The National Society of Dental Practitioners
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# Tips for meeting staffing challenges

The COVID-19 pandemic has reinforced the need for dental practice leaders to shift their approach to staff recruitment and retention, as the shortage of dental hygienists and assistants takes its toll on remaining staff and, in some cases, quality of care. Research by the American Dental Association (ADA) Health Policy Institute (HPI) has estimated that vacancies for dental assistants and dental hygienists have reduced dental practice capacity by 10% nationally. Further, recent HPI surveys have found that one in three dentists identified "trouble filling vacant staff positions" as a contributing factor preventing them from filling their appointment schedules.

Dental practice owners know that investing in their workforce yields financial rewards. High-quality support from dental hygienists and dental assistants helps to reduce the likelihood of patient safety events and costly medical malpractice lawsuits related to missed errors. Administrative staff are also essential for any dental practice to function properly and to ensure patients have a positive experience. Ensuring appropriate staffing levels is key to the financial health of dental practices, which means engaging in effective recruitment and retention strategies.

## Recruitment

You need to work closely with human resources professionals to ensure recruitment processes are efficient and effective.

**Craft ads that work.** First impressions count. Everyone is your competitor for a limited pool of talent, so do what you can to make your practice stand out as an attractive place to work. Be sure images in recruitment ads reflect who works for the practice, particularly when it comes to diversity. Some organizations feature their own staff in ads, which can have the additional benefit of employee recognition.

**Reach out early.** Ask colleagues or others who work with dental, dental assistant, and dental hygienist students to identify those who might make good employees when they graduate. Then get to know the students and encourage them to apply when the time comes.

**Promote digital efforts.** Dental practices' websites often miss the opportunity to feature dental hygienists and dental assistants. Your practice's website should have a special section highlighting the role of dental hygienists and assistants, including stories that feature individual staff members. In addition, your organization's job application process should not be so cumbersome that potential employees give up in frustration.

**Individualize benefits.** Avoid a "one size fits all" approach to benefits. Instead, offer a menu that staff can choose from. For example, a late-career dental hygienist may be more interested in retirement-matching funds, but a newer-to-practice dental assistant may be attracted to a flexible schedule, tuition or student loan assistance, or child-care benefits.

**Provide optimal onboarding.** This is often discussed as a retention tool, but it also falls under the recruitment category, as potential employees want to know how supported they will be in their new role. Be sure staff feel warmly welcomed. For example, some organizations send a signed welcome card to the employee's home before their start date. Others post the employee's name and photo in a visible location in the office.

Check in regularly with new staff to see how they are adjusting, such as weekly for a month, then every other month or so, and then after 6 months.

## Retention

The Society for Human Resource Management estimates that it costs about one-third of an employee's annual salary to replace them, due to expenses related to recruitment, temporary replacement workers, and lost productivity. This makes retention a key component of a dental practice's staffing strategies.

**Conduct "stay" interviews.** Stay interviews help you identify employees who might be thinking about leaving the organization and identify what factors are most important for helping them stay. You can use the information to create an individual retention plan and to inform your larger retention efforts for the practice. Here are some examples of questions that can help elicit useful information during stay interviews:

- *"What do you look forward to each day when you commute to work?"* This question focuses on the present and helps identify factors other than pay and benefits, such as relationships with colleagues.
- *"What are you learning here, and what do you want to learn?"* This helps managers focus their career coaching.
- *"Why do you stay here?"* Staff may have not thought about this before, so help them reflect on their reasons.
- *When is the last time you thought about leaving and what prompted it?"* Everyone sometimes thinks about leaving their job, but what prompted those thoughts can be informative.
- *What can I do to make your job better for you?"* Once you hear the response, be honest about what you can do and not do.

Employees often think about leaving their positions around their work anniversary date, so leaders should try to conduct stay interviews 60 to 90 days beforehand.

**Promote a healthy work environment.** For example, implement zero tolerance policies for patient or visitor violence against staff and policies that discourage staff from bullying their colleagues. Beyond policies, it is also important to ensure

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lines of communication are open, so your staff feel comfortable speaking with you when they identify problem areas. You can foster open lines of communication by taking time to get to know your staff on a more personal level, without crossing boundaries. For example, asking about a grandchild or a new pet takes little time, but signals your interest.

