Medical and Dental Errors and Omissions

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OBJECTIVES:

At the conclusion of this continuing education activity, the participant will be able to:

- Recognize the most common medical/dental errors in dental offices.
- Identify medical errors associated with prescriptions, including dosage errors, and diagnostic errors.
- Identify errors associated with dental record keeping, informed consent, failure to diagnose, misdiagnosis and failure to refer.
- Discuss methods of reducing errors, including using root cause analysis and risk management techniques.
- Discuss legal and ethical considerations.
- Discuss efforts at Federal/State to reduce medical errors.

OFFICIAL DISCLAIMER:

(From Laney Kay, President, Entertaining Training, LLC: This is necessary because a grown person pitched an absolute hissy fit.)

This program is intended to provide continuing education credit on the topic of medical and dental errors and omissions in dentistry. In addition, this program is intended only to offer general guidance about dentistry's role in understanding and minimizing medical and dental errors and omissions; any suggestions offered by me are only my opinion and should not be construed as advice, legal or otherwise. Any specific questions, circumstances, or situations you are concerned about in your particular office should be addressed by your own attorney, (such as issues related to malpractice, informed consent, standard of care, statute of limitations, negligence, etc). No one, including me, can "lawsuit-proof" an office and nothing said in this program will reduce your likelihood of an inspection/investigation or any other state or federal agency inspection/investigation, nor will it prevent you from getting fined, nor will it reduce the amount of the fine in the event of an inspection/investigation, nor will it prevent a lawsuit.

MEDICAL ERRORS AND OMISSIONS IN DENTISTRY

In the US, between 250,000-400,000 people die from medical errors every year, making it the third biggest killer of americans, behind heart disease and cancer. (Anderson, 2017)(Makary, 2016).

A 2017 national survey released by the Institute for Healthcare Improvement/National Patient Safety Foundation Lucian Leape Institute and NORC at the University of Chicago found that 21% of American adults report having personally experienced a medical error, and 31% had a friend/family member experience an error. http://www.ihi.org/about/news/Documents/IHIPressRelease_Patient_Safety_Survey_Sept28_17.pdf

In an earlier study in 1994, authors of the Harvard Medical Practices Study of adverse medical events analyzed 30,195 randomly selected records from 51 hospitals in NY state and estimated that there are almost 2 errors/day in the average ICU, and one out of five of those errors were potentially serious or fatal. If these performance levels were equated to other industries, it would be like 2 dangerous landings per day at O'Hare international Airport and 32,000 checks deducted to the wrong account per hour. (Leape, 1994)

Upwards of 250,000 people die every year from hospital errors, injuries, accidents, and infections.
Every year, 1 out of every 25 patients develops an infection while in the hospital, and a Medicare patient has a 1 in 4 chance of experiencing injury, harm or death when admitted to a hospital.
https://www.hospitalsafetygrade.org/errors-injuries-accidents-infections .

A 2011 study estimated that there were 6.3 million medical injuries in the US that year, and approximately 1.5 million of those were caused by a medical error. These injuries result in additional costs as high as $29 billion per year. (Van Den Bos, 2011). Medication errors are also a huge problem. In the US, there are approximately 7,000-9,000 deaths attributed to medication errors, and hundreds of thousands of other patients are affected. (Tariq, 2021)

A huge study was sponsored by the Society of Actuaries' Health Section in 2010. It used data from medical claims in 2008 to estimate how many medical errors occur annually in the US, and how much those errors cost the US economy. They found that, in addition to direct costs attributed to medical errors, there were additional indirect costs, as well. These errors resulted in more than 2,500 deaths, which resulted in an estimated cost of $1.4 billion related to increased mortality rates. Ten million excess days were missed from work due to short term disability, which resulted in a cost of more than $1.1 billion. (Van Den Bos, 2011)

Each year in the United States, more than two million healthcare-acquired conditions are responsible for 90,000 deaths and $5.7 billion in added healthcare costs. (NQF, 2008)

Some of the most recent statistics estimate that approximately 400,000 hospitalized patients experience some preventable harm each year, while another estimated that >200,000 patient deaths annually were due to preventable medical errors. Moreover, the reported cost of medical errors is wide-ranging, with some experts estimating $20 billion each year and others approximating healthcare costs of $35.7 to $45 billion annually for hospital-acquired infections alone. (Rodziewicz, 2025)

The Mayo Clinic performed a national survey of nearly 6,700 American doctors and found that 10% doctors reported that they had made a major medical error within the past 3 months.
(http://www.ihi.org/about/news/Documents/IHIPressRelease_Patient_Safety_Survey_Sept28_17.pdf)

It also found that "physicians with burnout had more than twice the odds of self-reported medical error, after adjusting for specialty, work hours, fatigue and work unit safety rating," said Daniel Tawfik, MD, an instructor

in pediatric critical care medicine at Stanford University School of Medicine and lead author, in a news release. "We also found that low safety grades in work units were associated with three to four times the odds of medical error." (Tawfik, 2018)

Bottom line, adverse events are a huge problem in medicine. This class is designed to help make us aware of potential issues and how to avoid them.

Definitions:

Let's discuss a few definitions.

First, what's a **medical error**? An unexpected medical problem that happens during treatment with a drug or other therapy. The error may or may not cause harm.

