Patient Safety & Risk Management for the Oral and Maxillofacial Surgeon
OMS National Insurance Company, RRG, welcomes you to our program, “Patient Safety & Risk Management for the Oral and Maxillofacial Surgeon.” OMSNIC is owned and operated by OMS, and we only insure OMS. For over 25 years, we have built up a comprehensive database of claims specific to the OMS practice. This database allows us to use teaching points from actual claims to provide contemporary and relevant risk management programs.

In this course, risk management strategies are applied to clinical cases in the areas of Nerve Injury, Infection & Failure to Diagnose, and Medications. The two pillars of risk management, Communication and Documentation, are also covered. Incorporating risk management into your practice can help support the delivery of higher quality patient care, which will in turn help you avoid litigation, or lessen the severity of a claim.

In addition to this live program, OMSNIC offers risk management education and resources online through our website, www.omsnic.com. The e-Learning Center is a resource for online risk management education, uniquely designed for the OMS office. Our online programs address basic risk management issues as well as emerging risks such as HIPAA, cyber liability, the use of electronic medical records and social media. Courses specific to the OMS staff are also provided. All courses are free of charge, offer continuing education (CE) credit, and are available on demand. You can also access a library of informed consent forms other practice management resources on the OMSNIC website. We encourage you to log on to www.omsnic.com to take advantage of these complimentary resources.

Lastly, as an added benefit, upon successful completion of this course, OMSNIC policyholders will receive a 5% premium credit applicable for three policy periods on their next policy term.

Sincerely,

James Q. Swift, DDS
Chair of the OMSNIC Board

Michael Stronczek, DDS, MS
Risk Management Committee Chairman
The following live presentation is dedicated to the education and scholarship of the OMS community. It is intended to provide you with information regarding risk management topics. OMSNIC makes no representations or warranties, expressed or implied, as to the quality, accuracy, or completeness of information provided herein. Because federal, state and local law varies by location and situation and changes over time, nothing in this presentation is intended to serve as legal advice or to establish any standard of care. Legal advice, if desired, should be sought from competent counsel in your state. Taking part in this presentation does not modify the terms and conditions of your OMSGuard™ Professional Liability Insurance Policy.

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Expiration Date: 09/20/2019
Patient Safety & Risk Management for the Oral & Maxillofacial Surgeon

OMSNIC DEFENDING THE SPECIALTY

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Disclosure Statement
Today’s presenters and OMSNIC do not have any financial relationships to disclose. OMSNIC does not endorse any products depicted in the presentation.
Course Objectives

• Identify aspects of communication and documentation with potentially challenging implications to the OMS practice
• Implement new strategies to help prevent failure to diagnose allegations and improve management of infection cases
• Establish best practices to help ensure preparation for and management of in-office emergencies
• Describe and manage informed consent challenges
• Recognize the potential effect technology and applied risk management can have on mitigating and managing nerve injury

How to use the Audience Response Keypads

1. You may vote as soon as the question appears on the screen, before the counting begins
2. Press the number that corresponds to your answer
3. You may change your answer as long as voting is open
4. Your last vote is the one that will be counted

4,959 OMSNIC Insureds – 83% (as of 3/30/16)

$1m/$3m – 44%
$2m/$6m – 37%
> $2m/$6m – 15%
< $1m/$3m – 4% *

*IN and LA have a state patient compensation fund
OMSGuard™ Policy: Enhanced Protection

- Stock Ownership
- Free corporation/partnership coverage
- New-to-Practice Discounts
- Loss-free credits up to 20% after three years in the program
- Waiver of tail premium after being insured for 5 consecutive years, upon retirement at any age
- $1 million of free Group Personal Excess (Umbrella) Liability coverage
- Coverage for practices with reduced hours, such as Part Time, Consultation Only and Volunteer
- EPL and DPR defense only coverage
- Medicare/Medicaid Fraud & Abuse defense only coverage
- OMS Data Defense Coverage/Cyber

OMSCap™ Plan
Preferred Stock Price Per Share (as of April 1st of each year)

Group Personal Excess (Umbrella) Liability Coverage

- OMSNIC policyholders automatically receive $1M in personal excess liability coverage
- Provides an extra layer of liability protection in excess of your primary homeowners, auto and watercraft policies for liability to third parties
- Can purchase additional limits up to $25M for Excess Liability Insurance and up to $5M for Excess Uninsured & Underinsured Motorist Protection at a discounted rate.

