Preventing Wrong Tooth Extraction

Vađenja pogrešnoga zuba

Introduction

Although no longer a “never event”, wrong-site tooth extraction (WSTE) is the most common serious patient safety incident in dentistry. Safety checklists have significantly reduced wrong-site surgery, although their benefit is unproven in primary care dentistry. Our quality improvement project developed and implemented a checklist optimised for oral surgery procedures in primary care to reduce WSTE risk. Material and Methods: Local best practice for tooth extraction record-keeping (LBP), using national guidelines and standards was devised. We then retrospectively audited tooth extraction record-keeping against LBP. Deficiencies in current record-keeping practice were identified and used to design a checklist aimed at improving compliance. We provided a computerised safety checklist compliant with LBP to eleven clinicians at three general dental clinics within our region. The checklist included a pre-operative safety check, a pause to re-confirm the surgical site and a post-operative record-keeping proforma. The checklist was linked to our record-keeping software for use during tooth extraction. We audited checklist completion and compliance with LBP fortnightly for ten weeks. Results: The introduction of a safety checklist resulted in increased compliance with LBP for tooth extraction record keeping. At week ten, 67% of records contained the computerised safety checklist. This resulted in a 50% increase in overall compliance with LBP for tooth extraction compared to baseline. Conclusions: A computerised safety checklist for tooth extraction in primary care has potential to improve patient safety by adopting measures to prevent WSTE and standardising communication between clinicians. Checklists in general practice should be encouraged.

Uvod

Vađenje pogrešnoga zuba najčešći je ozbiljni incident s pacijentima u Nacionalnoj zdravstvenoj službi (NHS) (1). Istraživanje među stomatolozima iz 2016. u Walesu u Velikoj Britaniji, pokazalo je da je 12 % kliničara tijekom svoje prakse izvadilo pogrešan zub te se ističe da to nije rijedak slučaj. Istraživanjem je također otkriveno da se samo 25 % kliničara koristilo prihvaćenom kontrolnom listom za vađenje zuba (2).

Opću stomatološku službu South Powysa čini jedanaest stomatologa s velikim rasponom kompetencija kad je riječ o oralnoj kirurgiji. Većina njih radi na više mjesta pa različiti kliničari izrađuju plan terapije i obavljaju potrebne liječenje povećavajući tako rizik od vađenja pogrešnoga zuba (3). Uzroci za vađenje pogrešnoga zuba višefaktorijski su i mogu se klasificirati u aktivne pogreške, poput ljudskih, i latentne koje se pojavljuju zbog loših radnih i organizacijskih uvjeta (3). U radu u kojemu se analiziraju profesionalne pogreške u Izraelu utvrđeno je da se većina dogodila zbog loše komunikacije između kliničara (4). Nadalje, u korejskim studijama identificirani su čimbenici rizika specifični za zube, uključujući više zuba planiranih za vađenje, djelomično iznike zube i zube izrazito oštećene karijesom (5). Dvosmisljeni zapis o zubu također povećava rizik od pogrešnoga vađenja, osobito ako pacijentima zubi nedostaju (3). To je u
teeth (3). This correlates with a study of Welsh general dental practitioners which found that 50% of WSTEs were prior to orthodontics (2).

155 WSTEs were reported to NHS England between 2015-19 (1). A systematic review showed that surgical checklists are a simple strategy for improving patient safety culture and are associated with increased detection of hazards and improved communication amongst team members (6).

The vast majority of patient safety research in dentistry has taken place in secondary care. However, 95% of dental treatment in the United Kingdom is performed in primary care (7), and specialist Oral Surgeons are increasingly working from dental practices (8). Currently there is no evidence demonstrating the effectiveness of safety checklists in general dental practice (7). However, general dental practitioners are knowledgeable about patient safety and are keen to adopt evidence-based interventions to drive improvement (9).

We aimed to explore whether implementing a patient safety checklist reduced the risk of WSTE in general dental practice by defining LBP record-keeping for tooth extraction and undertaking a quality improvement project to evaluate the effect of checklist implementation.

Material and methods

Model of Improvement

Our quality improvement project utilised plan, do study, act (PDSA) cycles. The project’s aim was for all clinical records for non-surgical tooth extraction in South Powys GDS to adhere to LBP by March 2021. The project’s outcome measure was the percentage of records for non-surgical tooth extraction complying with LBP, with a corresponding process measure assessing the percentage of records for non-surgical tooth extraction containing the safety checklist. The NHS research ethics committee decision toolkit was used to determine that this project did not require ethical approval.