Adverse event is an injury, preventable or nonpreventable, that causes harm to a patient as a result of medical care. An adverse event may be mild, moderate, or severe, and may be caused by something other than the drug or therapy being given. This includes never events; hospital-acquired conditions; events that required life-sustaining intervention; and events that caused prolonged hospital stays, permanent harm, or death. This term is often used instead of "error". Error is a negative word and a bad result can result from excellent care. The tesm "adverse event" tends to reduce blame and allows discussion without the doctor feeling as attacked. However, the truth is that whatever you call it, the goal is to reduce the number of problems.

If an unexpected adverse event results in death or serious temporary or permanent physical or psychological injury it is called a **sentinel event.**

A **"never event"** is a preventable adverse event that should NEVER happen. There is a list of never events that was developed in 2002 and now consists of 29 "serious reportable events," according to a Patient Safety Primer report from the Agency for Healthcare Research and Quality. (Mehtsun, 2012). According to a 2020 presentation by JCAHO, the five most common never events during the first half of 2018 were "falls, unintended retention of a foreign body, wrong-site surgery, suicide, and delay in treatment." https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/most-frequently-reviewed-event-types-2020.pdf

"**Negligence**" is defined as care that falls below the standard expected of health care practitioners in their community. (Brennan, 2004).

Medical errors and omissions can occur in any setting. Most of the ones we are dealing with are in hospital settings, but they can happen in any medical or dental setting. As more and more procedures are moved into outpatient facilities, there is significant potential for serious injuries b/c of lack of standardization of protocols and staff credentials.

Everyone hears horror stories about people who die from liposuction and other seemingly minimal procedures. Most of them are in outpatient facilities that aren't set up for emergency procedures and they have a reaction to anesthesia. Olivia Goldsmith who wrote the 1st Wives' Club and Joan Rivers both died after anesthesia administered during plastic surgery.

My personal opinion is that the traditional system of covering your butt is completely the result of lawyers. Any of y'all ever been home during daytime tv? Have you been injured? Have you eaten too much taco bell? Call us, we'll get you the compensation YOU DESERVE. Ugh.

Everybody's so scared of being sued that they cover their butts instead of trying to find out what actually happened and how they can prevent it from happening again. Preventing errors has to be a team effort. There need to be systems of checks and balances in place that will help us recognize and reduce errors before they happen.

Lack of education and understanding of why things are done the way they're done are common reasons for errors. Another common reason is that everyone is short staffed after COVID, and employees are overworked and many are suffering from burnout. It's easy to make mistakes when you can't take the time to look over a chart, or when you have so many patients that they get confused on your mind.

Another cause of so many mistakes is managed care. If you can't take time to get to know your patients, if you're running patients through your office like cattle, it's easy to make mistakes.

So here we are in a situation where nurses are overworked and fried, hospitals are understaffed, doctors are encouraged to spend less time getting to know their patients and therefore, their medical histories. COVID has added even more complications, between employee shortages, patient attitudes, and the fact that a significant portion of the American population has lost the ability to control their behavior. Add to this lovely mix the fact that a huge percentage of Americans are uninsured so they don't get timely care, and the butthead lawyers are just waiting for someone to screw up and you've got a situation that has a tone of mistakes waiting to happen. No wonder health care costs are through the roof!

Types of Errors:

In medicine, the types of errors you generally see are:

Administrative errors are generally caused by mislabeling of the person or procedure to be done. An example would be that someone goes in to get a shoulder fixed, and has a kidney removed instead because the patient names got mixed up. Systems now require multiply checks to avoid these issues.

It can also include errors involving a lack of checks on charting and treatment records. An example of this would be a situation where a biopsy comes back with a bad result and the patient isn't notified.

Treatment errors are errors done during a procedure or a test that results in damage, or when there are avoidable delays in treatment after receiving test results.

In surgery, you'll see errors involving the wrong body part, or the wrong patient, or the wrong procedure was done. When analyzed, it has been shown that most errors are cause because people are in a hurry, or they're making exceptions, or they're doing something out of the norm, or they're doing a procedure that involves several different procedures or doctors.

Another type of treatment error is avoidably delaying treatment. Examples of this would be not diagnosing a disease in a timely manner, which results in treatment being delayed. Conditions such as strokes, blood clots, cancer, heart attacks, and aortic dissections are often missed because the symptoms may be vague or misleading. Meningitis and encephalitis are the most commonly missed infectious disease diagnoses. Unfortunately, with all of these illnesses, even a small delay in treatment can be devastating, even fatal.

Diagnostic Errors involve making an incorrect diagnosis, which can lead to unnecessarily invasive tests or allows a disease to progress unnecessarily. Another error would be using an incorrect test, or failing to order a test that would have revealed the condition.

Medication errors:

"The most common reasons for medication errors include failure to communicate drug orders, illegible handwriting, wrong drug selection chosen from a drop-down menu, confusion over similarly named drugs,

confusion over similar packaging between products, or errors involving dosing units or weight. Medication errors may be due to human errors, but it often results from a flawed system with inadequate backup to detect mistakes." (Tariq, 2021)

Most of these errors occur while health care workers are in control of a drug, either when the prescription is written, or when it is dispensed. Many states have adopted legible prescription laws to reduce errors due to doctor's awful handwriting.

In emergency departments, one study showed that "the most prevalent types of medication errors were related to infusion rates (33.3%) and administering two doses of medicine instead of one (23.8%). The most important causes of medication errors were shortage of nurses (47.6%) and lack of sufficient pharmacological information (30.9%)". (Ehsani, 2013).

Several years ago, several hospitals had patients injured because a certain brand of insulin and heparin were packaged very similarly, and both of those drugs can have a big impact on the body. In one case, insulin was used to flush an IV line instead of heparin, and the patient died.

