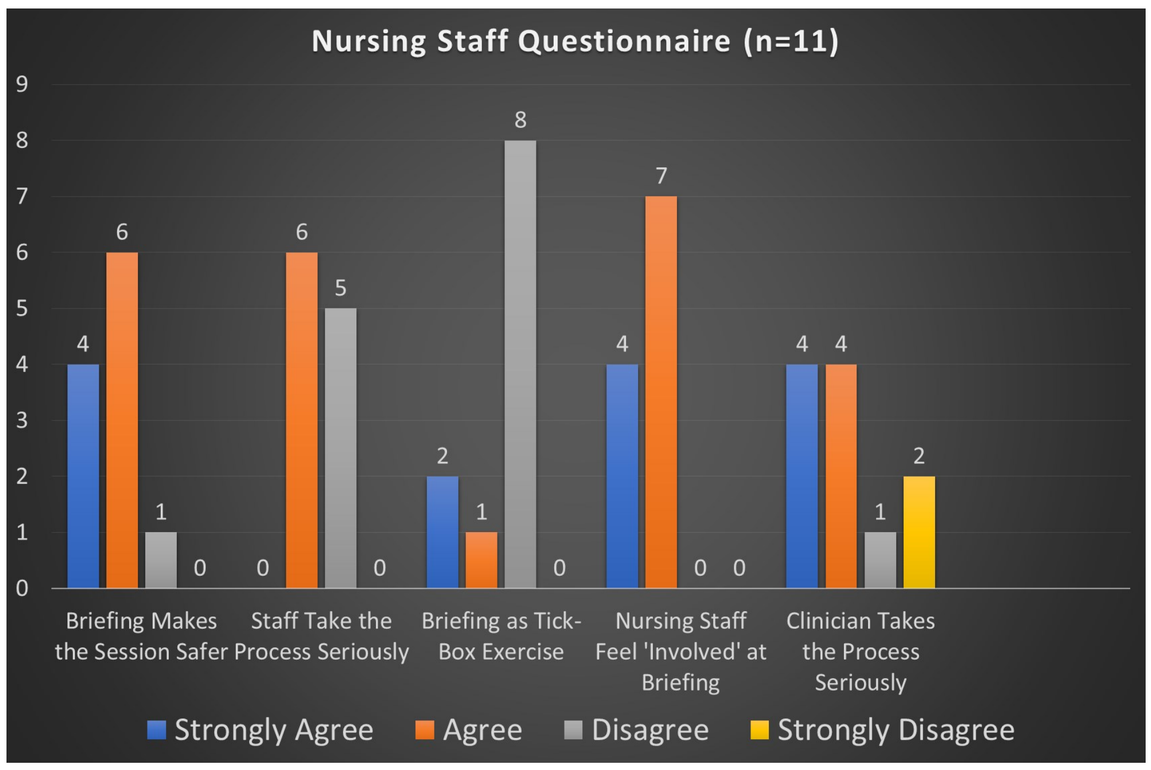
Sign in
(All staff present to confirm)
Patient ID confirmed
Wristband (for IVS only)
Medical history reviewed
Investigations actioned?
Oral surgical procedure Confirm procedure & site with patient Consent & radiographs visible
Oral/Facial soft tissue procedure Confirm procedure with patient Consent visible

Time out
(Before local anaesthetic given)
Confirm instruments sterile and working
Treat as prescribed on consent form

Sign out
(Confirm before patient leaves surgery)
Procedure completed as planned
Register complete
Specimens: Specimen in pot & labelled
Specimens: Form completed & labelled
Instruments, sharps & swab count correct
Untoward events/equipment problems?
Post -op plan
Post-op care instructions given
Arrangements for suture/dressing removal
Handover to recovery nurse (IVS only)
Medical records/TrackCare
Notes completed & marked 'Surgical Safety Checklist Completed'

GHNHSFT/Y1816/04_19 Review Date: 04_22

6) Staff Feedback



7) Conclusions

'To err is human, to cover up is unforgivable & failure to learn is inexcusable'
- Sir Liam Donaldson Chief Medical Officer 1998-2010

We have implemented a significant change in team practice

- Majority of nursing staff feel that the 'Safety Briefing' has made the session safer
- Work still required to engage those who do not see the benefits of the process
- Some staff still feel this is a 'box-ticking exercise' & ongoing staff involvement will be needed to address this & highlight process benefits
- Patients approve of adopting existing theatre safety checks to outpatient clinics
- No 'Never Events' reported so far (Jan 2018 on)
- Summary patient safety issues discussed at departmental QI meetings

⇒ **We would strongly encourage all specialities to develop their own 'LocSSIPs' to improve patient safety & boost team interaction**

Refs

1) www.betsylehmancenterma.gov 2) Pemberton et al. BJOMS. 2017.187-188 3) Nolan MBJ 2000

4) NHS Eng 2014 5) Haynes et al. NEJM 2009 & Bailey et al BMC Oral Health 2015