www.mygroupexcess.com
Office Credit Card Processing Fee Audit

• Arrangement with Merchant Fee Savers, independent expert in credit card processing
• Assists you in determining whether there are opportunities to reduce annual credit card processing fees.
• In the pilot program conducted by OMSNIC, four out of five practices saw savings; one practice had potential to reduce their annual credit card processing fees by over $10,000.
• Call (800) 522-6670 to request an audit

Incident vs. Claim

<table>
<thead>
<tr>
<th>Incident</th>
<th>Claim</th>
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<tr>
<td>Professional or bodily injury that an insured reasonably believes may result in a demand for money or services as compensation</td>
<td>Demand for money or services as compensation for a professional or bodily injury</td>
</tr>
</tbody>
</table>

Contact OMSNIC @ (800) 522-6670

• Death of a patient during or after treatment, under any circumstances
• Request(s) for release of medical records
• Legal action against a colleague involving a patient you have treated
• Receipt of a subpoena or suit papers
• Contact by an attorney, peer review, state dental board or licensing agency
• Request for compensation or refund from a patient
• Any incident, adverse event or patient complaint that may later turn into a claim or suit
In the Event of a Lawsuit...

- Remember to maintain:
  - The **Complete** Record:
    - X-rays
    - Treatment notes
    - Account notes
    - Informed consent forms
  - Basically, **EVERYTHING** related to the care of a patient
    **DO NOT ALTER THE RECORD**
- Stay the Course
  - Cases take time to resolve
  - Your continued involvement can help improve the outcome

OMSNIC is here to...

- Defend you
- Provide excellent malpractice defense
- Answer questions
- Guide you through the process from initial complaint → closure of the case

Additional Supportive Resources

e-Learning Center Courses:
  - “Anatomy of a Malpractice Suit” (ALL 206)
  - “Mock Deposition: What to Expect During Expert Testimony”

- Coping with Litigation:
  www.physicianlitigationstress.org
Communication

In the 21st Century

To Text or Not to Text...

- Cellphones in the U.S.
  - 90% of Americans
  - 46 glances every day

- Pro’s
  - Preferred method of communication
  - Convenient and “No Shows”
  - Patient Engagement Software

- Con’s
  - HIPAA
  - Does it need to go in the chart?
  - Too Much Information ("TMI")
From Snail Mail to E-Mail

- General Recommendations
  - Encrypted email server
  - Establish a BA agreement
  - Documentation
  - Oops (wrong recipient)
    - Disable Reply All & Auto Populate
- OMS ↔ Patient
  - TMI
  - Threshold
- Doctor ↔ OMS
  - Acknowledgement of receipt
  - Appropriate software to open it?

Social Media

- Marketing & communication tool considerations:
  - HIPAA
    - Written patient permission (redacted images)
  - Separate profiles
    - Personal vs. Professional
  - Website bios
  - Promises/Guarantees
  - Patient communication
    - Caution patients from posting health information

Did You Get A Negative Review?

Proceed With Caution!
Online Reviews

• Did you get a negative review?
  — Evaluate the options (respond, delete, ignore, hide)
• Things to consider before responding:
  — HIPAA violation
  — Reach out to the patient (not while your upset)
    • Phone or direct messaging
  — Post ONE generic response (no back and forth)
• Encourage positive reviews from other patients
• Monitor your online reputation

Contact OMSNIC Risk Management for guidance

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"We appreciate your feedback and are sorry that you feel you did not receive the best service possible from our practice. Our office strives to provide each patient with an excellent experience, and we work hard to constantly improve our practice. Please contact our office to provide us the opportunity to address your specific concerns."

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Mind Your “Chair” Side Manners

You Could Be Recorded
The Washington Post

“After five minutes of talking to you in pre-op,”
“I wanted to punch you in the face and man you up a little bit.”

Office Policy:
• Post signs in the office
• Provide patient/escort education

SAMPLE NOTICE
Due to federal HIPAA Confidentiality Regulations, there will be no cell phone use allowed in patient care areas. This includes phone calls, photos, videotaping and recording. Thank you for your cooperation and respect for our patients’ and employees’ privacy.

