Dental Professional Liability

Managing Adverse Events

Upon completion of this section, you should be able to:

- **Recognize the importance of appropriately managing medical emergencies** and implement processes to maintain/improve emergency response skills within the practice.
- **Collaborate with all members of the dental team** to identify risky procedures and/or behaviors.
- **Develop and implement processes and procedures** to reduce the risk of adverse events.
- **Understand the importance of and engage in open and effective communications** with patients and among dental team members when adverse events occur.

Please Note

A number of sample risk management forms and letters are available electronically in association with this manual, including written informed consent templates, patient termination letters, records release authorization forms and others. Dentist's Advantage-insured dentists may access these sample documents on the Dentist's Advantage website.

Each PDF sample permits customization: copy and paste the sample text from the PDF template document to a text editing file (MS Word, Apple Pages, etc.); edit text and add your dental practice information where appropriate; save the file to create a blank form for ongoing use. If necessary, customize the text of the form template for specific patient needs. You may wish to include components from various sources if the templates provided do not meet the needs of your practice.

While a number of form templates are available, documents are not available for every dental procedure. We encourage you to create consent forms for those dental procedures you perform frequently. You may wish to use the sample consent forms as an outline and review the manual section on informed consent. Consider consulting your attorney to ensure that your forms comply with state informed consent statutes.

Risk management content and resources are provided for illustrative purposes only. The information is intended to provide only a general overview of the matters discussed and is not intended to establish any standards of care.

The information, examples and suggestions presented in this material have been developed from sources believed to be reliable, but they should not be construed as legal or other professional advice regarding any particular situation.

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Adverse Events

A culture of safety is inherently important to the success of a risk management program. Establishing a positive work environment and promoting transparency empowers staff to report adverse events and to be a part of the solution in preventing recurrences. Success also requires a collaborative team approach that includes all providers, staff and managers through encouraging reporting and open dialogue to implement actions to prevent recurrence.

Responding to Adverse Events

The Institute for Healthcare Improvement (IHI) defines an "adverse event" as an "unintended physical injury resulting from or contributed to by medical care (including absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death." The Agency for Healthcare Research and Quality has additional information on defining adverse events, near misses and errors. These events may either be preventable medical errors or non-preventable occurrences.

Care must be taken to minimize the likelihood of negative outcomes and to prepare providers and staff to respond appropriately if an adverse event occurs.

The first priority should be patient stabilization and ensuring prompt emergency treatment, if indicated. Transparent communication with the patient and family regarding the event and subsequent treatment plans enhances trust, minimizing misunderstandings that often lead to litigious actions.

Patient Safety in Dentistry

Dentists and other healthcare practitioners have an ethical and legal duty to ensure that both their procedures and their premises are as safe as possible for patients, staff members and visitors. This section focuses on common treatment-related adverse events, but it is important to remember the importance of property risks and overall safety within the dental practice as well.

Research and reports on patient safety issues are becoming more common in the dental literature, but much more work is needed. One paper provides a list of 11 basic procedures and practices for patient safety in the dental office. While the authors are all based outside of the United States, most of their recommendations are consistent with issues covered in this and other sections of the CNA dental risk management manual. The key points include recommendations to:

1. Develop a culture of safety in the dental office.
2. Focus on the quality of clinical records.
3. Maintain control of procedures and protocols for infection control and instrument sterilization.
4. Exercise extreme caution with the prescribing of medications.
5. Limit exposure to ionizing radiation, by prescribing imaging based upon individual patient need.
6. Never reuse any products intended for single-use.
7. Protect patients' eyes during dental procedures.
8. Use barriers and other methods to prevent ingestion/aspiration of instruments, restorations, etc.
9. Use safety checklists for all surgical procedures.
10. Closely monitor the progression of oral infections.
11. Implement a protocol for medical emergencies in the dental office.

While these 11 points may not be new to any dentist, the frequency with which these topics arise in dental professional liability claims and lawsuits is noteworthy. Therefore, dental practitioners should consider and re-assess even their most basic patient safety practices and procedures.

Medical Emergencies

Medical emergencies in the dental office are relatively rare and most often do not result in significant or permanent injuries. In cases that involve significant or permanent injuries, criticism of the adequacy and timeliness of response on the part of the dentist and dental team may occur.

Dental patients may reasonably expect that dental office personnel receive at least a minimal level of healthcare training and are able to respond to medical emergencies. Consequently, all dental offices should have medical emergency response plans documented in the office policy and procedure manual, as well as regular training and practice sessions to reinforce the roles and responsibilities within the response plan. Failure to create an emergency plan or to adequately train personnel may result in confusion, treatment delays and patient harm. Furthermore, this may lead to a professional liability claim and/or state board of dentistry disciplinary action.

Numerous resources, including textbooks, manuals, and CE courses, address the management of medical emergencies in detail. In the interest of quality patient care and sound risk management, we encourage dentists to consult these sources and maintain a reasonable understanding and expertise in the subject.

Managing the Risks of Medical Emergencies

Recognizing risk factors

The key to preparedness begins with knowing those patients at greatest risk and the medical emergencies most likely to occur within your patient population. Patient populations at risk include:

- Older patients
- Patients taking numerous prescription medications
- Patients with significant medical histories (for example, cardiac disease, hypertension, or diabetes)
- Patients under increased stress due to fear, pain, or anxiety
- Patients and procedures requiring longer appointments

The most frequent adverse event reported to CNA is one that may result in a medical emergency: the swallowing or aspiration of a foreign object by the patient. This specific problem is addressed later in this chapter. Among other medical emergencies, those most common in dental practice include syncope, allergic reactions, angina pectoris, sudden cardiac arrest, respiratory distress (often caused by allergic reaction or asthma), and hypoglycemia.