The best means to avoid these problems in hospitals is the use of computerized drug administration systems. Errors can still occur, but it significantly reduces the incidence of issues.

Another problem is improper monitoring after a drug is administered, especially in today's understaffed hospitals. My grandma was given a beta blocker to control her high blood pressure-in hospital with liver failure so drugs clear slowly out of her system-gave it too soon and her BP crashed & she went into a coma. That would be considered a SENTINEL EVENT even though no permanent damage)

The populations most likely to be affected by drug-related mistakes are kids and older people. With older people, they often take multiple medications and their organs do not clear drugs out of their systems as easily as younger people. With kids, the problem is often dosing because it's determined by weight and age, and it's easy to mess up the conversion.

In dental offices, the medication problems that cause the most severe problems deal with allergies, overdoses and drug interactions when sedating kids. The greatest risk of problems occurs when 3 or more sedating drugs are used.

Several years ago a child died in south Georgia while under anesthesia for dental procedures. It was found that the problem was caused by a combination of mom not disclosing everything on a medical history form, plus too many drugs were given.

In hospitals, errors have occurred when the wrong gas tanks are hooked up to a supply system. Analysis showed that often they didn't check the labels and when the fittings didn't work they substituted one that would work. So, if several gases are used in a facility, always take time to verify labels to make sure it's the right gas and NEVER switch out the fittings on a tank to make it fit.

Dental errors:

Common errors in dentistry

- Prescriptions
- Neglecting current scientific evidence regarding treatment
- Errors during treatment/improper maintenance of equipment

- Failure to maintain records
- Failure to get informed consent
- Infection control failures
- Failure to diagnose
- Failure to prevent accidents or complications or failure to provide appropriate follow up
- Violation of standard of care

For hygienists, most board complaints involve not completing the CE requirements or not using approved CE providers.

Most Board of Dentistry violations for doctors involve recordkeeping problems, practicing below the standard of care, and compliance with records requests. Always keep thorough records, and keep good notes, especially on patients with problems, like poor home care, poor compliance with referrals, people who refuse treatment, etc. Make sure you always take necessary pre-and post-op x-rays to make sure that you can corroborate what you see.

The **MOST COMMON complaint**, and now the most common HIPAA complaint, is not sending patient records when requested. You MUST send a copy of a patient's record, even if they owe you money. Here's the problem. The HIPAA folks consider this to be a huge burden on a patient's "**Right to access**" medical information. You can't do it. Even if your state law says you don't have to give them a record, they can still report you under the HIPAA rules, so you have a problem.

Because this has become such a problem, the fines are getting bigger and more common. The smallest fine they listed for right of access violations was for a small psychiatric practice that failed to provide records to a single person when she requested it. That fine was $3,500. There were several other offices, all of them failing to send records upon request to a single person. Those fines were $10,000, 15,000, 38,000 and $70,000. **All of these fines were about a single person requesting a record, not a bunch of people being ignored.**
FYI: the fines have gotten much larger the past several years.

Most common Board complaints involving patient care were things like:

- **temporary insignificant injuries:** accidently nicking someone's tongue or lip with a bur
- **temporary minor injuries:** failure to diagnose an abscessed tooth, mismanaging a dry socket
- **permanent minor injuries:** failure to diagnose perio disease that had not progressed significantly

LESS common problems:

- **emotional distress** frightened patients negligently and unnecessarily
- **temporary major injuries**: failure to remove Gore-tex membrane, burning of a palate from failure to temper a hydrocolloid impression
- **permanent significant injury:** perio disease that had progressed significantly, organ damage from wrong drug prescription
- **permanent grave injury**: damage from anesthesia mishap
- **death**: anesthesia mishap or mismanagement of anaphylaxis

There have also been cases because of equipment failure, such as a file breaking off, or a patient aspirating an item. Several years ago, I had an office who had a situation with a difficult patient. While working on her, an air/water syringe flew down her throat and she swallowed it. She freaked out and the doctor wasn't very

supportive, and it became a huge deal.

Another type of equipment failure would be disease transmission from improperly maintained waterlines.

Misdiagnosing, or failure to diagnose, oral cancer is becoming a more common liability issue as the cases of oropharyngeal cancer continue to rise. In fact, it's estimated that, in 2021, 54,000+ people will be diagnosed with oropharyngeal cancer this year, and 10,800+ will die.

Here is the deal with oral cancer. "If the cancer is diagnosed at an early stage, the overall 5-year survival rate for all people is 85%. About 29% of oral and oropharyngeal cancers are diagnosed at this stage. If the cancer has spread to surrounding tissues or organs and/or the regional lymph nodes, the overall 5-year survival rate is 67%. Almost half of cases are diagnosed at this stage. If the cancer has spread to a distant part of the body, the overall 5-year survival rate is 40%". https://www.cancer.net/cancer-types/oral-and-oropharyngeal-cancer/statistics

One of the major problems is the location of the cancer. Oral cavity and oropharyngeal cancers occur most often in the following sites:

- The tongue
- The tonsils and oropharynx
- The gums, floor of the mouth, and other parts of the mouth
- The rest are found in the lips, the minor salivary glands (which often occur in the roof of the mouth), and other sites. https://www.pennmedicine.org/cancer/types-of-cancer/throat-cancer/types-of-throat-cancer (*Also, see handout, "Oropharyngeal cancer sites and treatment" for symptoms and treatment info*).

Because these areas are often difficult to visualize, they are difficult to diagnose. For example, many lesions occur on the BACK of the tonsils, the base of the tongue, or, in the throat, which is very difficult to see, especially in a patient who is a gagger. That's why it's so important to make sure you know the symptoms of oral cancer, in the event you can't see it.