Make rounds daily and listen to staff closely, even though you're busy and face multiple pressures of your own. Ask them questions such as, "What do you need to do your job more effectively?" If it's something that you can take care of, do so and let them know it's been done. If you can't address the issue, explain why and, if appropriate, note that it may be able to be addressed in the future. For instance, a requested new piece of equipment might have to wait until the next budget cycle.

**Avoid sign-on bonuses**. Sign-on bonuses may help to ease staffing woes short term, but don't ensure commitment, and can even lead to resentment from current staff. Instead, focus on improving staff pay scales or offering retention bonuses to show appreciation for your staff's commitment to the organization.

**Recognize employees.** Recognition is an easy, but often underutilized, retention tactic. Take every opportunity to offer words of praise. To reinforce the behavior, specify what specifically was done to earn praise; for example, a staff member may have taken extra time to help a patient with a billing issue. In these days of digital communication, a handwritten note can stand out, particularly if sent to the person's home. Small rewards such as gift cards can also be effective- but try to match them to the individual's interest. For example, a dental assistant who drinks coffee every day may enjoy a Starbucks card, but one who loves to read might prefer a card from Barnes & Noble.

**Support career development.** Explore staff members' professional goals and how you can help meet them during stay interviews and other conversations. It's a good idea to keep a mental list of options such as serving as a manager or mentor and leading project teams. Offer meaningful opportunities for professional growth based on performance, rather than solely based on tenure. Outline for your staff the types of experiences or skills that are most valuable for advancement and reinforce the value of experience for your staff members' long-term career growth.

**Consider a job embeddedness approach.** Job embeddedness (JE) focuses on why people stay in their jobs as opposed to why they leave. JE looks at ties related to employers and the community where they exist. These ties are considered in three dimensions: *links* (formal and informal connections people have with their employers or communities), *fit* (how compatible people feel with their employers or communities), and *sacrifice* (material and psychological losses people would experience by leaving their employers or communities). You can leverage these dimensions to promote retention. For example, to help promote JE within the practice:

- Links: Involve staff in problem-solving committees and practice management.
- Fit: Recruit staff whose goals align with the practice's goals.
- Sacrifice: Align vacation time and retirement plans with the time of service

## A multifaceted approach

Staffing challenges are unlikely to ease anytime soon. Dental practice leaders will need to be creative and take a multifaceted approach to staff recruitment and retention. These efforts will help gain—and retain—staff. Doing so in turn helps support optimal patient outcomes.

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RESOURCES

Advisory Board. *Struggling to keep entry-level staff engaged? Try a performance-based career ladder.* 2017. https://www.advisory.com/blog/2017/02/pef-career-ladder

ADA Health Policy Institute. *Dental workforce shortages: Data to navigate today's labor market.* October 2022. https://www.ada.org/-/media/project/adaorganization/ada/ada-org/files/resources/research/hpi/dental_workforce_shortages_labor_market.pdf

ADA Health Policy Institute. *Economic outlook and emerging issues in dentistry, week of September 12, 2022.* September 2022. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/sept2022_hpi_economic_outlook_dentistry_report_main.pdf

Agovino, T. To have and to hold. *Society for Human Resource Management (SHRM).* 2019. https://www.shrm.org/hr-today/news/all-things-work/pages/to-have-and-to-hold.aspx

CNA & Dentist's Advantage. *Dental Professional Liability Claim Report: 2nd Edition*. 2021. https://www.dentists-advantage.com/Prevention-Education/Claim-Reports

Pink D. When: The Scientific Secrets of Perfect Timing. *Riverhead Books*; 2019.

Reitz O, Anderson M, Hill PD. Job embeddedness and nurse retention. *Nurs Admin Q*. 2010;34(3):190-200.

Saver C. Retaining nurses in a post-pandemic era–Part 1. *OR Manager*. 2021;37(9):12-15.

Sherman RO. *The Nuts and Bolts of Nursing Leadership: Your Toolkit for Success*. Rose. O. Sherman; 2021.