Controlling the risks

The most important component of a medical emergency is its prevention. Prevention can best be achieved by the dentist's thorough physical assessment of the patient. Your assessment should combine the review of a complete, written medical history obtained from the patient, with findings from your clinical examination and evaluation. Allocate time to discuss the medical history with the patient, as well as to investigate further any responses that may be a cause for concern. For example, query diabetic patients about their drug and eating regimens and schedule them early in the day. Hypertensive patients should have their blood pressure recorded at each visit. Failure to assess the risks associated with planned oral healthcare treatment, and/or to discuss or investigate the patient's medical history, are frequently the root cause of severe adverse events leading to patient harm and professional liability claims.

Pre-event planning

After the potential emergency conditions for your practice have been identified, the next step is to determine an appropriate office procedure or protocol for each circumstance. Emergency policies and procedures should be based on a realistic assessment of the practice capabilities. These protocols should be tailored to the type of dental office, the clinical procedures performed, and the skill level of the office personnel. Access to the emergency medical system (EMS) in your area also represents an important consideration in the development of emergency procedures.

A small general dental office with a responsive EMS may decide to handle all medical emergencies by calling 911 and providing basic emergency measures. However, an oral surgeon may be reasonably expected to be conversant with more advanced resuscitation techniques than a general dentist. Similarly, dentists who provide sedation and/or general anesthesia services will be held to a higher level of knowledge and skill. These dentists are expected to manage medical emergencies due to the additional training they are required to undergo by many state dental boards. In addition, the staff members of different types of practices may have more or less training in medical emergency procedures and access to different types of emergency equipment, depending upon the practice activities. Regardless of these foregoing points, dentists must understand and comply with state requirements for medical emergency preparedness and response, which may vary significantly from state to state. Separate, more stringent requirements typically apply to dentist's and dental offices that administer procedural sedation and/or general anesthesia. Importantly, this also includes the administration of oral medications for minimal sedation (formerly known as "anxiolysis").

The next step is to train personnel to respond and to *practice* this training on a regular basis. All personnel should know the importance of contacting 911 to activate an EMS response. In addition, the personnel who will respond in a given manner to specific events should be identified. The designated job responsibilities and specific responses also should be documented in the office policy and procedure manual. No matter how simple your response plan, regularly scheduled emergency drills can help staff members develop the habits and reflexes needed to act quickly and smoothly. Contact local EMS personnel as they may be able to assist with conducting mock emergency drills.

Regularly review your system of reacting to medical emergencies in the dental office. The following is an example of steps for emergency preparedness. The dentist directs and supervises the sequence of actions, but staff members are empowered to take action, according to pre-assigned duties:

1. When an emergency occurs:
   - Notify the front office staff of the emergency. The staff calls 911 and activates the EMS.
   - The dental assistant helps to position the patient properly, then brings the emergency kit (if applicable), the portable oxygen, if needed, and assists as directed by the dentist.
   - Monitor vital signs, secure the airway, and begin CPR, if needed.
   - The front office staff also informs a family member that an emergency has occurred and reassures the family that you and your staff are responding to the event.
2. Verify that all staff members have current basic life support (BLS) certification. BLS certification should be renewed in accordance with dental licensing board requirements and current American Heart Association guidelines.
3. Utilize periodic emergency drills to test preparedness, at least on a quarterly basis.
4. Place emergency phone numbers for EMS, police, and the fire department prominently by each telephone.
5. Check oxygen tanks and the oxygen delivery system regularly to ensure that they are in good working order.
6. Check all emergency medications monthly to assure replacement of outdated medications. Designate a staff member to ensure completion and documentation.
7. Be familiar with emergency kit medications as packaging and administration techniques may vary significantly from those with which dentists and office staff are familiar.

In order to ensure the orderly and efficient response to a medical emergency, you and your staff should spend several sessions studying and practicing these procedures so that medical emergencies can be handled calmly and capably.

Equipment and drugs

Emergency equipment should be appropriate for the patient population and nature of your practice, and correspond to descriptions in the policy and procedure manual.

While emergency kits, or "crash carts," are available from a variety of vendors, it may be optimal to create your own kit, tailored to your practice and your abilities. The process of developing your own kit creates a familiarity with both the equipment and the drugs you select for inclusion. If your crash cart contains medications that are not used during an emergency due to your inexperience with them, an allegation may be asserted that you failed to properly manage your patient's emergency care.

Therefore, it is prudent to maintain only those drugs and instruments which you are comfortable using. Commercial emergency kits often contain equipment and drugs with which most dentists are either unfamiliar or have reservations about using. For example, if you do not plan to start intravenous medication drips in response to a medical emergency, then do not purchase an elaborate kit that includes IV equipment and drugs.

Sources vary somewhat in the equipment, drugs, and supplies recommended for availability during medical emergencies. The following is a sampling of commonly cited items:

- Oxygen tank and the ability to deliver positive pressure oxygen as well as supportive oxygen
  - Positive pressure systems include the bag, valve, and mask device
- Availability of latex-free equipment for latex-allergic patients
- Blood pressure cuffs of various sizes (automatic or manual)
- Epinephrine (and syringes) and antihistamines for allergic reactions
- Reversal agents for sedatives
- Sugar source for hypoglycemia
- Aspirin for myocardial infarction
- Ammonia inhalant
- Bronchodilator inhaler for asthma attacks
- Nitroglycerin for angina pectoris

You may add additional items based upon your level of competence with the item(s), state laws or regulations, the nature of your practice, and your patients' anticipated emergency needs.

Ensure that all staff members are trained in the use of emergency equipment and schedule routine refresher sessions to maintain a high state of readiness. Also consider cross-training needs, since not all staff members may be working at the time an emergency occurs.