After Hours Access in the 21st Century
Section 4.B. EMERGENCY SERVICE. Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record. Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, the dentist, upon completion of treatment, is obliged to return the patient to his or her regular dentist unless the patient expressly reveals a different preference.
### After Hours Accessibility Options

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<th>Unsatisfactory</th>
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<td>• On call</td>
<td>• Office voice mail</td>
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<td>+ Widely used</td>
<td>+ Existing system</td>
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<td>— Requires the OMS be available</td>
<td>— 24/7 surveillance?</td>
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<td>• Answering services</td>
<td>• Email</td>
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<td>+ Calls are triaged 1st then transferred</td>
<td>+ Convenient</td>
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<td>— Additional costs</td>
<td>— Slow communication</td>
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<tr>
<td>• OMS colleagues</td>
<td>— during an emergency</td>
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<tr>
<td>+ Familiar with the specialty</td>
<td>• Social Media accounts</td>
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<tr>
<td>— Might not be familiar with pt.</td>
<td>— 24/7 surveillance?</td>
</tr>
<tr>
<td>• The ER</td>
<td>— HIPAA violation</td>
</tr>
<tr>
<td>+ Immediate care</td>
<td>— Complications broadcasted</td>
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<tr>
<td>— Might not have an OMS on call</td>
<td>• Texts</td>
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<td></td>
<td>— Dead zone</td>
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### DO YOUR PATIENTS KNOW HOW TO CONTACT YOU AFTER HOURS?

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### MEDICATION MANAGEMENT
Novel Pharmaceuticals

- New medications constantly entering the market
  - Polypharmacy
  - Medication interactions
- How do you keep track of these concerns?

The Opioid Issue

- JAMA article: Too many opioids prescribed for extractions
  - Dentists may be prescribing an excessive amount of opioids after tooth extractions, according to a new study in the Journal of the American Medical Association.

CDC Opioid Prescribing Guidelines

*CDC Guideline for Prescribing Opioids for Chronic Pain — United States*
Deborah Dowell, MD; Tamara M. Haegerich, PhD; Roger Chou, MD. MMWR Recomm Rep 2016; 65:1–49

*Opioid Abuse in Chronic Pain — Misconceptions and Mitigation Strategies*
Case Study: Anticoagulants

- 68 year old woman
- Referred to OMS by general dentist for extraction of 8 remaining decayed maxillary teeth

Health History

Procedure

- OMS discussed with the patient and Cardiologist the risks and benefits of Pradaxa related to dental extractions
  - OMS did NOT document this conversation
  - OMS and Cardiologist both recommended the patient continue Pradaxa
  - Bleeding anticipated to be minimal and well controlled at home
- Surgical extraction of teeth under I.V. sedation
  - Patient discharged with escort; f/u 1 week
Post-Operative Complications
The Evening After Surgery
- Patient slept a lot but would wake up coughing and bleeding from the mouth
  - Blood collected in a cup on a bedside table

Post-Operative Complications
1 day Post-op
- Patient had a "small" amount of blood on her pillow
- Relative called OMS office (not the emergency hotline) after hours and left a voicemail

Post-Operative Complications
2 days Post-op
- Patient awoke with complaints of a stomach ache
- Fainted in the shower
- Daughter reports that her mother had blood coming from her mouth
Outcome

• 911 called
  — Patient transported to the hospital
  — Patient coded and expired in the ambulance
  — ED labs: Hgb 6.9 and Hct 21.6
  — OMS returned voicemail in the morning and learned
    the patient expired

• Autopsy
  — Probable cause of death: Ventricular arrhythmia due
    to MI and acute blood loss
  — 1,000 cc's of blood found in patient’s stomach

Allegations

• Failure to properly inform patient of all the
  risks associated with her procedure
• Negligently allowing patient to remain on
  Pradaxa

Case Study Analysis

**Strengths**
• OMS said that he verbally informed patient of the
  risks/benefits of remaining on Pradaxa
• OMS received written medical clearance
• Patient was told to contact
  office if complications occur
• OMS was initially unaware of
  post-op bleeding
• Patient had previous
  extractions by another
  provider while on Pradaxa

**Weaknesses**
• OMS did not document conversation about Pradaxa
  with patient/Cardiologist in
  the chart
• Daughter called office
  number instead of 24hr
  emergency line

Outcome: Defense verdict
What Can We Learn From This?