These tumors in the tonsils and back of the throat often spread easily to the lymph nodes before any other symptoms appear. In fact, the first symptom is often an unexplained lump in the neck. So, if you have a patient over 40 who has a lump in the neck, many doctors are saying that should be considered oropharyngeal cancer until proven otherwise. So immediately refer that patient out to get any unexplained lumps evaluated.

With these types of cases, the problem is usually failure to diagnose, or failure to follow up. If a patient has symptoms that are compatible with oral cancer, refer the patient for an evaluation immediately, if it's a situation you aren't able to properly evaluate. Make sure you biopsy, or refer out for a biopsy, any suspicious lesions. Make sure you follow up with patients to make sure they follow up, and make sure your documentation is very complete, ESPECIALLY if the patient refuses to follow up.

How do we prevent these errors?

Most error prevention experts agree that root cause analysis is the best method for reducing medical errors.

ROOT CAUSE ANALYSIS is an objective system of analyzing a situation. Instead of looking at whose fault a situation is, you look at it as a theoretical problem and figure out how to solve it.

It allows you to determine what happened, why it happened, and what can be done to keep it from happening again, WITHOUT assigning blame.

The idea is to take an adverse event and figure out why the situation happened. Which systems and processes in the office need to be changed to make sure that it won't happen in the future?

When organizations have done root cause analysis on adverse events, they often find that several systems broke down, which allowed the situation to happen. Years ago, a study was done that "did a root cause analysis of an event where a woman was given an invasive cardiac test by mistake. Fortunately, before any damage was done, the test was stopped.

When they did a root cause analysis, they found that there were 17 separate errors that allowed this one incident to occur. The patient she was confused with had a similar name. The nurses went to get her even though there was no written order. No one in the cath lab verified her identity.

Thanks to a sufficient analysis, there are new procedures in place that require identification verification at several different points, the patient is verbally asked what she's in for, and records, bracelets, etc. are all required to match at several different points. (Chassin, 2002)

We work in small facilities, where we don't have committees that discuss all this, but the process itself is actually very helpful.

ROOT CAUSE ANALYSIS:

How does the process work?

1. Establish procedures that examine the adverse event
2. Analyze existing procedures, systems and processes related to the event
3. Determine where flaws, breakdowns and/or mistakes in procedures, systems and processes caused the problem
4. Determine whether uncontrollable external factors and/or human factors contributed to mistake
5. Revise systems wherever needed to prevent same problem from occurring again

In order for the analysis to be successful, everyone:

1. Needs to be involved, including people who were involved with the event, plus leadership of the facility
2. Must be impartial. Of course, human factors must be considered, but the analysis should focus most on the systems that allow the human factors to occur
3. Should ask "why" at each level of cause and effect
4. Identify risks and their potential contributions
5. Identify improvements and changes that need to be made in systems or processes

How can we use Root Cause Analysis in a dental office?

Realistically, we don't have a huge facility that requires committees and several levels of checks and balances, but we still need to look at the same process.

We have a much more personal environment, which both helps and hurts us. We are more likely to break

established procedures because we know the patients, because we have personal involvement with patients, and we know their situations.

Think about it. You have an older lady patient, she's on a fixed income, you know her family, she needs an extraction. You KNOW you shouldn't do it because it's going to break, it's going to be ankylosed, she's going to bleed, but you do it anyway because she doesn't have the money to get it done at the oral surgeon's. We ALL do it.

Here's an example with a wrong tooth extraction: A mom brings her kid to get a baby tooth extracted for ortho. The extraction order is more than a year old. It's a day from hell and everyone is running behind, including this patient. The mom is a freak about dental x-rays and absolutely freaks out about a pre-op x-ray. Since it's just a baby tooth, the doctor doesn't push it. The orthodontist is going to eventually extract the 2nd premolars. The doc takes a look and everything looks exactly like it should. He elevates the baby tooth, it comes out…and it's a permanent tooth. It looked like a baby tooth, but it wasn't. It was a first premolar. The GP calls the orthodontist who tells him it's no big deal, he can do it with 1st premolar extractions instead, but it could have been a nightmare.

Using a root cause analysis to look at this program, what can you determine?

- **What happened?** Wrong tooth was extracted

- **Why did it happen**? Everyone was in a hurry, the doctor was trying to avoid a hassle with a patient who was a total pain, so they didn't verify x-ray/extraction order, and didn't take an x-ray. In this case, the existing procedures were fine, but human factors caused the doctor to violate established procedures.

- **How do you prevent it from happening again**? Understand there are some procedures that can't be violated because of convenience. In the future, always verify extractions with a pre-operative x-ray, always have a current extraction order, and if a parent refuses to allow you to do that, refuse to treat the patient.

Always remember the following rule:

The patient you break the rules for will bite you in the butt.

In the previous case, if the orthodontic treatment couldn't have been done because that tooth was extracted, that mother wouldn't have hesitated to attack.

Error Reduction and Prevention:

So, the best methods of reducing errors are setting up an environment where patient safety is the number one priority and setting up systems and procedures that limit mistakes. And if employees in the office see a procedure or system that may be problematic, they need to be comfortable to bring it up for discussion.

Take as much of the human factor out of procedures as possible. Use checklists, automated prescription programs, simplify processes and have enough people to take care of patients. Use computers to print prescriptions instead of writing them out.