Equipment must be stored in a readily accessible location, and personnel should be assigned to check and maintain the equipment on a routine basis. Medications, for example, must be checked regularly to identify and replace expired emergency drugs. Other types of equipment may need routine calibration. Instruct staff members who examine the emergency kit to initial and date their maintenance checks.

Automatic external defibrillator (AED)

The only treatment for sudden cardiac arrest (SCA), a leading cause of death in the United States, is the rapid delivery of a specific electrical shock within a critical time period. We are often asked if dentists are required to have an AED on hand to meet the standard of care for medical emergency management.

Some state dental licensing boards have instituted a requirement for an AED in the dental office. The requirements vary by state and can also vary by specialty and the types of procedures performed. For example, a state may require all dentists using sedation of any kind to have an AED. Conversely, it may only require certain specialties, such as oral and maxillofacial surgeons, to maintain an AED on the premises.

The first state dental practice act amended to require every dental office to have an AED states, "Any dentist practicing after [the implementation date] without an automatic external defibrillator on site shall be considered to be practicing below the minimum standard of care." In this state, as well as any other state that has instituted the same or similar requirement, all dentists affected by the ruling should comply with the dental practice act and purchase an AED. Dentists practicing in other states that have not adopted similar requirements would be permitted to opt against the purchase of an AED.

If not required to do so, should you purchase an AED? This determination becomes a personal decision for each dentist. When assessing the needs of your patients, some factors to consider are:

- The nature of your practice
  - How often do you treat patients at risk of sudden cardiac arrest?
  - How often do you treat patients who are medically compromised or have significant medical histories?
  - How often do you perform surgical procedures, including extractions?
- How often do you sedate patients?
- How long does it take EMS to respond to your practice location?
- Your perception of risk (both of having an AED *and* not having it)
- Your moral and ethical views regarding the need for an AED

Another consideration: dentists may wish to have an AED available for oneself and all office staff, depending upon their age, pertinent medical/family histories and other risk factors.

Notably, understand that sudden cardiac arrest may occur in individuals with no significant/related medical history. And if you choose to purchase an AED, *all employees* must be trained in its proper use, including non-clinical personnel. According to the manufacturer, the "defibrillator is intended to be easy to use for minimally trained responders." The American Dental Association (ADA) has suggested that "the user should have received training at a recognized course in CPR and AED use, such as those offered by the American Heart Association or the American Red Cross, or be certified in basic life support, advanced life support or other physician-authorized emergency medical response."

Most consumers expect that healthcare personnel are, at least, "minimally trained" to manage medical emergencies. If an average layperson can use an AED properly, you and your staff should be able to do so as well. See the Bibliography for a link to further resources for dental office medical emergencies on ADA.org.

Complications During Treatment

Complications occasionally occur during treatment and sometimes result in claims. However, there are steps that can be taken to reduce the likelihood of a complication and also the impact of that complication on both the dentist and patient.

Before a Complication Occurs

- Assess whether or not the procedure (such as an extraction, root canal, or periodontal surgery) *and the foreseeable complications* are within your skill level. If not, refer the patient to the relevant dental specialist.
- Inform the patient that in the event of a complication, you will refer him or her to an appropriate specialist. The risks and potential complications of the treatment must be explained as part of the informed consent process. Therefore, the *possibility of specialist referral* should be provided at the same time. If the patient objects to the prospect of referral, re-evaluate whether or not you wish to proceed.
- *Determine in advance* your office policy concerning charges for procedures during which a complication arises, requiring a referral.
  - It is neither right nor wrong to charge the patient – it is an individual dentist's decision whether or not to do so. However, many dentists decide not to bill the patient for "patient satisfaction" reasons, since satisfied patients generally do not allege malpractice. **Waiving the fee does not constitute an admission of liability.**

Once a Complication Occurs

- Be objective about your ability to address the complication. Use prudent judgment. Ask yourself, "What is in my patient's best interest *at this point in time*?" A referral made following a treatment complication is *not* an admission of negligence in and of itself. In fact, it can often help your defense.
- Be confident about the referral. If you've told the patient of the potential for a referral in advance, there should be no resistance.
- If you refer mid-treatment, follow up with the patient after treatment. Call the specialist as soon as you think the patient has arrived for care. Ask the specialist to contact you when the treatment is complete so you may talk to the patient. Call the patient that evening to ask about his or her condition.
- Document the events thoroughly. Start by collecting your thoughts. Review the events with any staff members who assisted you or the patient. Then, write your treatment note, considering the following elements:
  - Factually document what occurred.
  - Focus on what you did that best served your patient's needs.
  - Do not imply that you were careless.
  - Do not rationalize or attempt to defend the complication in the record.
  - Depending upon the nature and severity of the event, your state board may require filing a report with the board. Contact your state board or consult the state board website for resources and for information about requirements that may apply.

Once **a complication** occurs **be objective** about your ability to address it. Ask yourself, "What is in my **patient's best interest** at this point in time?"

Post-treatment Complications

Some treatment complications will not manifest themselves until after the patient has left the office. The following suggestions are offered if a post-treatment complication arises.

Clinical

- Insist the patient come to the office for evaluation and/or observation, allowing you a better opportunity to make the correct diagnosis and prescribe the correct treatment and/or medication.
- Have the patient return to the office periodically for your continued evaluation until the problem is fully resolved.

Communication

- Inform all patients of your post-operative protocol before treatment begins, including the manner in which you follow up with post-treatment complications.
- Inform patients in advance that in the event of a post-treatment complication, they will be required to come to the office one, two, or more times for examination, diagnosis and treatment.
- Explain to all patients the possibility of post-operative complications. For example, extraction patients should be informed of the possibility of infection, bleeding, swelling, pain, and paresthesia/dysesthesia/anesthesia, to name a few.