Development of Local Best Practice

LBP was designed and optimised for non-surgical tooth extraction under local anaesthetic, using the Faculty of General Dental Practice (UK) Clinical Examination and Record-Keeping: Good Practice Guidelines (10), Oral Surgery Local Safety Standards for Invasive Procedures (LocSSIP) (11) and a consensus discussion between clinicians. LBP consisted of 5 domains: LocSSIP, pre-operative details, local anaesthetic, intraoperative details and post-operative details (Table 1).

Baseline Compliance

A pilot study retrospectively assessed compliance with LBP generating baseline data and facilitating the creation of an intervention. We analysed 28 non-surgical tooth extraction records obtained from the Software of Excellence computerised record-keeping system. The patients were treated by two general dentists at one South Powys GDS clinic. A data collection sheet was designed to collect all data defined korelacji s istraživanjem općih stomatologa iz Waleza u kojem je istaknuto da se 50% pogrešnih vađenja dogodilo prije ortodoncije (2).

Između 2015. i 2019. godine engleskome NHS-u prijavljeno je 155 pogrešnih vađenja (1). Sistematizirani pregled rad pokazao je da su kirurški kontrolni popisi jednostavna strategija za povećanje sigurnosti pacijenata i povezani su s većim otkrivanjem opasnosti i boljom komunikacijom među članovima tima (6).

Velika većina istraživanja o sigurnosti pacijenata u stomatologiji bavila se sekundarnom zaštitom. Međutim, 95% liječenja zuba u Ujedinjenom Kraljevstvu provodi se u primarnoj zdravstvenoj zaštiti (7), a specijalizirani oralni kirurzi svečešće radite u operacijama (8). Trenutačno nema dokaza koji upućuju na učinkovitost kontrolnih popisa za povećanje sigurnosti u općoj stomatološkoj praksi (7). No opći stomatolozi svjesni su koliko je važna sigurnost pacijenata i žele usvojiti intervencije utemeljene na dokazima za poticanje poboljšanja (9).

Cilj je bio istražiti je li vođenje kontrolnog popisa smanjilo rizik od vađenja pogrešnog zuba u općoj stomatološkoj praksi definiranjem najbolje lokalne prakse vođenje evidencije i provedbom projekta o poboljšanju kvalitete za procjenu učinka implementacije kontrolnog popisa.

Materijal i metode

Model poboljšanja

Naš projekt o poboljšanju kvalitete uključivao je cikluse planiranja, proučavanja i djelovanja (engl. plan, do, study, act PDSA). Cilj je bio da svi stomatolozi u South Powys GDS-u slijede u kliničkim zapisima o vađenju zuba najbolju lokalnu praksu do ožujka 2021. Ishod projekta mjerenc je kao postotak zapisa o neoperativnom vađenju zuba u skladu s najboljom lokalnom praksom, s odgovarajućim postotkom zapisa o neoperativnom vađenju cije sladavšću sigurnosnu kontrolnu listu. Priručnik za odlučivanje Etičkog povjerenstva NHS-a korišten je kako bi se potvrdilo da za ovaj projekt nije potrebno odobrenje toga tijela.

Razvoj najbolje lokalne prakse

Koristeći se Smjernicama za klinički pregled i vođenje evidencije za fakultete i stomatološke ordinacije (UK) za nekirurško vađenje zuba u lokalnoj anesteziji (10), lokalnim sigurnosnim standardima oralne kirurgije za invazivne zahvate (LocSSIP) (11) i konsenzusnom raspravom između kliničara, razvijena je i optimizirana najbolja lokalna praksa. Sastojala se od pet područja: LocSSIP-a, preoperativnih detalja, lokalnoga anestetika te intraoperativnih i postoperativnih detalja (tablica 1.).

Početna usklađenost

U pilot-istraživanju, generirajući osnovne podatke i olakšavajući razradu intervencije, retrospektivno je procijenjena usklađenost s najboljom lokalnom praksom. Analizirano je 28 zapisa o vađenju zuba dobivenih iz računalnog sustava za čuvanje podataka Software of Excellence. Pacijente su liječila dva opća stomatologa na klinici GDS u South Powysu. Za prikupljanje svih podataka definiranih kao najbolja lokal-
as local best practice for non-surgical tooth extraction. Clinicians were calibrated prior to collecting data.

