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'

3) Reducing Error - ‘Safety Standards’
- 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]
- 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
- 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
- 'Safe systems should be designed considering “Human Factors” to reduce error towards zero' [3]
- 'System process analysis should be undertaken with a view to mitigating human factors by 'Standardising, educating & harmonising' patient care episodes' [3]
- 'Near-Misses' offer learning opportunities in the absence of actual harm

6) Staff Feedback
- 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

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

Staff Feedback
- Patients strongly agree to improve patient safety & boost team interaction
- No ‘Never Events’ reported so far (Jan 2018 on)
- Summary patient safety issues discussed at departmental QI meetings
- We would strongly encourage all specialties to develop their own ‘LocSSIPs’ to improve patient safety & boost team interaction

Refs

#PatientSafety #GHNSFT #GlosOralSurg #J2O #GHTFest19

Development of Outpatient ‘LocSSIPs’ for the Oral & Maxillofacial Department—the Gloucestershire Experience
TFA Lees (Associate Specialist in OMFS) AN Beech (Consultant in Oral Surgery)