• Implement a policy of same day follow up calls for patients at high risk of bleeding
• Obtain medical consult, and document discussion in the chart
• Ensure that patients are aware of after hours contact information – add the phone number to the post op instruction sheet
• Educate your patient on what is “excessive” bleeding and stress the importance of contacting the OMS immediately or calling 911
• Consider OMSNIC Resource: “EDUCATION FOR PATIENTS ON BLOOD THINNERS”

Case Study: Medication Interaction

• 80 year old man referred to OMS by General Dentist
  – Extraction of #20
  – Excision of hyperplastic tissue lingual and interproximal to #2 and #3
• Health History
  – Positive for history of Heart Attack and Bleeding Disorder
  – INR: 2.4

Medication List

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<td>Naprosyn 650 mg. 1 daily</td>
<td>Klor-Con 50 mg. 1 daily</td>
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<td>Hydrocodone 7.5 mg/75 mg 2 mg/30 mg 2 tablets</td>
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<td>Metoprolol 50 mg. 1 daily</td>
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<td>Flaxseed Oil supplement 1 daily</td>
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<td>SIMPLE DRESSING</td>
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Procedure

- Extraction and excision performed with local anesthesia
  - No complications
- OMS diagnosed papillary hyperplastic tissue as a possible manifestation of a fungal infection
  - Prescription for 14 day course of Fluconazole

Post-Op Complications

- Seven days post-op, PCP advised OMS of possible adverse drug interaction between Coumadin and Fluconazole
  - Insurance company issued a drug interaction warning
  - OMS contacted patient and advised to discontinue
- Patient suffered a bifrontal intracranial hemorrhage, secondary to coagulopathy, three days after discontinuing Fluconazole (INR: 9.6)
- Patient expired five months later

Allegations

- Failure to determine the existence of a drug interaction between Fluconazole and Coumadin
- Failure to direct patient to an acute care facility when the potential adverse drug interaction was learned
Case Study Analysis

**Strengths**
- Referring dentist noted the hyperplastic tissue
  - Demonstrated the possibility of fungal infection
- Papillary hyperplasia is documented in chart

**Weaknesses**
- OMS’s lack of knowledge of known drug interactions

*Outcome:* Settled in mediation

---

What Can We Learn From This?

- Stay current with pharmaceuticals and drug to drug interactions
- Utilize a drug interaction App or Website eBrosselow; SafeDose, epocrates, Medscape, Lexicomp or book when prescribing a medication to a patient
- Reach out to the pharmacist before prescribing medications you do not frequently prescribe

---

Case Study: Staff Involvement

- 17 year old young man referred to OMS by Orthodontist for consult and extraction of 3rd molars
- Health History
  - Allergies: Seafood, latex and Tylenol
  - Asthma
Procedure

• Vitals
  – BP 127/65, Pulse 88, Respirations 16
  – Assistant placed the EKG, pulse oximeter, blood pressure cuff and started oxygen via nasal cannula
• Local anesthesia administered
  – 4 carpules Lidocaine 2% w/epinephrine
• I.V. Placed
  – OMS ordered medications but were administered by assistant while the OMS was out of the operatory
  – 11:49AM 1cc Fentanyl, 11:55AM 2 cc’s Versed, 11:56AM 2 cc’s Dexamethasone, 12:00PM 1 cc Propofol

Complication

• Patient stopped breathing 25 minutes after I.V. placed
  – Assistant alerted OMS
  – Oxygen saturation 75%
• OMS assessed patient
  – Patient masked with 100% O2
  – OMS did not detect airway swelling, wheezing, obstruction
• 1mg epinephrine administered as bolus
  – No pulse
  – EKG indicated ventricular tachycardia
• CPR Initiated and 911 called
  – AED used (2 shocks given)

Outcome

• Patient admitted to the ICU in critical condition
  – Treated with therapeutic hypothermia
  – Hospitalized for 6 weeks
• Injuries:
  – Cardiac arrest
  – Diminished endurance and stamina, cognitive difficulties and anxiety
Allegations

• Inappropriate delegation of anesthesia administration to unlicensed personnel
• Doctor was negligent in leaving the room
• Improper management of anesthesia and resuscitation
• Permanent sequelae of hypoxemic encephalopathy

**Outcome:** Settled at mediation

What Can We Learn From This?

• OMS are held to the same standards as anesthesiologists
• Know your state’s regulations, including the dental practice act, regarding the delegation of duties to licensed and non-licensed staff

Case Study: Patient Selection

• 33 year old woman referred to OMS by general dentist
  – Complaints of swelling and pain in the right mandible
• Diagnosis: Dental caries extending into the pulp
• Treatment plan: Extraction of #31 and #32
Health History

MEDICATIONS: Please list any medications you are currently taking and the dose and frequency. Include any over-the-counter medications, aspirin, birth control pills, or herbal remedies.