Preventing medical and dental errors:

- Take a thorough medical history and schedule enough time to adequately listen to your patients (sometimes what they don't say is as important as what they do say)
    - Regularly update medical histories. Make sure you get info about all medications and dietary supplements, and all allergies or previous adverse reactions to any drugs; history about diseases; info about lifestyle and habits, like alcohol and tobacco use, and unintentional weight loss; pregnancy status and info on family violence; and always ask whether the patient wants to talk to the doctor privately.
    - In dentistry, the problem we have is that most patients don't think of their general health as having to do with their mouth. We had a patient come in for a prophy, and I updated her medical history. She said she'd had no changes in her medical history. As she was checking out, she said something in passing about changing her previous appointment, and she said she had to because she was in the hospital having her aortic valve replaced. I questioned her, because I'd personally updated her medical history and I reminded her that she had just told me she hadn't had heart surgery. She looked at me like I was crazy and said, "it wasn't my heart, it was my valve. My heart is in perfect shape."

To avoid treatment errors:

- In medical facilities, verify patient name at several levels, verify surgical sites and procedures, verify relevant history, verify blood type and allergies, make sure everything is documented at every level and all instructions are documented in the chart so they can be followed easily.

- In dental facilities, verify patient name, procedure, and tooth numbers. Update medical histories, including information about allergies, and medication, including supplements and over the counter medicines. Make sure all relevant xrays are taken before a procedure is performed and extraction orders or orders from other doctors are verified. Make sure the patient has been informed about all risks/benefits/alternatives to treatment, including doing nothing, and has given consent. If signed consent is necessary, make sure all forms are signed. Check the chart to ensure that the procedure is correctly and completely documented.

To avoid medication errors:

- In hospitals, make sure instructions are clear for nurses and technicians. Most errors occur when titrating IV medications, so always check any math before submitting an order. Make sure all machines are correctly set up to dispense medications correctly. When submitting a medication order, always check name of the drug, dosage amount, and instructions on dispensing the drug. Before dispensing the drug to a patient, make sure it's the correct drug.

- Make sure that prescriptions are correctly and legibly written. Make sure you are familiar with all medications the patients are taking, including supplements and other over the counter drugs. Don't prescribe anything that may cause problems with other drugs or can cause an allergic reaction. Be very careful of dosage, especially with kids, where you have to consider both age and weight. If you're not sure about a dosage, call the child's pediatrician to get dosage recommendations.

To avoid errors related to devices and equipment:

- In hospitals, there can be failures of anything from catheters to life support systems, so always visibly

inspect equipment to be used and make changes when the equipment is worn or broken. When patients are sent home with any sort of equipment, make sure they understand how to use it.

- In dentistry, making sure patients know how to use an appliance or device is very important. If you deliver a denture, partial, retainer, or other appliance, explain how it works, how to care for it and how to put it in/take it out. Don't just explain how to do it. Show them and have them show you so you can see them do it, especially with older patients. Being able to take out and put in a denture or partial is very important.

    - The ADA recommends that lead aprons should be used whenever possible, even if you use digital xrays. Even though the amount of radiation that patients are exposed to are generally low, our goal is to minimize exposure as much as possible, since radiation exposure is cumulative. Plus, there is always the possibility that an xray unit could malfunction and patients could be exposed to abnormally high levels of radiation.

    - For other dental equipment, such as burs, endo files, etc., always visually inspect before using them to make sure they're intact. Make sure air/water syringe tips are secured well before using. Use eye protection on patients, make sure all infection control procedures are in place and are followed, and test and treat waterlines regularly (according to manufacturer's recommendations).

Risk Management, Damages, and Reporting adverse Events

The best way to reduce errors is to set up policies and procedures and follow them. When it comes to dealing with patients, take your time, talk to your them and educate them. Educated patients can participate in their own health care and are responsible for making sure that their care is done properly.

When you communicate with patients, always use language that is adequate for the patient's education and intelligence. Make sure that there are no language barriers when explaining something to a patient. Use non-technical language and always take responsibility for ensuring that the patient understands. Instead of saying "Do you understand?" (which could make the patient feel stupid if they say they don't understand), try "Did I explain that okay or is there anything that I need to go over again?"

Listen to the patient and look at the patient's body language

Always make sure you get informed consent before doing a procedure. Different states require different methods of providing informed consent. Some require signed forms, some require disclosure and documentation, but not necessarily a signed form, some require signed forms for some procedures, other require a combination of all those. So check with your state to make sure you're complying with the rules.

It's always a good idea to use brochures, videos, or any other materials that will help explain it better, if you feel it will be helpful. You can't just hand materials to the patient, you also have to explain it to the patients.

A signed form isn't absolute protection; it's basically evidence that you did what you said you did.
It's better to have patients participate in their own care so they can make informed decisions about their own care.

If you screw up, it's best to say you're sorry and how you're going to fix it. "I'm sorry" is not necessarily an admission of liability. You can be sorry for what happened, sorry for the result, without having caused it. (We

all know about bad results, despite good treatment.) **However, if possible, you should speak to a lawyer before you talk to the patient so you can confirm the wording to make sure that you're not opening a can of liability worms, especially if it's a serious injury**.

Studies have been done in hospitals, and most of the time, people just want to know what happened, they want an apology, and they want to know what you're doing to make sure it won't happen again. They also may want financial compensation, too, but saying you're sorry rarely makes the situation worse. Ethically, trust and disclosure are important parts of the doctor/patient relationship.

