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Out of harm's way

Claire Morgan charts the 40-year path of evolving patient safety in dentistry

All healthcare professionals, including dentists, aim to do their job without harming their patients, but some may suffer harm and this is often preventable.

The patient safety movement began in medicine and rapidly evolved in the US with the publication of a landmark report, *To Err is Human: Building a Safer Health System*, in 1999. The often quoted, shocking detail in the *Francis Report* in 2013 further raised awareness in the UK. However, 10 years on, the UK press continues to be peppered with patient safety scandals hitting the headlines.

Maternity care has often been identified as an area of concern and has been subject to another high-profile investigation, the Ockenden Report, published this year. Globally, around one in 20 patients come to harm as a result of medical care, with one in 10 of those patients suffering permanent disability or dying as a result (Panagioti *et al*, 2019).

Dentistry lags medicine in patient safety, mainly attributable to lower mortality and morbidity rates. A leading light in patient safety in dentistry, Mike Pemberton, published his seminal piece, Developing Patient Safety in Dentistry, in the *British Dental Journal* in 2014. Five years later the NHS developed its first Patient Safety Strategy and produced a National Patient Safety Syllabus in 2021.

A Medline search of 1982 did not reveal any publication dedicated to patient safety in dentistry. However, a similar search of 40 years on revealed 86 such publications. During this time the bar has been set by the aviation industry with its scrupulous approach to accident investigation, learning and prevention.

In England it was not until 2009 that the Care Quality Commission (CQC) was born to regulate and inspect all health and adult social care practice in England, with similar bodies in the other three nations.

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Prior to this date there was no comparable scrutiny of inspection of dental practices. One of the highest impacts on patient safety in primary dental care practice arose from the Poswillo Report of 1990. Forty years ago dentists with often minimal training could administer general anaesthesia for patients in primary care. Despite documented evidence of preventable deaths, this practice was not banned in the UK until 2002.

Another huge stride forward in the protection of dental patients was the introduction of infection prevention control (IPC) practice, in part driven by the emergence of HIV in the early/mid 1980s. At that time, it was not unheard of for dentists to boil dental instruments and wipe down handpieces between patients, and not wear gloves even for dental extractions.

ON THE RECORD

Another major change has been the approach to record keeping: paper records were the only form of record keeping 40 years ago, with no supporting computers or information technology. The detail of record keeping in this era could be somewhat lacking: oral health assessment was often routinely documented as 'ex S&P' – as in, 'examination, scale and polish'.

This was all against the backdrop of the lack of regulation of dental nurses, for whom registration with the General Dental Council (GDC) only became compulsory 14 years ago. In 1982 dental nurses were referred to as dental surgery assistants (DSAs). Dental nurses are now recognised as an integral part of the dental team and encouraged to support patient safety and speak up by raising concerns. A further empowerment of dental nurses was move from 'dentist knows best' 40 years ago to the current concept of shared decision-making.

Prior to 2008, continuing professional development was not a requirement of registration with the GDC, with arrangements being left to personal choice. As the overarching regulatory body for dentistry, the GDC specifically addresses patient safety in the current standards of 2013, providing guidance for the dental team. GDC expectations are now directed towards scope of practice, whistleblowing, management of medical emergencies, IPC and record keeping as examples of prioritising patient safety.

> **"Openness and transparency are paramount to sharing and learning to reduce harm to patients"**

Reporting systems to facilitate shared learning from incidents have been slow to evolve and were not formalised 40 years ago. While secondary care has had this facility using systems such as DATIX for some years, it is only now with Learn from Patient Safety Events (LFPSE), as seen in England, that learning and sharing can become a reality that includes primary care.

The spotlight was thrown on dentists with the declaration by the NHS that wrong tooth extraction (WTE) was classified a Never Event in 2015. WTE emerged as the most common Never Event until it was removed from the qualifying list in 2021 due to the admission that it was not possible to prevent. While admitting mistakes and saying sorry has always been very much part of most health care professionals' ethos, there has been a reticence to do this for fear of admission of failure and the legal implications. Science has shown that patients are less likely to take legal action against healthcare professionals when they act openly and honestly.

MODERN-DAY RISKS

Along with established risk, there are a number of challenges that may not have been present or realised 40 years ago that place patients at increased risk of harm in dentistry. Risks include the management of our increasingly aged population, with multiple comorbidities treated with polypharmacy, retaining more teeth. Increasing health inequalities with poorer access to dental care, compounded by COVID-19, have led to higher levels of untreated oral disease, which has now been acknowledged as a reality (Marmot Review 2010/2020).

Dental implants using osseointegration were not available 40 years ago and have led to an elevated number of medico-legal claims. All dental care professionals should strategically embrace the concept of patient safety. A no-blame culture is a major driver to improving patient safety, with openness and transparency paramount to sharing and learning to reduce harm to all patients.

Below: Infection prevention control practices, such as single-use instruments and gloves were not introduced until the 1980s

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