# Alleged Negligence Results in Multiple Implant/Restoration Failures, Mandibular Fracture, Infection and Nerve Injury

Professional liability claims associated with dental implant placement and restorative procedures consistently involve severe (costly) outcomes. Beyond corrective surgical and restorative expenses, alleged harms often involve nerve injuries, integration failure, fractures and/or infection with related sequelae. This case study encompasses all of these components, among others.

## CLAIM CASE STUDY

**Practitioner:** General dentist-primary provider; subsequent providers--oral maxillofacial surgeons, a prosthodontist, and an infectious disease physician

**Claimant:** Female, aged 62 years, history of poor oral hygiene, partial edentulism, smoking (discontinued X 5 years), asthma, emphysema, chronic pain (back/lumbar), substance use

**Risk management topics:** informed consent, patient assessment and selection, treatment referral, documentation

**Facts:** The patient treated with the general dentist for approximately 12 years. The first seven years of treatment involved irregular visits for dental prophylaxis, examinations, and urgent care (lower denture-associated pain/adjustments; maxillary decay, root canal therapy/crowns). The patient reported a history of substance use, in part associated with chronic back pain and years of heavy opioid use. After seeking treatment for substance use, the patient decided to pursue dental care recommended by the insured general dentist.

Due to very limited mandibular bone and the patient's history of poor dental care compliance, the dentist proposed an implant-retained full lower denture (two anterior implants) opposing an existing maxillary removable partial denture.

The next five years of dental care summarized below resulted in multiple challenges, including recurrent peri-implantitis, pain, infection, and failed implants.

- The patient's home care remained poor throughout the treatment period.
- Peri-implantitis led to recurrent pain, localized infection, multiple surgeries, and bone grafts, followed by implant failure and replacement of both implants after two years.
- After integration, the replacement implants began to suffer bone loss by the end of year three.
- The dentist then recommended that the patient consider a fixed implant-supported prosthesis, but the patient refused. Instead, the patient preferred to proceed with the option offered for three new implants (retaining the two existing implants) and a new overdenture.
- The general course continued, with loss of bone after initial implant integration, relatively constant peri-implantitis with periodic pain, localized infection, removal of granulation tissue, and placement of bone grafts in several areas.
- The dentist replaced two failing implants by the end of year four. Six months later, the implants at the positions of 27 and 20 required removal and replacement. The new implant at 27 did not integrate. Following graft placement and bone healing, the next implant placement was initially successful.
- By the end of year five, the implant at 22 had lost significant bone and required replacement. The implants placed during the five-year period were 8.5 to 10 mm in length. In replacing the implant at the tooth 22 position, the dentist decided on an 11 mm length.
- Four days after surgery to remove/replace the implant at 22, the patient complained of moderate pain and discomfort in the area. Upon examination, the dentist noted minor external swelling. He prescribed an antibiotic but did not obtain a radiograph of the area.
- About a month later, the insured dentist entered several chart notes for communications that occurred since the last visit. The chart notes on this day indicated that the patient's spouse called, demanding the patient be seen immediately due to the ongoing pain on the lower left side of her mouth.
- The patient presented to the office that afternoon, and the dentist obtained a new cone beam CT scan. The image revealed a mandibular fracture inferior to the implant at 22. The patient did not report paresthesia during this visit. Her primary complaint was pain, and there was no documentation of nerve injury assessment. This was the last visit with the insured dentist.
- The insured immediately referred the patient to an oral and maxillofacial surgeon whose assessment revealed loss of nerve sensation in the fracture area and chin. The surgeon scheduled and completed repair of the fractured mandible a week later.

Unfortunately, the post-fracture repair period resulted in further complications. Over the next ten months, the oral surgeon removed the remaining implants at various times due to poor integration and bone loss. The patient developed left mandibular infection with an external draining fistula. Following two hospitalizations involving a second oral surgeon and the help of an infectious disease specialist, the patient's infection was eventually eliminated.

Near the end of the ten-month period, and after consulting a prosthodontist regarding restorative options, the patient and her spouse filed a lawsuit against the insured dentist.