Documentation

- Include information about post-operative complications in your informed consent discussion and in any written patient treatment information or post-operative instruction documents. Review consent form templates available online for useful examples. *Please refer to page IX for information about access to risk management forms.*
- Thoroughly document cases involving post-treatment complications using the SOAP format of record keeping. The SOAP format is outlined in the Record Keeping and Documentation section of this manual.
- Document all pertinent phone conversations and email communications, including patient complaints, return calls to patients, and calls to pharmacies or other practitioners.

Message systems and answering services

- Every dental office must have an after hours patient management procedure and contact number. It is not appropriate to only provide office hours availability.
- When voice mail or an answering machine is used:
  - Provide a clear message with a phone number to call in case of an emergency.
  - Allow ample time for patients to leave a complete message.
  - Monitor for messages frequently.
- If you are completely unavailable, change your message to inform callers of your lack of availability and provide clear directions on the alternative care plans that you have implemented in your absence.
  - Always state how patients can access emergency care if you are unavailable or do not respond – such as "If you do not receive a return call from me within 20 minutes and you feel you have an emergent problem, call Dr. Smith at 434-765-4321." Whenever possible, avoid referring patients of record to urgent care centers or hospital emergency rooms.
- Answering services must specifically identify themselves as such and not as the dentist's office.
  - Develop a list of questions for the answering service to use to initially assess emergencies.
  - Have your service promptly report all calls so emergencies can be handled immediately.

Infections

Infections are potential unwelcome sequelae for almost any dental procedure. Infections often precede or exist concurrently with dental treatment, possibly compromising the treatment's outcome or complicating the health status of the patient.

Therefore, it is understandable that malpractice claims against dentists often cite infection as the claimant's injury. The following are common allegations associated with infection claims:

- Failure to diagnose
- Failure to treat
- Failure to refer
- Inadequate medical history review
- Negligence by the dentist as a cause of the infection

The defensibility of an infection claim is related to the quality and quantity of the dentist's diagnostic efforts – usually in response to the patient's complaint – and the comprehensiveness of the chart documentation. Testimony from plaintiffs and their experts typically allege that a successful outcome would have resulted without injury to the patient if the dentist had properly assessed, diagnosed, treated, or referred.

Managing the Risks of Infection

Recognizing risk factors

Many infections are difficult to diagnose due to a lack of clinical signs, symptoms, or patient complaints. Nevertheless, certain risk factors for infection can be identified, involving variables that relate to the patient, the dentist, and the treatment performed. They include:

- Patients with poor oral hygiene
- Patients who are immunocompromised due to disease, medication, or simply a poor host response
- Dentists who do not employ proper infection control practices
- Dentists who elect to perform procedures that would have a lower morbidity rate if referred to another practitioner

Controlling the risks

Prevention

- Inform patients whenever infection is a risk of treatment.
- Perform thorough diagnostic tests and examinations. Many allegations of failure to diagnose relate to asymptomatic infections that were "missed" during initial or maintenance appointments at which there was no "chief complaint."
- Follow current infection control guidelines.
- Inform patients about recognizing complications and seeking treatment for them. Written post-operative instructions for this purpose should be given to the patient.
- Inform patients about obtaining care outside of regular office hours. Ensure that your patients can access you after office hours (or another practitioner who may be covering emergency calls for you or your practice).
- Follow up with patients you suspect to be at risk of infection via telephone calls and postoperative return visits.

Responding to an infection

- Thoroughly evaluate the patient and assess all possible sources of the infection.
- Clearly inform the patient of his or her condition.
  - Explain the urgency of treatment.
  - Explain the potential consequences of no treatment or delayed treatment.
- Recognize and refer immediately when the patient's condition is beyond your treatment expertise. This may include patients taking antiresorptive medications, such as bisphosphonates or denosumab, who have delayed healing, infection and/or signs of osteonecrosis.
- When appropriate, prescribe an antibiotic regimen suitable in dosage, duration, and choice of medication.
- Consider antibiotic sensitivity testing for infections that do not respond to initial therapy. You also may wish to consider medical consultation or referral, if determined to be in the patient's best interest.
- It is prudent to increase follow-up and monitoring efforts for patients that do not respond to initial interventions. Establish and emphasize direct communication for specific/potentially severe signs or symptoms.

Documentation

- Consider using the SOAP format of record keeping described in the Record Keeping and Documentation section of this manual.
- Document the patient's physical appearance and status, and the performance and results of examinations and diagnostic tests.
- Document radiographic findings by retaining the radiograph and describing your positive or negative findings in the record.
- Document why you performed a specific treatment and why other alternatives were not selected.
- Document all antibiotics and other medications prescribed and the reasons for the prescription.
- Document any complications as well as corrective action taken.
- If a referral was recommended, document to whom you referred and the patient's response to the recommendation. Follow-up on the referral outcome.
- If the patient refuses the referral, document the referral and re-emphasize the potential consequences of inadequate or no treatment.
- If the patient does not follow through on the referral, document any additional communication you present to the patient, including reminders and reiteration of your position.

Swallowed and Aspirated Objects

Swallowed object claims often demand payment for follow-up radiographs and medical services to initially visualize the object and to track its normal course through the digestive tract. However, some objects, especially endodontic files and implant drivers, have required surgical removal to prevent or correct penetrations in the gastric or intestinal walls. Obviously, claims requiring surgical intervention are much more severe than the average non-surgical claim.

While foreign body aspirations are less common than ingestions, the potential consequences and medical care required are considerably more serious. The injuries alleged by patients who have aspirated objects include mental anguish, surgical removal of the object, infection, and death. Allegations have included an inadequate use of precautions and a failure to exercise due care. Be aware that aspiration may cause choking or severe coughing initially. In some cases, however, the patient may have no immediate reaction to the event. Nevertheless, do not assume that no reaction indicates no adverse event.