Baseline Results

The initial study found that overall compliance with LBP was poor, with LBP achieved in only four categories. 12 of the 17 LBP features were present in over 50% of records. However, none of the records achieved complete compliance with LBP (Fig.1).

Intervention

Baseline results highlighted the need for improvement in record-keeping standards for non-surgical tooth extraction. Potential interventions were mapped on an ease-benefit matrix (Fig. 2). A computerised safety checklist was deemed the most appropriate intervention due to its ease of implementation and high likelihood of improving LBP compliance.

A computerised safety checklist corresponding with LBP was created on Software of Excellence (Fig. 3). The checklist consisted of three phases. The “sign-in” phase, completed before delivery of local anaesthetic, is used to check the patient’s identity and medical history, confirm the surgical site with the patient and dental team, ensure that relevant investigations are available and that procedural risks are discussed. The “time-out” phase is a definite pause before applying instruments to the tooth, re-confirming the surgical site before extraction. The “sign-out” phase is completed after the tooth has been extracted to identify any operative complications, ensure the patient has received post-operative instructions and that records comply with LBP.

10 GDS dentists and one dental therapist consented to participating in the study. The checklist was linked to all participants Software of Excellence accounts and instructions for its use were provided. When clinicians treatment planned an extraction, the checklist automatically became available. All non-surgical extractions completed by participating clinicians were audited against LBP using a data collection sheet.

na praks za neoperativno vađenje zuba pripremljena je lista za prikupljanje podataka. Kliničari su calibrirani prije prikupljanja podataka.

Početni rezultati

Početno istraživanje pokazalo je da je ukupna usklađenost s najboljom lokalnom praksom bila loša, a najbolja praksa postignuta je samo u četiri kategorije. U više od 50 % zapisa bilo je upisano 12 od 17 značajki najbolje lokalne prakse. No nijednim zapisom nije se postigla potpuna usklađenost s najboljom lokalnom praksom. (slika 1.).

Intervencija

Početni rezultati pokazali su da je potrebno poboljšati standard vađenja evidencije neoperativnoga vađenja zuba. Potencijalne intervencije su mapirane (slika 2.). Digitalni sigurnosni kontrolni popis ocijenjen je kao najprikladnija intervencija zbog svoje jednostavnosti u provedbi i velike vjerojatnosti da će se poboljšati usklađenost s najboljom lokalnom praksom.

Digitalni sigurnosni kontrolni popis koji odgovara najboljoj lokalnoj praksi izrađen je u programu Software of Excellence (slika 3.). Sastoji se od triju faza. Tako faza prijave završava prije davanja lokalnog anestetika. Prijava se koristi za provjeru identiteta pacijenta i povijesti bolesti, s pacijentom i stomatološkim timom potvrđuje se mjesto vađenja, osigurava se dostupnost relevantnih nalaza i raspravlja o proceduralnim rizicima. Faza time-out zapravo je stanka prije postavljanja instrumenta na zub, čime se ponovno potvrđuje mjesto vađenja prije same ekstrakcije. Faza odjave dovršava se nakon vađenja zuba radi identifikacije bilo kakvih komplikacija tijekom operacije, provjerava se je li pacijent dobio postoperativne upute i jesu li zapisi u skladu s najboljom lokalnom praksom.

Ukupno 11 stomatologa pristalo je sudjelovati u istraživanju.

Kontrolni popis bio je povezan sa svim korisnicima računa programa Software of Excellence i dane su upute za njegovu uporabu. Kad su liječnici planirali ekstrakciju, kontrolni popis automatski je postao dostupan. Sva neoperativna vađenja koja su obavljala stomatolozi revidirana su prema najboljoj lokalnoj praksi s pomoću tablice za prikupljanje podataka.

