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Editorial

Patient safety in oral surgery: where are we?

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Patient safety and quality culture have evolved at the hospital since 2008, when the WHO proposed an operative checklist aimed at securing surgical procedures: the right procedure, on the right patient, at the right time, while ensuring the presence of all necessary complementary examinations [1]. Since then, this checklist has been used before every operation in the operating room. One key aspect is the cross-verification of information by different actors present in the operating room: the patient, who must know what procedure they are undergoing and confirm their identity; the anesthesia team, which ensures the patient's history is known, checks for contraindications or precautions, and coordinates the postoperative plan with the surgical team, who, in turn, announces the patient's identity (cross-verification), the procedure to be performed, and the side to be operated on if applicable. Only after these checks can the intervention begin. Similarly, at the end of the intervention, a new verification of the correct course of the intervention is carried out, with systematic checks (counting compresses, removal of packing, *etc.*). In principle, the use of the WHO's preoperative checklist is systematic in the operating room, even if the different steps are sometimes condensed into a cross-verification of a few questions: patient identity, procedure to be performed, absence of allergies or specificities, prescriptions, and postoperative plan for the patient.

In oral surgery, many procedures are performed under local anesthesia, and in most cases, no standardized verification is carried out. The high number of brief surgical procedures performed in a day and their technical complexity increase the risk of adverse events. In oral surgery, while various adverse events related to medical devices, anesthesia, and surgical contingencies can occur, there is a specific event classified by the National Health Service (NHS) as a "never event," meaning a serious event largely avoidable through the implementation and adherence to preventive measures: the extraction of the wrong tooth [2]. This is the most frequent "never event" (27 events in 6 months according to the NHS). Thus, the implementation of a checklist adapted to oral surgery under local anesthesia was proposed by Graham [3]. It consists of a section where the planned intervention is noted in full, and three parts: preoperative time-out with 5 questions, a pause in case of intraoperative changes (operator's position or any interference with the course of the intervention), and a brief postoperative debrief. The structuring of their checklist follows the "five steps to safer surgery" proposed by the National Patient Safety Agency [4], which includes (1) a preoperative briefing, (2) the sign-in to verify the procedure to be implemented, (3) the time-out, (4) the sign-out before leaving the operating room, and finally, the debriefing. In addition, Graham adds the rule of the three Rs: reposition (when the operator changes position or instrument), recheck (regularly during the intervention), reaffirm (cross-verification between the surgeon and the surgical assistant). A wall chart, not accessible to patients, serves as a safety briefing checklist and includes the successive interventions of the day with their specificities and preoperative checks. Graham emphasizes that despite adapting procedures, the overall team's adherence to them is not absolute, and these verification steps are often perceived as unnecessary and unimportant by some team members.

Therefore, education on patient safety appears to be an essential element in the training of young oral surgeons, so that they incorporate verification procedures into their daily routine. Such practices improve communication within teams and prevent the occurrence of adverse events or "never events."

So, when do we start?

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