DENTIST'S ADVANTAGE
PROFESSIONAL LIABILITY & PRACTICE PROTECTION

The National Society of Dental Practitioners and the Dentist's Advantage Insurance Program for Dentists

RISK MANAGEMENT ARTICLE

Patient Safety and Liability Considerations for the Dental Team Dental Expressions® – From the CNA Claim Files

Dentistry is a team business. No matter how or where you look in a dental practice, dental team members are vitally important to patient safety, risk management and practice success. With multiple patient contacts in a variety of interactions, dental team members have a profound ability to improve patient satisfaction and safety, reducing the likelihood of a professional liability claim.

To illustrate, this article provides several examples of patient safety, professional liability and/or dental licensing board incidents involving dental team members. The scenarios support the importance of training team members on risk management concepts, involving them in the development and improvement of office protocols, and mentoring/monitoring activities over time to ensure consistent quality and compliance.

Incidents that arise due to dental team member activities may lead to "vicarious liability."
The legal theory of vicarious liability holds employers responsible for the acts and omissions of their employees, based upon the legal concept of *respondeat superior.* Vicarious liability risks are typically clinical in nature, although they can be based upon communication errors or omissions. Non-owner dentists also must mentor/monitor dental team member performance: the owner/employer may be vicariously liable, but a supervising dentist is also directly responsible for professional patient care-related acts or omissions of dental team members under their supervision.

Scenario 1: Infection Control Breach
Facts and allegations. A dentist contacted the risk management support line after discovering that a dental team member had breached the office infection control protocol. This issue involved dental handpieces where the team member failed to comply with the office protocol by only treating the devices with a surface disinfectant to prepare them for re-use. The handpieces were not sterilized, increasing the risk of cross-contamination and patient exposure to pathogens. The dentist learned that this was not a one-time breach, as may occur with sterilization equipment failure, but had been occurring for several weeks. The dental team member explained that she decided to process the equipment in this way to save time. The number of handpieces available was insufficient, and running them through the sterilization cycle was causing delayed operatory setup and scheduling backlogs. She further stated that she did not think it was a "big deal," since she had used the same process in the past when working for other dentists. The dentist indicated that the employee had been with the practice for several years and that the office conducted annual OSHA bloodborne pathogen and infection control training. The dentist immediately terminated the employee.

Scenarios 2: Scope of Practice Breach
Facts and allegations. In this scenario, a dental board complaint alleges "substandard care" during crown treatment. After the preparation and impression visit, the patient returned for removal of the temporary and delivery of the final crown. The complaint alleges that "The dental assistant attempted to remove the temporary tooth and was having difficulty. She then "used the drill" and removed the temporary. Finally, the assistant "attempted to apply the drill to the very sensitive [prepared tooth] area, not once but several times. I jerked away, causing her to bump into adjacent teeth with the drill. It was horrifying. I believe the dental assistant was practicing out of her scope of practice."

Scenario 3: Inappropriate Patient Contact
Facts and allegations. The mother of an adolescent female patient was very upset and filed a police report after the following incident. The patient visited the dental office for removal of her braces. Active treatment was complete, and she would be receiving retainers. A male orthodontic dental assistant, employed by the practice owner, had worked with the treating independent contractor orthodontist for a number of years. The assistant removed the patient's braces and when finished, the assistant kissed the patient on her cheek. This behavior was unexpected and disturbed the patient. She missed school the following day and later met with the school counselor. According to the two dentists, nothing like this had ever happened in the past. Soon after the incident, the assistant was terminated.

Scenario 4: Failure to Follow Documentation Procedures
Facts and allegations. This scenario resulted in the filing of a liability claim and lawsuit against a dentist involving an alleged patient injury during tooth extraction. In the course of preparing the dentist's defense, a problem was discovered with the informed consent documentation. Only the signature page of the two-page consent form was included in the dental record. Moreover, there was no documentation in the record of a consent discussion. The office had transitioned to electronic records and at this time, paper consent forms were being scanned and saved electronically in PDF file format. Original paper documents were not retained. It was later determined that a long-time dental team member made an independent decision to save computer space and simplify/speed up the process. Only the signature page was scanned into the record. As the office failed to validate the transition from paper to e-records and did not conduct routine chart audits, the erroneous process was not discovered until significant time had elapsed the team member's decision.

Overall analysis and recommendations:
From a claim perspective, these specific incidents did not represent "high loss" outcomes. (However, two cases did result in significant losses in the mid-five figure range.) For each example, a relatively minor variation in the facts, or in the actions taken by the patient or parents in response to the incident, may have led to much greater losses, and even criminal prosecution. Were dentists/employers at fault? Employees? Both? Importantly, were processes, protocols and training implemented *and understood* to help prevent the incidents? Is "placing blame" necessary in all cases?

Related to the dental team training theme, a few points to consider include:

- All training efforts are important and some topics are required by laws/regulations. However, documented training does not equal understanding and compliance. It is important for dentists/employers to train, but also to discuss with team members: (i) the rationale for training; (ii) the risks associated with non-compliance; (iii) the corrective actions or consequences for non-compliance; and (iv) the steps required to propose and gain approval for process/protocol changes and improvements.
- Does the practice embrace a "just culture" approach? [Resource: "Understand Just Culture" video clip- https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/videos/07a_just_culture/index.html] A just culture recognizes that while human beings are fallible, they are also capable of learning from errors. When individuals feel comfortable disclosing and discussing errors and lapses in judgment, it becomes possible to correct problems via process improvements, education and coaching. While incidents such as those described often lead to placing blame and termination, the circumstances may implicate a system or process failure as the root cause. On the other hand, a just culture does NOT condone reckless behavior or decisions that reflect a disregard for patient safety. Some of the behaviors in the scenarios MAY have been associated with a lack of training or other process issues, leading to a failure to understand the risks associated with a decision. It is also possible that a detailed review of each scenario may lead one to conclude that one or more of the individuals acted in a reckless manner.

- Dentists and other employers generally want to hire individuals who are proactive, innovative and driven to improve their knowledge and skills. In the clinical setting, innovation and skill enhancement must follow an appropriately mentored and monitored process that incorporates safety and risk assessment concepts, while also considering the appropriate scope of practice. Are dental team members engaged in risk assessment and protocol development when the office implements a new procedure? Do they understand the scope, the training required to expand it, and the process for implementation?

As dentists and dental team members read this article and consider the scenarios, we hope that more questions and considerations come to mind. Then, take the next step. Discuss those questions and discover the best answers and approaches to address them within your practice environment.

Achieving a just culture requires the fostering of accountability on the part of both the employer that implements systems and processes, and the individuals who make choices within those systems. When we acknowledge that no practice is perfect, and then begin to recognize, track and objectively analyze adverse events as a dental team, we establish a solid platform for learning and improvement that will benefit patients and the dental practice.

Article by: Ronald Zentz, RPh, DDS, FAGD, CPHRM
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