**Key Allegations:** Negligent dental care including: failure to refer/offer referral; substandard implant therapy; inappropriate implant placement leading to injury; failure to diagnose/treat infection; delayed diagnosis of the fractured mandible

**Alleged Injury/Damages:** Treatment expenses and physical damage from multiple failed implants, bone grafts and gingival surgeries; iatrogenic fracture of the mandible secondary to implant placement; mandibular osteomyelitis; infection-related external fistula and resultant scarring; permanent mental nerve injury; hospitalization; future dental/medical treatment expenses; and loss of consortium. Initial demand was in the high six figures.

**Analysis:** As discovery for the lawsuit proceeded, the defense assessment indicated probable liability related to the mandibular fracture. Moreover, review of the records for the five-year implant treatment period revealed documentation concerns. Defense experts opined regarding possible deviations from the standard of care as well. Key points included:

- Diagnostic and implant treatment records were mostly adequate. However, progress notes and treatment records were missing for several visits during the treatment period.
- The dental patient information record consistently documents the patient's poor oral hygiene and home care. However, there is no documentation of patient education efforts, recommendations, or treatment options to improve or address this concern.
- Defense experts questioned patient selection. Although the initial plan for an implant-retained overdenture seemed reasonable, no rationale was documented for expanding the number of implants. Specialty referral for treatment or a second opinion would have been reasonable and in the patient's best interest, especially in view of the patient's poor response to therapy and ongoing implant failures.
- Although the records included a written informed consent for the initial treatment plan, there was no progress note to document a doctor-patient discussion. Furthermore, the record did not include a rationale, or an updated consent form associated with the modified treatment plan to increase the number of implants.
- Regarding the mandibular fracture, the experts agreed that the dentist breached the standard of care when he removed the implant at 22 and immediately placed a longer implant with an active/aggressive thread pattern. Although jaw fracture is a possible complication, the experts concluded that a reasonable and prudent dentist would have placed a graft followed by three months healing before implant placement.

**Outcome:** In consultation with the claim specialist and defense counsel, the dentist agreed that the best course of action would be to settle the case before trial. At mediation, the defense effectively presented the insured dentist's qualifications and the patient's history of poor home care. The defense also convinced the mediator that the proposed future treatment costs were much higher than required to meet the patient's functional and cosmetic needs. Negotiations resulted in a total incurred claim cost (settlement plus claim expenses) of $300,000, well below the plaintiff demand.

Dental implant therapy entails inherent risks, and implant failures may occur even when treatment meets the standard of care. Notably, the patient plays an important role in treatment success. The patient's medical history, overall health, medications, and home care compliance all contribute to long term positive outcomes.

Dentists should consider and discuss the benefits and risks of therapy with patients, with a focus on the unique needs and challenges related to the individual patient. If a claim is asserted, a comprehensive dental patient information record is critical to a successful defense. The record should include a rationale to support treatment decisions, especially in cases that involve adverse outcomes and treatment plan changes. Ensure that the informed consent process is revisited, as necessary, including comprehensive documentation of the doctor-patient discussion.

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CNA Dental Risk Control


## New Dental Claim Report Released!

You have invested your life in your career, all of which can be threatened by a single malpractice lawsuit or state licensing board complaint. Dentist's Advantage, in collaboration with CNA, has released their newly updated claim report: Dental Professional Liability Claim Report: 2nd Edition. Included within the report are in-depth analysis and risk management recommendations designed to help dental professionals avoid claims and improve patient outcomes.

### Key findings from the 5-year study include:

- **$134,497:** Average cost of a malpractice lawsuit against a dental professional, including legal defense costs
- **30.5%:** The increase in the average cost for a malpractice claim against a general practitioner since the 2016 claim report
- **Inadequate precautions to prevent injury:** Most common malpractice allegation against dental professionals
- **Corrective Treatment:** Procedure resulting in the highest percentage of injury claims (25.5%)
- **$4,428:** Average legal cost to defend a dental professional from a licensing board complaint – an increase of 18.7% from the previous dataset

Click here to get your free copy of the report.

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