Managing the Risks of Swallowed and Aspirated Objects

Recognizing risk factors

A wide variety of dental objects have been ingested or aspirated by patients. The items are usually small to moderate in size, but larger items (such as removable appliances or prostheses) are also rarely involved. Examples include:

- Dental instrument fragments (explorers, periodontal probes, curettes, and scalers), endodontic files and reamers, dental burs, prophylaxis cups and brushes, handpiece heads, ultrasonic scaler tips, mirror heads, implant screwdrivers, dental dam clamps, dental dam fragments, suture needles, amalgam restorations, castings, crowns, space maintainers, orthodontic bands, impression materials, teeth and tooth fragments.

In addition to small objects being a risk factor, certain patients can be considered at higher risk to swallow or aspirate an object. They include patients with:

- Strong gag reflexes
- Hyperactivity of the tongue and other intraoral muscles
- Pharmacologically depressed gag reflexes
- A history that includes a previously swallowed or aspirated dental object

Controlling the risks

Prevention of accidental ingestions or aspirations is the primary means of managing the risk. Other methods include maintaining an adequate level of preparedness in anticipation of a swallowed object incident, responding prudently following such an incident, and documenting all measures and actions taken to prevent the event. Each of these elements should support the contention that the patient's alleged injuries were not caused by negligence or a breach of the standard of care.

Prevention

A number of clinical techniques can be used to minimize the risk of an object being ingested or aspirated during treatment. They include:

- Dental dam – arguably the best preventive device. However, it is not always possible or practical to use.
- Pharyngeal gauze block
- High velocity evacuator – to remove tooth and restoration fragments
- Dental floss – tied to dental dam clamps and other small instruments; tied around the pontics of bridges
- More upright chair position
- Modified patient head position – turning the patient's head toward the side of treatment, allowing objects or debris to fall onto the buccal mucosa or into the buccal vestibule

Other preventive steps include patient communication and proper staff training.

- Warn patients that temporary crowns can loosen and unseat.
- Provide written home care instructions to patients who have received a temporary crown or who have been directed to self-administer at-home dental treatment, such as the use of orthodontic keys or elastics. The written instructions should direct the patient to appropriate medical or dental care following any at-home swallowed object incident.
- Train all office personnel in basic life support, including the Heimlich maneuver.
- Develop an action plan to respond to in-office swallowed and aspirated object incidents and train your staff on its implementation. Include in the action plan that a staff member may be required to transport the patient to a medical care facility as part of his or her job responsibility.

Responding to an event

Whenever a foreign object is lost intraorally into the oropharynx, it is prudent to assume that it has been aspirated. Aspirated objects pose an immediate hazard to the patient's health and life.

- Consistent with basic life support principles, first ensure that the patient has a patent airway.
- Initiate appropriate medical referrals unless the patient is certain that the object has been ingested.

If the airway is completely obstructed,

- Initiate the emergency medical system by dialing 911.
- Perform the Heimlich maneuver and cricothyrotomy, if necessary.
- Be prepared to perform additional emergency procedures if the airway becomes patent. Such procedures may include artificial respiration and, if the patient experiences cardiac arrest, cardiac compression.

If the airway is partially obstructed, the patient will likely be able to breathe and to explain his or her symptoms.

- Provide oxygen, as needed.
- Initiate the emergency medical system by dialing 911.
- Be cautious about the partial obstruction moving and causing a complete obstruction.

Unless the patient is absolutely certain that they swallowed the object, assume that it has been aspirated since many aspirated objects have no associated symptoms. Arrange for the patient to be transported to a facility for medical evaluation. If the patient is stable and breathing unassisted and you choose not to have EMS transport the patient, understand that anyone who transports the patient (you, your staff, the patient's family member) must be prepared to respond if the patient's condition deteriorates while en route to the medical facility. The patient should be accompanied until discharged from medical care.

If the patient has ingested the object rather than aspirated it, refer the patient for medical evaluation and follow-up radiography. Even small objects may irritate or partially obstruct the digestive tract or contribute to gastrointestinal problems.

In every instance, referral to a medical provider is the most prudent course of action, as it demonstrates that the dentist was acting in the patient's best interest.

Documentation

Whenever an object is swallowed or aspirated, the patient healthcare information record should include the following:

- All preventive measures (dental dam, pharyngeal drape, etc.) taken to avoid a swallowed object incident
- Copies or notations of any home care instructions or educational materials provided
- Any referrals or discussions about referrals. If the claim is related to a root tip that was lost during an extraction, the patient may allege that the injury would have been avoided if an oral surgeon had performed the extraction.
- The dentist's actions following the swallowed object incident, including:
  - Emergency procedures performed
  - The result of the emergency procedures (for example, did the patient begin to breathe after the Heimlich maneuver was performed?)
  - Any discussion urging the patient to seek a medical evaluation. If the patient refuses to pursue the evaluation, document the reason for the patient's refusal. Also, ensure that the patient understands the potential for acute and chronic complications resulting from the object. Provide the patient with written information and instructions.
  - How the patient was transported for medical evaluation and by whom
  - Any telephone discussions with the medical facility and treating physician, with a copy of the treating physician's report retained in the patient's file.

Report the swallowed or aspirated object incident to your malpractice insurer in a timely manner by first contacting your agent.

Swallowed/aspirated object claims have the potential to be financially severe. Sound risk management procedures can prevent or minimize some claims and provide a stronger defense for those that arise.

Treatment of the Wrong Tooth

Wrong tooth claims usually involve technical errors leading to the performance of dental procedures on the wrong tooth or damage to adjacent teeth. For example, root canal therapy may be performed on the wrong tooth because the dental dam was incorrectly placed. The reason for this claim can be described as a technical error, which would be discovered immediately upon removing the dental dam.