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<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
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<tr>
<td>Hydrocodone</td>
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Have you taken any of these medications for osteoarthritis, Paget's disease, or cancer?

- Yes
- No

Procedure

- Extractions performed under local anesthesia
  - 2 carpules of 4% Septocaine w/epi
  - No complications
- Patient discharged
  - OMS dispensed 20 tabs of Vicodin 5/500 in the office
  - 1-2 tabs every 4-6 hours as needed

Outcome

- Evening of surgery
  - Patient goes to bed at 7:30pm
- Morning after surgery
  - Patient found unresponsive by husband
  - 911 called
  - EMS arrives and pronounces patient DOA
- Autopsy Report
  - Cause of Death: Hydrocodone toxicity (Contributing Condition: Seizure disorder)
  - Post mortem iliac blood labs: Hydrocodone .113 mg/L
    - Not a lethal level according to expert testimony
Prescriptions Found at Patient’s House

- Anti-Seizure Medicines
- Prescriptions for Hydrocodone

Allegations

- Failure to adequately assess patient’s medical history
- Dispensing narcotic medication to a patient already on a narcotic substance
- Failure to warn patient of the dangers of using both narcotics together

Case Study Analysis

**Strengths**
- No complications with procedure
- Overdose could have been from prescription written by surgeon who removed gall bladder. She only took one tab from OMS Rx
- Epilepsy contributory to death

**Weaknesses**
- Drug dispensed directly from office
- No documentation of drug safety sheet for combining meds

**Outcome:** Defense verdict
What Can We Learn From This?

- Adjust prescription to specific procedure, patient, and anticipated duration and severity of pain
- Counsel patients about prescriptions and document the discussion
- Utilize Prescription Drug Monitoring Program (PDMP)*

* Mandatory in some states

Prescription Drug Monitoring Program (PDMP)

- Most states have an active PDMP
  - Details prescriptions filled, even if cash payment
- Decreased prescribing Schedule II opioids
- Decreased substance abuse admission rates
- Decreased the annual increases in misuse or abuse compared with states without PDMP

Consider The Whole Patient

- Have a thorough knowledge of our patients’ medical history and current medications
- Consider all potential interactions and adverse reactions of medications that we prescribe
- Educate our patients about medication management
Communication

Back to the Basics

Patient Education

- Pre-Operative
  - Website
  - Video
  - Handout
  - Verbal
- Post-Operative
  - Handout
  - Verbal

Patient Education Considerations

- Clear
  - No ambiguity = “Bleeding is normal” (quantify)
- “One size fits all” model
- Documentation
  - Acknowledgement of receipt of signed form
- Staff involvement
  - Who delivers the education?
- Comprehension
  - Is he/she lucid?
  - “Does this make sense?”
Americans with Disabilities Act (ADA)

• Most prevalent accessibility issues:
  1. Lack of “effective communication”
     • Complicated and interactive communications require a Sign Language Interpreter or translator
     • Additional Options
       – Written Forms (when appropriate)
       – Video Interpreting Services

  Family or friends cannot be forced to interpret

ADA Prevalent Accessibility Issues

2. Lack of accessible equipment & services
   • Health care service, medical equipment and diagnostic tests are accessible to individuals with disabilities

3. Refusal of care
   • Refusal to treat HIV patients (Bragdon v. Abbott)
   • “A medical provider may NOT refuse to treat by invoking the “direct threat” defense...”

Limited English Proficiency (LEP)

• Must ensure effective communication at NO cost to the patient
• The patient determines if he or she has Limited English Proficiency
  – Read
  – Write
  – Speak
LEP Frequently Asked Questions
1. Who decides interpretation is needed?
2. Can an appointment be rescheduled if interpreter is not available?
3. Can the patient be asked to bring in a family member?
4. Do you have to use an interpreter selected by the patient?
5. Who pays for the interpreter?

