BAOS
BRITISH ASSOCIATION OF ORAL SURGEONS
Promoting excellence in Oral Surgery through education, training and research for better patient care

BAOS Newsletter
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BAOS Feature

Patient Safety

Patient safety must be at the heart of everything we do in healthcare. The focus on this may appear to be a recent concern; however, the origins of this concept can be traced back to somewhere between the third and fifth centuries BC in the wording of the Hippocratic Oath which states: 'First do no harm'.

Oral surgeons will be aware of the Never Events framework and the impact of wrong tooth extraction being featured on the list of Surgical Never Events from 2015 to 2021. I feel that the inclusion of this on the list brought patient safety into sharp focus and it has led to the development of many of the patient safety initiatives we are now familiar with.

There is far more understanding now as to why error occurs, and we have more reliable approaches for managing the consequences of these events.

Human factors come into our work on a daily basis. When errors do occur, it is recognised that there are common factors that can make it more likely that people will make mistakes. These are:

- Lack of communication
- Distraction
- Lack of resources
- Stress
- Complacency
- Lack of teamwork
- Pressure
- Lack of awareness
- Lack of knowledge
- Fatigue
- Lack of assertiveness
- Norms (workplace culture)

There are also two useful acronyms used to describe the circumstances in which staff might become unsafe. These are:

Hungry Angry Late Tired (HALT)

Illness Medication Stress Alcohol Fatigue Emotions (IMSAFE)

It is important that we are aware of these factors so that we can endeavour to mitigate these so that their impact on us is minimised. If we reflect on our own mistakes and oversights, this list and the acronyms will resonate with us.

Much of the work on patient safety has focused on retrospective analysis of incidents and the attempts at learning from these including the use of root cause analysis. This approach assumes that when errors occur, it is due to deviations from standard, successful care with a focus on what went wrong rather than what went right. This approach is termed 'Safety I'. More recently, an approach termed 'Safety II' has been suggested.

The theory behind this is that errors are actually rare, and we need to focus on why we have successful outcomes the majority of the time. We need to examine the resilience in the systems we work in. These approaches are summarised in the table below:

	Safety I	**Safety II**
Definition	Things only go wrong on rare occasions	Most things go to plan
Humans / Workforce	Can be seen as a hazard / liability	Necessary resource
Management principal	Reactive approach. Responds to incidents.	Proactive, anticipates events and considers the impact that changes will have
Purpose of investigation	Identify the causes of failings	Understand what works well to explain why things occasionally go wrong
Risk Asses	Identify causes from investigations/ contributary factors	Understands that performance variability in complex systems is difficult to monitor/control.

Oral surgeons should be making efforts to create a patient safety culture where safe care is delivered through:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all.

We should also strive for a 'just culture' where staff will not feel blamed or be disciplined for errors. NHS England has created a Just Culture Guide which aims to support consistent, constructive, and fair evaluations of the actions of staff involved in patient safety incidents. This acknowledges that the majority incidents are due to deeper causes than the actions of one individual. It also includes aspects about the individual involved and whether there is a need for disciplinary or regulatory action, this will rarely be necessary, however, it is a fundamental aspect of patient safety and especially relevant to dentistry.

When patient safety incidents do occur, it is recognised that support for the healthcare workers involved is important in preventing such incidents from occurring in the future. The term 'second victim' is sometimes used to describe the psychological harm caused to the clinical team involved in the incident.
It is widely recognised that a six-stage cycle occurs in the aftermath of an event:

1. Chaos and accident response
2. Intrusive reflections
3. Restoring personal integrity
4. Enduring the inquisition
5. Obtaining emotional first aid
6. Moving on

Providing emotional and psychological support to those involved can help them to progress through this cycle more rapidly.

In the autumn of 2023, the process for serious incident reporting changed. This is known as the Patient Safety Incident Response Framework. This new system aims to develop a 'Just Culture' rather than fostering blame. It seeks to encourage curiosity about what happened and why, in a safe space where individuals don't feel under threat. It is about doing it better next time rather than finding fault. The new system will allow national data collection of incidents so that themes can be identified, and solutions can be explored.