Wrong tooth claims also are brought following a dental procedure that was appropriately performed in accordance with the treating dentist's professional judgment. This may occur after a patient consults a second dentist whose philosophy or professional judgment contradicts that of the prior treating dentist. Alternatively, it may occur when patients have not been fully informed of either their dental condition or of the treatment provided.

In certain instances, treatment may be completed on the proper tooth. If more than one tooth in the same area requires treatment, however, the patient may question the necessity of the first treatment if he or she continues to experience symptoms. Although the dentist provided appropriate care for the treated tooth, a wrong tooth claim may arise. A common allegation in wrong tooth claims is that the patient did not provide his or her informed consent for treatment of the tooth in question.

Damages have been requested in wrong tooth claims for:

- Unnecessary past dental expenses
- Future medical or dental expenses to correct the error
- Disfigurement or loss of a body part
- Pain and mental anguish
- Lost wages

Wrong tooth claims resulting from a patient's **perception of error**, either related to the patient's own **opinion** or the opinion of a subsequent treating dentist, can be **defended competently** only with complete and **accurate dental records**…

Managing the Risks of Treating the Wrong Tooth

Recognizing risk factors

Technical errors are typically the reason the wrong tooth is treated. Technical errors include:

- Inaccurate or incomplete review of dental records
- Lack of concentration
- Incorrect dental dam placement
- Miscommunication of a referral

These technical errors may lead to:

- Extraction of the wrong tooth
- Initiation or completion of root canal treatment on the wrong tooth
- Preparation of the wrong tooth for restoration
- Incision performed on the wrong side or area of the mouth
- Removal of a crown or other restoration from the wrong tooth
- Errors by a referral dentist based on erroneous or misunderstood instructions from the referring dentist

Controlling the risks

To effectively manage the risk of wrong tooth claims, dentists should minimize the potential for technical errors, obtain the patient's informed consent before starting treatment, and fully document all dental procedures. Proper documentation of all of the above can help defend the dentist against allegations of improper dental treatment.

Also consider protocols to prevent wrong tooth treatments, such as a "time-out" policy, based upon the Joint Commission's Universal Protocol for preventing wrong site surgery. The Universal Protocol is applied in hospitals and outpatient surgery facilities to help prevent wrong site/wrong side surgeries. Integrating components of this approach and involving the entire dental team and the patient in the verification process are important. The online Safety Net Dental Clinic Manual provides information about the "time-out" approach (part of the Universal Protocol) and describes the Joint Commission and American Dental Association (ADA) recommendations for its application in dentistry. See the Adverse Events section of the Bibliography for a URL to access this information.

Prevention

In order to reduce the risks of technical errors that result in treatment of the wrong tooth, dentists should:

- Document the reason(s) for extractions at the time of diagnosis. This information may help to prevent mix-ups at the time of surgery, whether in your office or the referral office.
- Review immediately prior to treatment all patient chartings, radiographs, treatment plans, prior treatment progress notes, and medical and dental histories.
- Consistently mount and label all film-based radiographs to minimize the risk of inadvertently misreading them.
- Double check the tooth number and position in the arch prior to initiating any treatment, especially if the intended treatment is irreversible, such as an extraction or endodontic treatment.
- Begin preparation of the tooth before placing the dental dam to minimize the risk of isolating the wrong tooth.
- Write comprehensive and clear treatment plans, based upon a complete patient charting, examination findings and radiographic interpretation.
- Write progress notes that clearly record the patient's dental needs, identifying those needs that have been treated and those that remain to be treated.
- Provide a clear indication of the treatment to be performed and an accurate identification of the tooth or teeth involved whenever a referral is made to another dentist.
  - Use written referrals and place a copy of the referral in the patient's record.
  - If a referral must be duplicated or transcribed by staff for any reason, require confirmation of the instructions by the prescribing dentist.
  - Engage in a dentist-to-dentist discussion during telephone referrals to minimize communication errors that may occur by using intermediaries.
  - Provide a written follow-up to all telephone referrals. The referring dentist, in addition to the referral dentist, may be subject to malpractice litigation if miscommunication leads the referral dentist to perform dental treatment on the wrong tooth.

Dentists to whom patients are referred also can take steps to minimize technical errors that result in wrong tooth claims.

- Take a new radiograph if the needed diagnostic radiograph is unclear or unavailable from the referring dentist.
- Retain a copy or original of digital or film radiographs used for treatment in the referral dentist's records.
- Contact the referring dentist for discussion or clarification if the treatment for which the patient was referred is unclear or questionable.

Many wrong tooth claims do not allege that the dental procedure was performed incorrectly. Rather, they allege that the patient did not authorize or consent to the procedure. Further, patients may assert that they would not have consented in advance had they been properly informed of the consequences.

In order to reduce the risks of patient misunderstandings resulting in claims alleging treatment of the wrong tooth, dentists should take the following steps.

- Obtain the patient's informed consent prior to treatment. Fully inform the patient or guardian about the recommended procedure and its risks, consequences and alternatives, as well as the ramifications associated with no treatment.
- If additional facts become known during a procedure that dictate a change in treatment, discuss these facts and recommendations with the patient before the treatment change is begun.
  - For example, if the patient has authorized a four-unit bridge, and after preparations have begun it is determined that the bridge should be extended to six units through two additional abutments, the patient must authorize the modified plan.
- Document in the patient healthcare information record all discussions related to informed consent through progress notes and/or informed consent forms. This documentation is especially important when the indicated treatment is irreversible.

Responding to an event

While there is no absolute means of precluding a malpractice claim following treatment of the wrong tooth, the following suggestions will minimize the potential of a claim for fraudulent concealment, which may substantially increase the value of a negligence claim and could result in a punitive damage award.