Set your Staff up for Success
• Hire SMART
  – Customer service oriented
  – Administrative vs. clinical staff
• Open lines of communication
  – Adverse Event Notifications
    • Sending patients to collections
    • Managing patients with post-op complications
  – Open Door Policy

TIME OUT!
Encourage staff to SPEAK UP
Seize the Opportunity

Educate Your Staff:
• Morning huddles
• Lunch and Learn
• Team building activities
• Continuing Education
  ― BLS or ACLS
  ― Courses on omsnic.com
    • HIPAA compliance (HIP 101, HIP 102, HIP 103)
    • STF 101 - Protecting Your Patients Through Team Risk Management

The Policy Manual

• Include communication
  ― Cell phone use
    • Where and when is it appropriate?
      ― Distractive in the surgical suite
    • Emergencies
  ― Office phone use
    • Triage “key words”
      ― “Request for records”
    • Who answers clinical questions?
      ― Clinical “point person”
    • Document the conversation

FAILURE TO DIAGNOSE
Case Study: Infection

- 39 year old woman presented with complaint of pain in the area of #30
- History: DM type1, Kidney Disease, Dialysis & HTN
- Allergy: PCN
- Examination:
  - pain at #30
  - “deep” distal decay
  - no abscess /facial swelling

Pre-Operative X-ray

Health History Form

First Visit

Second Visit
Procedure: Extraction

- Informed consent form was signed for extraction of tooth #31 (not #30)
- Tooth #30 was extracted
- No immediate complications
- Prescription was given for PCN

Post-Operative Phone Call

- 2 days later, patient’s mother contacted the office
  - Reported the patient had pain, swelling, nausea and vomiting, and limited jaw opening
  - Office staff advised to apply a warm compress to the area
  - No recommendations were made for a post-op evaluation
  - The OMS was not informed of the call

Post-Operative Complication

- 4 days later, patient admitted to the hospital:
  - “swollen, red, painful right mandible with dysphagia”
    - “Odontogenic infection extending to the right submandibular and submental spaces”
    - CT showed possible right sided mandibular osteomyelitis
  - Abscess was drained & antibiotics administered
  - Discharged after 7 days with 6wks on Avelox
Outcome

• The patient’s symptoms completely resolved after 2 months
• The patient’s significant medical history resulted in multiple hospital admissions unrelated to the post-operative complication
• Claim was filed against the owner of the OMS practice who, incidentally, did not treat the patient
  – An associate OMS (employee) performed the procedure

Allegations

• Negligent prescription of penicillin to a patient who is allergic to penicillin*
• Failure to direct the patient to return to the office when contacted by her mother
  – Required additional surgical care and treatment
  – Damage to dentition with bone and soft tissue defects

*Previous prescription for penicillin only caused N/V

Case Study Analysis

Strengths
• Informed consent identified infection as a possible risk

Weaknesses
• Prescription for PCN given when patient has PCN allergy
• Informed consent with the wrong tooth number on it
• No post-op follow up scheduled
• Delay in further evaluation and possible treatment
  – Staff did not inform OMS of patient’s complaints

Outcome: Settled before trial
What Can We Learn From This?

• Log all allergies when they are identified
  – Only eliminate if history changes (develop a system)
  – Verify with log/list before prescribing/administering
• Utilize a TIME OUT
  – Verify documentation and procedure match
• Develop follow-up protocols for all patients
  (phone call, office visit)
  – Sometimes it’s hard to identify who’s “at risk”
• Staff should have a triage system

Case Study: Oral Cancer

• 18 year old woman referred by DDS for TMJ discomfort
  – Patient mentioned “growth”/“sore spot” on the right side of her tongue
• History:
  – Hay fever & sinus problems
  – Third molars removed
  – Branchial cleft cyst removed
  – Mouth guard use, PT, counseling and medication

Examination

• Max interincisal opening was 35-40mm with pain
• “Hole” noted on the right lateral border of the tongue measuring 2cm
• Subjective report: right TM joint pain for 6 months, neck tightness and tongue biting
Diagnosis & Plan

- **Diagnosis:**
  - Tongue biting
- **Plan:**
  - Mandibular splint needed to push tongue away from dentition
    - Patient only had maxillary splint
  - TMJ Botox injections
  - Viscous Lidocaine

Return Visit

- 2 days later patient presented with her old splint
  - Only fit over her maxillary teeth
  - Did not assist to stop her tongue biting
- 2 weeks later patient returned and received a TMJ Botox injection
  - She was asked to follow up with her splint
- 1 week later, patient reported she was doing slightly better; “wound revision” scheduled
Procedure: Tongue Surgery