| LocSSIP | Pre-Operative | Local Anaesthetic | Intra-Operative | Post-Operative |
|---------|---------------|-------------------|-----------------|---------------|
| Assistant • Asistent | Medical History • Anamneza | LA Site • Mjesto LA-e | Instruments Used • Korišteni instrumenti | Haemostasis Confirmed • Hemostaza |
| Patient Details • Detalji o pacijentu | Pre-Op Risks / Consent • Preoperativni rizici/pristanak | LA Solution • Dropina LA-e | Apices Extracted • Izvadeni zub | Post-Op Instructions • Postoperativne upute |
| Diagnosis • Dijagnoza | Patient Eaten • Je li pacijent jeo? | LA Dose • Doza LA-e | |
| Treatment Plan • Plan terapije | | LA Batch Number • Serijski broj LA |
| Radiographs Displayed • Analiza rendgena | | LA Expiry Date • Rok valjnosti LA-e |
| Site Confirmed • Potvrda mjesta vađenja | | | Confirm Anaesthesia • Potvrda uspjeha anestezije |
Results

Ten dentists and one dental therapist performed seventy non-surgical tooth extractions at three GDS clinics over ten weeks.

The median percentage checklist completion over ten weeks was 75.5%. Initial uptake was low, with only 18% of records containing the safety checklist at two weeks. Check-

Rezultati

Ukupno 11 stomatologa u deset je tjedana obavilo sedamdeset neoperativnih vađenja zuba u trima klinikama GDS-a. Srednji postotak ispunjenosti kontrolnoga popisa tijekom tih deset tjedana iznosio je 75,5 %. Početni unos bio je nizak – poslije dva tjedna samo je 18 % zapisa sadržavalo sigurnosni kontrolni popis. Popunjavanje kontrolnoga popi-
list completion significantly increased, reaching 94% at week eight before falling to 67% at week 10 (Fig. 4). 56 of the 70 records assessed contained the safety checklist.

We defined overall compliance with LBP as the presence of all record-keeping features in each of the five domains. Median compliance with LBP was 39.5%. Initial compliance with LBP was low, reaching 9% at two weeks. Compliance peaked at 77% in week four before falling to 29% at week eight and rising to 50% at week 10 (Fig. 4). When clinicians used the safety checklist, we noted weaknesses in naming the assistant for the procedure and recording local anaesthetic details. Compliance with LBP for each domain is explored below.

The LocSSIP domain of LBP consisted of six record-keeping features: Name of assistant, patient details checked, diagnosis recorded, treatment plan checked, radiographs displayed, and site confirmed with the patient and dental team. Compliance with the LocSSIP domain was 9% at two weeks. LocSSIP compliance peaked at 82% in week six and fell to 50% at week ten. Weaknesses in compliance with the LocSSIP domain were predominantly due to failures in recording patient details and displaying radiographs.

We defined compliance with the pre-operative details domain of LBP as the presence of three record-keeping features: Relevant medical history and allergies detailed, pre-operative risks and discussion of consent detailed and patient eaten. Compliance with the pre-operative details domain dropped from a baseline of 46% to 18% at week two, peaking in week six at 91% before falling to 50% at week 10. The recording of medical history (93%) and pre-operative risks/consent (90%) was strong. However, recording of whether the patient had eaten was poor, being present in 67% of records.

Compliance with the local anaesthetic (LA) domain of LBP was defined as the presence of six record-keeping features: LA site, solution, dose, batch number, expiry date and confirmation of successful anaesthesia. After introducing the safety checklist, compliance with LA local best practice was 36% at two weeks. LA compliance peaked at 85% in week four before falling to 61% at week 10. Weak LA compliance resulted from the poor recording of anaesthetic batch number and expiry dates, present in 71% and 70% of records, respectively.

We defined compliance with the intra-operative details domain of LBP as the presence of two record-keeping features: instruments used for tooth extraction and confirmation of complete tooth extraction. Compliance with intra-operative details was strong, increasing from 54% at baseline to 100% at week two. We also achieved 100% compliance with recording intra-operative details in weeks six and eight, with the lowest compliance recorded at 92% in week 4.

Compliance with the post-operative details domain was defined as the presence of two record-keeping features: haemostasis and delivery of post-operative instructions. Compliance in this domain was strong, falling from 100% at baseline to 91% at week two before maintaining 100% compliance in weeks four to ten (Fig. 5).
Discussion

We carried out a quality improvement project to improve record-keeping standards for non-surgical tooth extractions in primary care, to protect patients and the dental team against WSTE. Since implementing a computerised safety checklist in our service, there have been no serious patient safety events or WSTEs.