- If treatment is unintentionally performed on the wrong tooth, *inform the patient* of the error and of any immediate/specific corrective action you recommend or will perform, as well as procedural corrective action(s).
  - The specific treatment corrective action may be to place a restoration in an erroneously prepared tooth or to refer the patient to an endodontist for completion of root canal treatment begun on the wrong tooth.
  - The process of root cause analysis will help lead to procedural corrective action, which should be addressed thoroughly and quickly. This process and the response answers the questions; "what went wrong?" "why did this occur?" and "how will this error be prevented in the future?"
- Do not intentionally withhold information from a patient about a known error. Most patients will eventually discover the error.
- Do not attempt to conceal the error from the patient in the hope that the patient will discover the error only after the statute of limitations has expired. There is no clear statute of limitations for fraudulent concealment.
- Document in the patient healthcare information record what the patient was told about the error and your proposed corrective action.
- Do not bill the patient for a procedure performed in error. Doing so can provide motivation for the patient to file a malpractice claim.

Documentation

In wrong tooth claims, the patient's attorney will request the dentist's records. The patient healthcare information record should include the following information, entered at the time of the incident or within 24 to 48 hours. Do not modify or add to the record after receipt of an attorney's request for records.

- A clear, comprehensive examination charting
- The correct treatment plan
- Receipt of the patient's informed consent for the procedure
- Any referrals or discussions about referrals. (If the claim is related to the treatment of the wrong tooth, the patient may allege that the injury would have been avoided if a specialist had performed the treatment.)
- The dentist's actions following the treatment of the wrong tooth, including:
  - Corrective procedures recommended and/or performed
  - The result of the corrective procedures

Wrong tooth claims resulting from a patient's perception of error, either related to the patient's own opinion or the opinion of a subsequent treating dentist, can be defended appropriately only with complete and accurate dental records justifying the treatment performed. Optimally, these records would include medical and dental histories, radiographs, diagnostic models, laboratory exams, informed consent documentation, charting, progress notes, clinical photographs, documented referral communications, documented recommendations for second opinions and documentation of all pertinent discussions with the patient and other consulting healthcare providers.

Risk management to minimize the frequency and severity of wrong tooth claims is best achieved by proper diagnostic and procedural techniques and thorough recordkeeping.

Nerve Injury

Nerve injuries can result in outcomes diagnosed as paresthesia, hypoesthesia, anesthesia, and dysesthesia. (CNA claim data compiles these injuries collectively under the term "paresthesia" for claim data analyses.) Although nerve injuries can be temporary and reversible, they also can be permanent. Claim demands and costs associated with nerve injuries have increased significantly in recent years. This increase may be due to a number of factors, including heightened awareness of this outcome on the part of both patients and plaintiff attorneys. Unfortunately, it may not be possible to accurately predict injuries that will resolve and those that will not. Moreover, nerve injuries can occur following proper and meticulous treatment.

Juries often look sympathetically upon patients with nerve injuries, drawing the frequently erroneous conclusion that an otherwise healthy patient must have suffered a negligent act. Allegations of lack of informed consent regarding the risk of nerve injury associated with surgery often becomes the focus of nerve injury claims.

A common allegation in nerve injury cases is that the dentist failed to refer the patient to an appropriate specialist in a timely manner and that the referral delay resulted in the loss of any opportunity to pursue the microsurgical repair of the injury. Referral after a period of evaluation/observation may be necessary if the patient is not improving. However, immediate referral to a specialist may be required, depending upon the type of injury, the patient's symptoms, and/or the dentist's ability to effectively manage the patient (see "Controlling the risks" in this section). Although each patient injury is unique, it is clear that early intervention is a key factor related to successful outcomes for both surgical and non-surgical nerve injury treatments. From both a patient safety and risk management perspective, prompt referral to a nerve injury specialist is strongly recommended if there is any question about the course and treatment of the patient's recovery.

Managing the Risks of Nerve Injuries

Proper training, good clinical skills, and timely follow-up are invaluable for quality patient care and to reduce the risk of a professional liability allegation.

Recognizing risk factors

Nerve injury claims are most commonly associated with the following procedures:

- Extractions
- Implant placement
- Periodontal surgery
- Local anesthetic injections

Once a nerve injury has occurred, critical liability risk factors include: the timeliness and quality of the post-injury patient assessment; effective doctor-patient communications; and the timeliness of the referral, if necessary.

Controlling the risks

Dentists can control the exposure presented by nerve injury claims through implementation of the following strategies.

- Avoid performing procedures that present the highest risk of nerve injuries, such as extraction of mandibular third molars or placement of implants in the mandibular molar region.
- Improve knowledge and clinical skills in the procedures that most commonly lead to nerve injuries.
- Perform a thorough preoperative clinical and radiographic evaluation of the proposed treatment area. Assess the risks and the advisability of referral for the planned treatment. Note that patient age is a significant risk factor. Patients over 25 years of age are at an increased risk for non-resolving nerve injuries. Some data indicates that the female gender is overrepresented overall and specifically for non-resolving injuries.
- Take appropriate steps once a nerve injury is known.

One system of nerve injury classification describes five degrees based on the extent of the injury. First and second degree injuries are the least severe and can completely resolve or show signs of improvements by one to three months. Complete recovery of second degree injuries may take up to 12 months. Third, fourth and fifth degree nerve injuries are characterized by a three to six month delay in improvement or permanent damage. Neurosurgical repairs of third, fourth and fifth degree injuries have been attempted, often with some level of success. A "successful" repair leads to sensory improvement, rather than a full restoration of sensory function.