What about when you really screw up? Rule is, friends don't sue friends, so if you take the time to have a good relationship with your patient, you are less likely to be sued. Also, fortunately, most of the incidents we have in dentistry don't result in serious injury or death, so people are less likely to immediately look for a legal remedy. Most of the time, they just want the problem fixed.

Documentation:

The way documentation works is that if it's not written down, it didn't happen. Always document that you updated patient's medical history and note any changes. Document blood pressure, any screening questions for diabetes, smoking, pregnancy, etc. Document that patient passed COVID screening.

When documenting treatment, make sure you always document the type, and amount of anesthetic (or note "no anes", or something similar if no anesthetic was used. Document xrays taken and what they showed. Document any treatment accomplished, any complications/problems, prescriptions, information on shades/materials (if relevant), lab used, any followup instructions, and any other relevant information.

Always document any comments made by the patient. I use the "weird" rule…when the patient says something and think in your head, "Hmmm…that was kind of weird," write it down and put it in " ". Especially note comments if a patient is refusing recommended treatment.

Once you get a patient back and start examining and treating the patient, one of the best methods to make sure your documentation is thorough is to use the SOAP method.

- Subjective
- Objective
- Assessment
- Plan

Subjective: What is the patient's major complaint? What symptoms does the patient exhibit? Does the patient have health issues that could affect the treatment?

"1/10/25 Patient presented with pain on the upper right. Currently having allergies and sinus problems. Cold sensitive entire quadrant. #4 very sensitive"

Objective: What is noticed when examining the patient? Is there swelling/redness/etc.? Broken teeth? Does the mouth exhibit widespread issues (like rampant decay everywhere, possible meth mouth, extreme dryness, etc.) Are there any symptoms affecting the area (Teeth/gum/bone) such as evidence of periodontal disease, abscesses, endodontic infection, broken/decayed teeth, missing teeth, broken fillings/crowns/partials?

"#4 sensitive to touch/cold/percussion on #4. No redness/swelling/decay visible. Checked bite. Took xray #4."

Assessment: What treatment needs to be done based on the examination? Most immediate needs should be written first, then other needs should be documented.

"*No infection/decay/visible crack noted on xray. Bite was high, possible sinus infection*."

Plan: Establish a written treatment plan of action for the patient including number of appointments, codes and procedures and phases of treatments and any referrals to other specialists or providers.

"*Dr adjusted bite, no anesthetic, and recommended decongestant/antihistamine to reduce sinus symptoms. Told patient to call if sinuses don't improve. If pain gets worse or see swelling/redness in area, call immediately for appt and possible referral for RCT. Schedule comprehensive exam*. LPK"

When documenting an initial examination of a patient, include:

- Existing conditions
- General status of mouth and teeth
- Existing problems, such as decay, fractured teeth, broken cusps, existing fillings/endo, perio condition
- Occlusal issues
- Soft tissue/periodontal conditions (bleeding, pockets, mobility, recession, furcation involvement, etc.)
- Cancer evaluation

Document diagnosis, treatment plans, and organize future treatment by appointment.

Let's say you have a patient who comes in for an SRP. This documentation is insufficient:

"*SRP right side. Local anesthetic. Home care instructions. Pat dismissed stable*." is not detailed enough.

Here's a better example:

"1/10/25 SRP max/mand R. side. Lidocaine 2% 1:100,000 epi, 1 carp each mand/max. No N2O. Generalized plaque. Generalized heavy calc, espec. lower lingual ant/premolars. Tissue red and swollen. Heavy bleeding upon scaling and probing. Probing depths recorded. Told pat to rinse with warm salt water (1 Tbs/glass very warm water) 2x/day until soreness decreased. Take Advil as necessary. Pat said "I felt you chipped my lower teeth while you were scraping them." Explained it was actually calc, not teeth, that was removed while scaling. Pat dismissed stable. LPK"

Should you dismiss a patient in the middle of a treatment?

Technically, no, you should never dismiss a patient with uncompleted work, although different states have different requirement. However, what do you do when you have a patient who won't come back in and get their work completed? You keep calling and they keep not showing up. What do you do?

You can't drag people into the office and make them complete work. Document all phone calls, and if that doesn't work, write a very specific letter where you spell out when you called, what has been done, what still needs to be done, how important it is that they get this work done, and what will happen if they don't. Ask

them to contact you immediately so you can get them in. If it's a situation that could cause some real problems, I would probably also send the letter certified.

If you feel like their non-compliance is compromising their health, you could argue that they are refusing to comply with treatment and dismiss them as a result, but you're taking a real risk with patient abandonment,

This is one of those lame lawyer situations where I tell you some of the arguments and still don't give you a good answer. Since the answer really depends on state law, call your state dental society or a local attorney for some answers. Your malpractice carrier could also be a helpful source of information.

The same thing goes for a patient who has not finished paying for work. Should you complete the work or insist on payment before continuing?

We get completely robbed on these situations. This is basically the same situation as the one we talked about before. Refusing to finish treatment may be perceived as abandonment, regardless of the circumstances. You have to finish the work, THEN pursue any collection procedures.

There may be some leeway if the patient is stable, even if the work isn't completely done. For example, if a patient has had a completed root canal and now has a temporary crown on a tooth, the situation is stable, even though the treatment is not completed. It might be different if the patient had a root canal that wasn't finished or some other situation that could cause a problem. Then, it MIGHT be possible to dismiss the patient at that stage without as many issues. You'd still have to document, write a letter, and all that, but the patient's health wouldn't really be compromised if you stopped at that point. Ask your dental society or state board to see what the law in your state would require.