In the absence of a serious patient safety event, a key measure of success was whether using the computerised safety checklist resulted in increased compliance with LBP record-keeping for non-surgical tooth extraction. This is a strong indicator of patient safety as implementing a surgical safety checklist has been linked with a reduction in harm to patients undergoing tooth extraction (3,6,12).

After ten weeks we found that checklist completion led to increased compliance with LBP record-keeping in a primary care setting. Informal conversations with clinicians revealed that they found the computerised safety checklist accessible and efficient, increasing the likelihood of usage and potentially reducing the high levels of workplace stress experienced by dental professionals (13,14). However, at week 8, 94% of records contained a safety checklist, but only 29% complied with LBP.

Weaknesses in compliance with LBP in the presence of a safety checklist were generally the result of failure to record the assistant's name and the LA batch number and expiry date. There was no dedicated area in the checklist for the clinician to name their assistant. This error in checklist design relied on the clinician to record the assistant's name in a free text box. There is no legal or obligatory requirement to record LA batch number and expiry dates (15). However, we included this as part of LBP because in our department we do not operate a robust system to track LA. We postulated that clinicians did not record LA details as this required the clinician to refer back to the cartridges after surgery. The cartridges' information is displayed in small font, and cartridges are often discarded before the end of surgery. To rectify this weakness in compliance, we aim to introduce a white board system where LA details are updated before each session.

Our study demonstrated the benefit of implementing a safety checklist for non-surgical tooth extraction in primary care to protect patients by ensuring compliance with LBP record-keeping and standardising communication between clinicians. However, data was collected over a short timeframe from three general dental clinics with similar demographics, limiting generalisability.

Furthermore, implementation of a safety checklist is one small part of four strategic areas identified by Pemberton (16) when developing a patient safety culture in dentistry:}

Usklađenost s domenom postoperativnih detalja definirana je kao bilježenje dviju značajki vođenja evidencije – hemo- staze i davanja postoperativnih uputa. Usklađenost u toj domeni bila je velika, no pala je sa 100 % na početku na 91 % u drugome tjednu prije nego što se vratila na 100 % u četvr- tome do desetome tjednu (slika 5.).

Rasprava

Projekt o poboljšanju kvalitete proveden je kako bi se poboljšali standardi vođenja evidencije o neoperativnom vađenju zuba u primarnoj zaštiti da bi se zaštitili pacijenti i stoma- tološki tim od vađenja pogošnog zuba. Poslije uvođenja u našu službu digitalnoga sigurnosnog kontrolnoga popisa nije bilo ozbiljnijih događaja u vezi sa sigurnošću pacijenata ili vađenja pogošnog zuba.

Ključna mjera za izbjegavanje ozbiljnih incidenata, kad je riječ o pacijentima, bila je potreba digitalne sigurnosti li- ste, što je rezultiralo povećanom usklađenostišću s evidencijom najbolje lokalne prakse za neoperativno vađenje zuba. To je snažan pokazatelj sigurnosti pacijenata jer je vođenje kontrolnog popisa povezano sa smanjenjem štetnih događaja pri va- denju zuba (3, 6, 12).

Nakon deset tjedana ustanovljeno je da je ispunjavanje kontrolnoga popisa povećalo usklađenost s vođenjem eviden- cije o najboljoj lokalnoj praksi u ustanovama primarne zdrav- stvene zaštite. Neformalni razgovori s kliničarima otkrili su da se digitalni sigurnosni kontrolni popis smatra pristupačnim i učinkovitim, što povećava vjerojatnost upotrebe. Me- đutim, u ošmnom je tijeku 94 % zapisa sadržavalo sigurnosni kontrolni popis, ali samo je 29 % bilo u skladu s najboljom lokalnom praksom.