A dentist would not be expected to know all five nerve injury classifications. However, a dentist would be expected to know the following regarding nerve injuries that may require surgical or other interventions:

- The recommended window for surgical repair is from one to three months for the lingual nerve and from three to six months after the injury for the inferior alveolar nerve. Because of the location and anatomy of the inferior alveolar nerve, it spontaneously heals more often than the lingual nerve and a longer observation period is appropriate.
- The success rate for surgical repair decreases substantially after six months. If the referral specialist suggests waiting more than six months before evaluating the injury, find another professional to follow the case.
- Surgery is rarely contemplated after one year.
- Surgical repair is not possible for some injuries such as for injuries associated with local anesthetic injection or a known chemical insult (e.g., sodium hypochlorite). Prompt and thorough assessment is recommended and appropriate since the timely implementation of pharmacological and/or behavioral therapy may be indicated.

Microneurosurgeons and/or neurologists are the practitioners who possess the knowledge and skill necessary to definitively treat patients with nerve injuries that do not spontaneously resolve. However, all dentists can perform initial evaluations and ongoing assessments while symptoms continue to improve.

As noted, the potential for improvement via microsurgery diminishes with time. Based upon our experience in managing nerve injury claims, the patient should be promptly evaluated for any opportunity to assess and potentially seek repair of the nerve injury. Recent work on non-invasive therapies shows that other treatments also may prove helpful when surgery is not an option or to enhance surgical outcomes. Consider consultation with the patient's physician regarding corticosteroid therapy, which may decrease perineural edema and help in long-term recovery. Sensory retraining may improve patients' perception of altered sensations and administration of vitamin B12 may accelerate functional recovery. More research is needed in these areas specific to trigeminal nerve injuries.

The following steps suggest a prudent course of action when a patient reports a nerve injury. Remember to inform your malpractice insurer and check on the availability of new information on the management of nerve injuries.

1. **Examine the patient immediately, if possible, or within one to two days.** Document the patient's description of the nerve deficit as well as all clinical findings of your examination. If the injury is due to extractions, implant placement or other surgical procedures, radiographically assess the area to rule out root tips, fracture, foreign bodies or the position of the implant or endodontic filling material as a source of nerve pressure or compression.
   - For patients with an open surgical injury (the treating dentist witnesses the nerve injury), refer the patient immediately to a healthcare professional knowledgeable in treating nerve injuries of the head and neck, such as an oral and maxillofacial surgeon, a neurologist, or an ear, nose and throat physician. If reparative microsurgery is warranted, the rate of success is higher when attempted within the time frames noted previously.
   - For a closed surgical injury (injury not witnessed) or patients whose injury is not related to surgery (local anesthetic injection or a chemical insult, e.g., sodium hypochlorite), the patient's signs and symptoms should be evaluated as noted above and followed closely for 4 weeks (see below for neurosensory test suggestions).
   - If the symptoms have not resolved or improved significantly in 4 weeks, referral to a nerve injury specialist is recommended. If access to appropriate specialists is limited where the patient resides, referring sooner than 4 weeks may be necessary.
   - While microsurgery is not an option for nerve injuries associated with local anesthetic injection or chemical insult, non-surgical treatments may help as previously described.
   - Note that if symptoms arise after implant placement, the implant could be compressing a nerve (also a type of closed injury). Immediately backing out or removing the implant is appropriate, followed by prompt referral to a nerve injury specialist.
   - Similarly, pressure from an endodontic overfill may cause nerve injury symptoms. Prompt removal of the filling material is indicated to relieve the pressure and prevent long-term damage to the nerve.

2. During the initial evaluation and at follow-up assessments, **map the extent of the sensory deficit and describe or sketch it in the patient healthcare information record.** A neurosensory examination may include a number of tests such as static light touch, two point discrimination, brush directional discrimination, and pin pressure discrimination. These and other tests are discussed in oral surgery textbooks and other sources. Several tests are relatively simple to conduct and provide useful subjective and objective information related to nerve recovery. The tests are repeated at each patient visit to monitor for improvements. They are indicative of the overall injury status and aid in determining the recovery prognosis.
   - Subjective test: ask the patient to rate the sensation in the involved area from zero to ten, with zero being no sensation and ten being fully normal sensation. This test may be conducted using a visual analog scale (VAS), where the patient makes an "X" on a line to indicate the level of sensation.
   - Objective test 1: two-point discrimination. With the patient's eyes closed, the bare wooden end of two standard cotton-tip applicators are held a few millimeters apart and then touched to the skin or mucosa in the affected area. The two applicators are moved progressively closer together until the patient is not able to discern that there are two rather than just one point. This test is performed bilaterally for comparison.
   - Objective test 2: brush directional discrimination. With the patient's eyes closed, use the cotton tip side of a cotton-tip applicator to brush the skin or mucosa in one direction. Move the applicator from right-to-left and then left-to-right (or back-to-front and front-to-back). The patient is asked to determine the direction of the motion. This test is performed bilaterally for comparison.
3. If the patient is referred to a nerve injury specialist, maintain regular contact to follow his or her progress. Document your discussions in the patient's record. After the initial assessment, contact the patient at least every other week during the first month and then re-assess the condition at one month, as noted. Contact the patient at least monthly during the second and third post-injury months, and monthly for the fourth through sixth months if symptoms persist.
4. If the patient refuses to follow through on your referral, advise of the need for early evaluation for both surgical and non-surgical treatments. Also, emphasize the diminished opportunity for surgical intervention, if the patient is deemed to be a candidate. Advise that certain non-invasive treatments may be beneficial as well, depending on the condition.
5. Document all consultant conversations and follow up with written correspondence confirming the information discussed. Retain copies of all patient and consultant correspondence in the patient record.

If the **patient is referred** to a nerve injury specialist, maintain regular contact to **follow his or her progress**. **Document** your discussions in the patient's record.

For more information call Dentist's Advantage at 888-778-3981, or navigate to the Dentist's Advantage website Risk Management section.

In addition to this publication, CNA and Dentist's Advantage have produced additional risk control resources on topics relevant to dental professionals, including: newsletters; articles; forms; letters; and claim scenarios.

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