SUPERVISED NEGLECT:

Here's another issue that I'll have to give you a lame lawyer answer…

What do you do with patients who refuse to do necessary treatment, or refuse to let you do things like take x-rays. Do you boot them, do you give them advice and then do what they want?

Problem is, we all have a certain number of patients we do supervised neglect on. We know their perio disease is progressing, but we keep seeing them and keep warning them and they keep refusing. The problem is, if we don't treat them, who will? You're just passing off your problem to someone else.

I just want to make sure you realize the liability you're taking on, so you can at least be careful about who you'll put yourself out on a limb for…if the patient's a pain, don't put yourself out there.

Here are the issues. You absolutely have the right to dismiss patients who refuse to follow your treatment plans. The problem you run into is that, depending on the circumstance, you could be dismissing a lot of patients. People do things on their own time schedule a lot of times, not ours.

Bottom line, it's their choice whether to do work or not…it's their mouths.

You also don't want to use patient's refusals to discriminate against them. In other words, if you have a lot of patients who refuse treatment, but you only dismiss those who refuse treatment AND have HIV, you've got a problem.

They've done studies and found that the money used for dental procedures is generally disposable income, which means that we're not competing with whether little Janie gets that kidney transplant she's been wanting, we're competing with things like huge HD flat screen tvs.

So, if it comes down to a crown on # 31, or a big screen, a lot of times we're going to lose. We need to take the time to educate patients so they recognize the value of what we provide, even though it's not even close to as much fun as a big screen tv.

Always mention work that needs to be done. Hygienists, mention it to the patient when you see something that may need some work. Docs, when you come in, ask the hygienist what she's seen, so the patient hears it again. Doc, do your exam and tell the patient, you've got an old filling here that's starting to look a little rough. We don't need to do anything right now, but the next time or two I see you we're going to need to do something about that. That way, the patient's heard it from, the hygienist, from the hygienist speaking to you, and from you. When that patient comes in next time and it's time to do something about it, he won't remember, but at least it will sound familiar and he'll be more likely to go ahead and do the work.

Anyway, so what if a patient needs treatment, you give all the pros and cons and the patient still refuses to do it. That's informed refusal. The best way to protect yourself is to document, document, document. Have the patient sign an informed refusal form and give him a copy and keep a copy for yourself. Write a letter specifically telling the patient exactly what can happen if they refuse to do the work. Talk about it every time they come in and document the conversation every time.

What if the patient refuses x-rays? That's a problem. What if a patient has a toothache and refuses an x-ray but wants you to fix a tooth anyway? Do you do it?

The safe answer is not to do the work. If you do work without obtaining necessary diagnostic information, you aren't upholding the standard of care and are performing a procedure negligently.

What if you get the patient to sign a release?

A release isn't helpful because a patient cannot consent to a negligent act. If a dentist performs a procedure knowing he's not meeting or exceeding the standard of care, that's negligent.

Also, if you have insufficient diagnostic information, you can't give a full explanation of the procedure you're doing, so the patient can't give informed consent.

If you're going to go ahead and do the work, make sure you document all of the other diagnostic information (symptoms, observation, hot/cold test, percussion, perio evaluations, whatever).

Medical and dental history (Presenting conditions)
Current thinking on a proper patient medical history says the following should be included:

1. Medical Errors are the _____ leading cause of death in the United States.
    a. 1st
    b. 2nd
    c. 3rd
    d. 4th

2. An Adverse Event:
    a. is an injury, preventable or nonpreventable, that causes harm to a patient as a result of medical care
    b. is a preventable event that should never happen.
    c. care that falls below the standard expected of health care practitioners in their community.

3. Some "never" events are preventable and some are not preventable
    a. True
    b. False

4. An example of an administrative error would be:
    a. A person goes in to get shoulder surgery and has a leg removed by accident.
    b. Mrs. Lisa E. Jones gets mixed up with Lisa A. Jones at the hospital and receives the wrong medication.
    c. A biopsy comes back but the patient isn't informed about the results.
    d. All of the above.

5. We all play a role in reducing and preventing Medical Errors.
    a. True
    b. False

6. If an unexpected adverse event results in death or serious temporary or permanent physical or psychological injury it is called a:
    a. Negligent event
    b. Sentinel event
    c. Medical event

7. These are examples of medical errors (check all that apply)
    a. Wrong Diagnosis
    b. Wrong Treatment
    c. Operating on the wrong leg
    d. Equipment failure
    e. All of the above

8. The following can be found to contribute to the root cause of an error
    a. Communication problems
    b. Inadequate procedures
    c. Inadequate policies
    d. All of the above

9. Using the SOAP method of documentation, the letters stand for Subjective, Objective, Appraisal, and Plan
    a. True
    b. False

10. The most common HIPAA complaint (and one of the most common Board complaints) is refusing to send a patient a copy of their record in a timely manner. This is considered a “right to access” problem and can result in large fines and penalties.

    a. True
    b. False

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(Oropharyngeal) Cancer Regions

Individuals are at higher risk for throat cancer if they are smokers, drink alcohol or have been exposed to the human papillomavirus (HPV). Throat cancer can form in various regions of the oropharynx, including:

Common Sites:

Oropharyngeal Wall

The oropharyngeal wall refers to the side and back walls of the throat. The most common type of cancer to form in the oropharyngeal wall is squamous cell carcinoma. These types of tumors occur mostly due to a history of smoking and less often due to human papillomavirus (HPV) infection. Common symptoms may include a chronic sore throat, difficulty swallowing, problems opening the mouth fully, weight loss, ear pain and a lump in the throat or neck area.