Nedostatci, kad je riječ o usklađenosti s najboljom lokal- nom praksom u sigurnosnom kontrolnom popisu, najčešće su bili rezultat neuspjeha evidenciranja imena asistenta, se- rijskoga broja lokalne anestezije i roka njezine valjanosti. Na popisu za provjeru kliničar nije imao gdje upisati ime svoje asistente. Taj propust u kontrolovljene popise navodio je klini- čara da ime asistenta zabilježi u neki slobodni okvir za tekst. Ne postoji pravni ili obvezni zahtjev (13) za evidenciranje se- rijskoga broja lokalne anestezije i njezina roka valjanosti (13). Međutim, to smo uključili kao dio najbolje lokalne prakse jer na našem odjelu nemamo strogi sustav za praćenje lokal- ne anestezije. Pretpostavili smo da kliničari nisu bilježili poje- dinosti o anesteziji jer je se od njih nije zahtijevalo da nakon zahvata ponovno pregledaju ampule. Podatci na ampulama navedeni su sitnim slovima i one se često bacaju prije kraja zahvata. Kako bi se ispravio taj nedostatak u skladu s pravili- ma, nastoji se uvesti sustav bijele ploče u kojem se detalji o anesteziji ažuriraju prije svih sesije.

Naše je istraživanje pokazalo korist od ispunjavanja sigur- nosnog kontrolnoga popisa za neoperativno vađenje zuba u primarnoj zaštiti radi zaštite pacijenata, osiguravajući usklađenost s evidencijom najbolje lokalne prakse i standardizirajući komunikaciju među kliničarima. No podatci su pri- kupljeni u kratkom razdoblju u trima općim stomatološkim klinikama sa sličnom demografijom, čime su ograničeni za- ključci o općoj populaciji.
1. Incident reporting; 2. Evaluating incidents to identify best practice; 3. Communication and education about patient safety; 4. Building a safety culture

Although safety checklists have shown promise in reducing harm to patients undergoing dental procedures, Saksena (3) reported multiple WSTEs, despite introducing a safety checklist in a large teaching hospital. There is also some concern surrounding the notion that implementing a safety checklist improves patient care, with the nuances of checklist culture requiring further exploration (7).

Our experience was that the safety checklist was often used as a “box-ticking exercise”, with clinicians failing to record the “sign-in” process before the procedure and neglecting to undertake a formal pause for site verification. This view is supported by Saksena (3), who identified deficiencies in teamwork and communication leading to poor compliance with patient safety measures in the presence of strong checklist compliance.

Safety checklists are a powerful tool in the patient safety armamentarium for reducing the risk of WSTE. They act as an aide-mémoire and standardise record-keeping procedures. However, for checklists to be effective, they must be used correctly and contribute to the broader departmental safety culture. We must take a pro-active approach to patient safety and avoid becoming comfortable in the absence of adverse patient safety incidents. All team members must understand their role, communicate effectively, have accountability for their actions and feel empowered to voice any ideas or concerns (3,7). Empowering team members and creating a blame-free environment stems from effective leadership. Patient Safety First recommends introducing patient safety champions at all seniority levels within an organisation (3). Workforce training is also key to ensuring patient safety and should start at undergraduate level for clinicians, continuing through their career (17). A systematic review demonstrated that involving junior staff in a training session on wrong-site surgery and clinical guidelines resulted in a reduction in the incidence of WSTE (18).

To further investigate the role of safety checklists in preventing WSTE, we must refine our checklist for use in primary care and ensure that it complies with LBP. Firstly we will formalise initial discussions held during this study by undertaking a series of structured interviews with participating clinicians to investigate their views on patient safety culture and gather suggestions for checklist optimisation. We will then undertake a second PDSA cycle to assess changes in compliance with LBP and checklist completion. We will also build upon our departmental patient safety culture by appointing staff champions and ensuring that all staff receive patient safety training.

Patient safety is a relatively new concept within primary care dentistry, although it is strongly supported by general dental practitioners (7,9). We intend to expand our quality improvement project to a wider cohort of general dental practices to benefit the greatest number of patients and dental teams.

Nadale, vođenje kontrolnoga popisa mali je dio četiri strateških područja koja je identificirao Pemberton (14) pri razvoju kulture sigurnosti pacijenata u stomatologiji:

1. prijavljanje incidenata; 2. vrijednovanje incidenata radi utvrđivanja najbolje prakse; 3. komunikacija i edukacija o sigurnosti pacijenata; 4. ustroj sigurnosne kulture.

Iako su se sigurnosni kontrolni popisi pokazali korisnim u smanjenju štete za pacijente koji se podvrgavaju stomato-loškim zahvatima, Saksena (3) je prijavio više pogrešnih vađenja unatoč uvodenju sigurnosnoga kontrolnoga popisa u velikoj bolnici. Također postoji problem s prihvaćanjem sta-jališta da vođenje kontrolnoga popisa poboljšava skrb o pa-cijentima (7).