Another recent initiative by NHS England via the Office of the Chief Dental Officer is known as Project Sphere. The project aims to develop safety initiatives in Dentistry and to deal with the blame culture which is often cited in Dentistry.

In conclusion, whichever ways patient safety incidents are handled and investigated, we all need to work to ensure that patients and clinicians are supported through the process.

References and further reading:

Bailey, E. and Dungarwalla, M. (2021), 'Developing a Patient Safety Culture in Primary Dental Care', Primary Dental Journal, 10 (1), 89-95.

Carthey, J. (2019), 'Creating Safety II in the operating theatre: The Durable Dozen!', Journal of Perioperative Practice, 29 (7-8), 210-15.

Lachman P, Brennan J, Fitzsimons J, Jayadev A, Runnacles, J. (2022), Oxford Professional Practice Handbook of Patient Safety. Oxford University Press: Oxford.

Learning from patient safety events, 2023: https://record.learn-from-patient-safety-events.nhs.uk

NHS England and NHS Improvement Just Culture Guide: https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf

NHS England. Safety culture: learning from best practice. 2022. https://www.england.nhs.uk/wp-content/uploads/2022/11/B1760-safety-culture-learning-from-best-practice.pdf

NHS Patient Safety, Project Sphere: https://www.england.nhs.uk/primary-care/dentistry/leading-the-change/patient-safety/

Ed Bailey

BAOS Council Member

Send me the link – Or is there a QR Code?

We cannot deny that technology is the way forward in all aspects of life. Putting aside a Terminator-style digital takeover, all forms of technology and AI will become a part of everyday life in a useful way. With our phones we have all the information in the world at our fingertips. I'm sure many clinicians recognise this is increasingly becoming part of our practice! Comments such as, 'So I Googled it and it says…....' or 'I saw a video of a wisdom tooth extraction, it was gross!' are common phrases heard in consultations these days.

There's no way to stop this information tidal wave, but we must be wary of the issues it can bring. Misinformation can be a real issue.

Shining a spotlight on the BAOS website, big changes are coming to help us all with this. Giving patients access to credible, reliable and, importantly, easily accessible information is vital, so we are focusing our efforts to overhaul the patient area of our website. We hope to create an area clinicians can direct patients toward where there is a variety of media to help explain, demonstrate and educate patients in regard to all things Oral Surgery. From videos to pictures, information leaflets to useful links, we hope this will become a go-to resource for all

By developing this, we hope to minimise misinformation and provide a reliable resource to which we can all direct patients. Watch this space as we make some positive changes!

Jack Williams

BAOS Social Media Representative

SAS Grades

Adrian Curtis

BAOS Council Member

Those of us who work as SAS practitioners and are members of the BDA have recently received a ballot paper from the BDA. This is about the SAS pay dispute 2023 in England.

If you have received a ballot paper, then I strongly recommend you complete it. Voting yes does not mean that you will have to strike if the ballot approves industrial action. It only allows industrial action to occur. At the time of such action individual BDA/BMA members can decide if they wish to strike or not. Details available at:

Restoring pay for SAS doctors in England (bma.org.uk)

SAS and primary care practitioners who are not on the specialist list should be aware that the GDC is working its way through the backlog of specialist applications. A new assessment process for SLAA (Specialist List Assessed Applications) has been introduced with more assessors appointed across all specialities. Details available at:

Specialist list assessed applications resume at pace (gdc-uk.org)

As part of my wider reading, I have become aware of a new term “Rust out” (1) this is a term used to define chronic boredom due to unstimulating work. As an SAS doctor I can identify with this. It is important for SAS grade to have additional roles to avoid this. The main headings I think off when looking for additional roles are

- Education
- Management
- Medical politics
- Compliance

You can look for opportunities in these fields at a local, regional or national level

(1) https://www.mindtools.com/blog/what-is-rust-out-meet-burnouts-boring-alter-ego/