Treatment for cancer of the oropharyngeal wall may include TransOral Robotic Surgery (TORS) and/or radiation therapy with or without chemotherapy.

Soft Palate

The soft palate, also known as the velum, is the soft tissue at the back of the throat that closes the nasal passages during swallowing. Isolated cancers of the soft palate are rare and is usually associated with a history of cigarette smoking and less commonly related to human papillomavirus (HPV) infection.

In early stages, the most common symptoms that develop may be an ulcer in the mouth, and as the cancer enlarges can be associated with difficulty swallowing, throat pain, a lump in the throat and problems with dentures fitting.

The most common type of cancer that develops in the soft palate is squamous cell carcinoma. As with other cancers of the oropharynx treatment for soft palate cancer may include TransOral Robotic Surgery (TORS) and/or radiation therapy with or without chemotherapy.

Tonsils

The tonsils are lymphoid tissues that are found at the back of the throat and help fight infection. The tonsils that we all know about are the ones on the sides of the throat and can be seen when you look at your throat in the mirror and these are called palatine tonsils. There are also ones you cannot see behind the nose and at the back of the tongue. Even individuals who have had their tonsils removed can develop tonsil cancer if any tonsil tissue that was left behind following prior surgery (tonsillectomy).

Today about 90% of tonsil cancers are caused by prior human papillomavirus (HPV) infection. Like those in the lingual tonsils, these cancers begin in the deep pits of the tonsil and usually spread to lymph nodes in the neck while they are still small and silent so the first symptom is actually a lump in the neck. In fact any person today, over the age of about 40, with a lump in the neck should be considered oropharyngeal cancer until proven otherwise.

The most common symptom of tonsil cancer, one they enlarge, is asymmetrical tonsils followed by a persistent sore throat. In later stages, individuals may have ear pain and enlarged lymph nodes.

Tonsil cancer can develop as squamous cell carcinoma or other rare cancers such as lymphoma or sarcoma. Treatment for tonsil cancer may include TransOral Robotic Surgery (TORS) and/or radiation therapy with or without chemotherapy.

Base of Tongue

The base of tongue refers to the back one-third of the tongue that continues down the throat. The surface of the tongue in this area is made up primarily of lymphoid tissue known as the lingual tonsil. Most of these cancers are squamous cell carcinoma and caused by human papillomavirus (HPV) infection. The cancer begins silently in the pits of the lingual tonsils where it has no or just minor symptoms. Signs and symptoms show up after it has spread to a lymph node causing a lump in the neck. As it progresses, base of tongue cancer may cause pain, difficulty swallowing, a feeling of fullness in the throat, ear pain and voice changes. The most common type of cancer that develops at the base of the tongue is squamous cell carcinoma. Treatment for base of tongue cancer may include TransOral Robotic Surgery (TORS), and/or radiation therapy with or without chemotherapy.

Course Hours: 2 hours

Sponsored by: Entertaining Training, Inc./HPA
(Academy of General Dentistry Provider # 91250)

Instructor: Laney Kay, J.D.

Course Name: Medical Errors Prevention

Course Outline

I. Introduction:

A. Definition: What is a Medical Error
B. Epidemiology
C. Who is at greatest risk?
D. In what settings do most errors and omissions occur
E. Adopting system to recognize and reduce errors

II. Types of errors :

A. General information on medical errors:
    1. Errors resulting in death/serious injury (sentinel events)
B. Types of medical errors
    1. Administrative (mislabeling of person/procedure/etc.)
    2. Treatment
    3. Diagnostic
    4. Medication
    5. Equipment/Medical Device
C. Dental Errors:
    1. Wrong tooth
    2. Failure to diagnose
    3. Failure to refer
    4. Medication
    5. Equipment/Device
    6. Infection

III. Root Cause Analysis:

A. Goals
    1. Discover
        a. what happened
        b. why it happened
B. How to prevent it from happening again
    a. focus on flaws in systems and procedures, not blaming individual individual
C. Protect all patients by promoting patient safety

D. Process

1. establish procedures that examine the adverse event
2. analyze procedures, systems and processes related to the event
3. determine where flaws, breakdowns, and/or mistakes in procedures, systems and processes caused the problem
4. determine whether uncontrollable external factors and/or human factors contributed to mistake
5. revise systems wherever needed to prevent same problem from occurring again

Improving patient safety in your own office by using root cause analysis

IV. Error Reduction and Prevention

A. Communication with the patient
1. Listen to patients
2. Update Medical histories
3. Schedule enough time

B. Preventing most common types of errors:

1. Diagnostic errors
    a. x-rays
    b. lab testing
2. Treatment errors
    a. Medical (verify correct patient, surgical site, procedure, blood type, etc.)
    b. Dental
        i. correct patient
        ii. correct tooth
        iii. correct procedure
        iv. allergies
3. Medication errors
    a. Legible Prescription Law
    b. contraindications and allergies
    c. anesthesia

4. Medical Device/Equipment
    a. likely equipment failures in dentistry (endo files, burs, etc.)
    b. reduce radiation exposure

V. Risk Management and Reporting Adverse Events

A. Communication with patient
B. Documentation
B. Reporting to state/federal agencies where required

VII. Patient Safety

A. Educating patients
    1. Effective communication
    2. Informed consent
    3. Participation in own treatment

B. Office Procedures
    1. Update medical histories
    2. Understanding and usage of root cause analysis
    3. Schedule enough time to allow for effective communication, a full medical history update and proper explanations of all risks/benefits/alternatives for a given procedure