Naše je iskustvo pokazalo da se sigurnosni kontrolni popis često koristi kao vježba za označivanje kućica, pri čemu kliničari nisu uspjeli zabilježiti proces prijave prije postupka i zanemarili su formalnu stanku za provjeru mjesta vađenja. To stajalište podupire Saksena (3) koji je identificirao nedostatke u timskom radu i komunikaciji koji rezultiraju lošom usklađenošću s mjerama sigurnosti za pacijenata, uz prisutnost ja-ke usklađenosti s kontrolnim popisima.

Sigurnosni kontrolni popisi moćan su alat koji jamči sigurnost pacijenata i smanjuje rizik od vađenja pogrešnoga zu-ba. Oni djeluju kao pomoćnici i standardiziraju postupke vođenja evidencije. No kako bi kontrolni popisi bili učinkoviti, moraju se pravilno upotrebljavati i pridonijeti široj sigurnosnoj kulturi. Moramo zauzeti proaktivans pristup sigurnosti pacijenata i izbjegavati ući u zonu opuštenosti zbog izostanja sigurnosnih incidenata u obradi pacijenata. Svi članovi ti-ma moraju razumjeti svoju zadaću, učinkovito komunicirati, odgovarati za svoje postupke i osjećati se ovlaštenima pred-ložiti bilo kakve ideje ili istaknuti nedoumice (3,7). Osna-zivanje članova tima i stvaranje okružja bez krivnje proizla-zit iz učinkovitoga vodstva. Patient Safety First preporučuje uvodenje prvaka u sigurnost na svim razinama unutar organiza-cije (3). Izobrazba osoblja također je ključna za sigurnost pacijenata i trebala bi početi na preddiplomskom studiju kli-ničara i nastaviti se tijekom njihove karijere (15). Sistema-tizirani pregledni rad pokazao je da je uključivanje mladeg osoblja u izobrazbu o vađenju pogrešnoga zuba i davanje kliničkih smjernica rezultiralo manjom učestalošću pogrešnoga vađenja (16).

Kako bi se dodatno istražila uloga sigurnosnih kontrolnih popisa u sprječavanju vađenja pogrešnoga zuba, mora se poboljšati kontrolni popisi za upotrebu u primarnoj zaštiti i osigurati da je u skladu s najboljom lokalnom praksom. Najpri-nje ćemo formalizirati početne rasprave odražene tijekom ovog istraživanja nizom strukturiranih intervjua s kliničarima sudionicima kako bismo istražili njihova stajališta o sigurno-snoj kulturi i prikupili prijedloge za optimizaciju kontrolnih popisa. Zatim će se poduzeti drugi ciklus PDSA-e za procesnu promjenu u skladu s najboljom lokalnom praksom i ispu-njavanje kontrolnoga popisa. Također će se poticati sigurno-snu kultura na odjelju imenovanjem prvaka među osobljem i osiguravanjem da sve osoblje pohađa preduvijek o sigurnosti pacijenata.

Sigurnost pacijenata razmjerno je nov koncept u stoma-toškoj primarnoj zdravstvenoj zaštiti, iako ga snažno po-
Conclusion

A computerised safety checklist for non-surgical tooth extraction in primary care demonstrates the potential to improve patient safety, by adopting measures to prevent WSTE and standardising communication between clinicians. However, we must ensure that safety checklists are used correctly and contribute to a broader patient safety culture. Further research amongst general dental practitioners is needed to optimise the use of safety templates in primary dental care.

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Conflict of Interest

The authors declare no conflicts of interest.

Sukob interesa

Autori nisu bili u sukobu interesa.

Zaključak

Digitalni sigurnosni kontrolni popis za neoperativno vađenje zuba u primarnoj zdravstvenoj zaštiti pokazuje da se može poboljšati sigurnost pacijenata ako se donese mjere za sprječavanje vađenja pogrešnoga zuba i standardizira komunikacija između kliničara. No mora se osigurati da se oni pravilno koriste i pridonijeti široj kulturi sigurnosti pacijenata. Potrebna su daljnja istraživanja među općim stomatologima kako bi se optimizirala uporaba sigurnosnih predložaka u primarnoj stomatološkoj zaštiti.

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