• Patient returned and had an excisional revision of her right tongue wound
  – No biopsy performed
  – No tissue sent to pathology

• Patient returned 1 week later and was reportedly doing well
  – Plan: follow up in 2 weeks; referral for 2nd opinion by the OMS

Post - Procedure

• 3 weeks after the procedure, the patient returned and was doing well
  – Right tongue wound was healing well
  – Plan: return in 4 weeks

• 2 weeks later patient had a small opening in her tongue laceration
  – The OMS closed with sutures

Oral Examination
Post – Procedure

• 1 week later the patient returned and reported pain even with use of viscous lidocaine; TMJ pain unchanged
  – The OMS opened the tongue wound & debrided
  – Sutures removed
  – Plan: advised to use lower splint and cleanse with hydrogen peroxide

Follow Up Visits

• The patient continued to see the OMS
  – Complaints of swollen tongue, pain and lacerations to the tongue from “uncontrollable tongue biting”
  – Patient was treated with antibiotics, hydrogen peroxide rinses, Botox injections, Vicodin, IMF, sleep guards, multiple episodes of suturing the tongue, etc.
  – Patient referred to multiple specialists
    • Psychiatrist, PMD, Neurologist

Complication

• 10 months after the patient initially presented to the office:
  – The patient’s parents requested 18, 19, 30 & 31 be extracted
  – During the extraction the OMS removed a lesion from the right tongue and sent it for biopsy
• The biopsy results:
  – Squamous Cell Carcinoma
• Patient referred to ENT by her DDS
Outcome

- Patient lost most of her tongue and a portion of her mandible
  - Subtotal glossectomy, FOM resection, bilateral neck dissection, free flap repair, and tracheostomy performed
  - Post op chemotherapy and radiation
  - Recurrence in submental region with invasion to skin margin
- Claim was filed against the OMS

Allegations

- Damages:
  - Loss 95% of tongue tissue
  - The floor of the mouth
  - Mandibular teeth & gingivae
  - A portion of her mandible
  - Mucosa & tissue from her hypopharynx
  - Muscle, fat and skin from both thighs (used for reconstruction)

Case Study Analysis

**Strengths**
- Frequent follow up visits
- Multiple providers saw patient and failed to diagnose SCC
- MRI of brain read as negative by Radiologist

**Weaknesses**
- OMS documented tongue looks worse than ever months before biopsy
- No differential diagnosis for non healing lesion
- No palpation of tongue documented
- Indurated mass of tongue never noted by OMS

**Outcome:** Settled prior to trial
**What Can We Learn From This?**

- Early diagnosis is critical in the treatment and survival rates for squamous cell cancer in the head and neck region.
- A biopsy is a low morbidity/high yield procedure
  - Why not do a biopsy as the first procedure when abnormal tongue tissue is present?
- When abnormal tissue is removed, always send the specimen for histopathologic evaluation.

**Oral Cancer: Contributing Factors**

**Historically**

- Man:Woman = 2:1
- Approx. 95% > 40yrs
- Average age at presentation 60 yrs.
- Classic carcinogens include tobacco and alcohol.

**Oral Cancer: Contributing Factors**

**Present:**

- Since 1973 there has been a significant increase in the incidence of SCCA of the tongue, base of tongue, and tonsils in white patients between 20-44 years of age.

**“New” Carcinogens:**

- Marijuana (debatable)
- Human Papillomavirus (HPV)
Case Study: Jaw Fracture

- 54 year old woman referred for extraction of #21, 28 & 32 due to amalgam restorations
  - “Mercury could be causing medical problems”*
  - New partial denture to be made soon
- History: TMJ (under treatment), IBS, RA, fibromyalgia, tension HA
- Examination: Teeth did not need extraction
  - OMS suggested they were “perfectly healthy” & mercury should not be causing problems
- Plan: Extract teeth based on patient’s wishes

*According to patient and her naturopathic physician

Pre-Operative X-ray

Procedure: Extraction

- Consented for extraction of 3 teeth under IV anesthesia
- Prior to extraction patient c/o headache and jaw pain
  - OMS assured her he will not “aggravate the situation”
- Extractions performed
Follow Up Phone Calls

- Patient received a call from the office RN later that day
  - “patient in some pain but doing fine”
  - Recommended to use ice packs

- POD #6 patient called the office:

1st Post-Operative Office Visit (Day 6)

- Patient returned to the office
  - During dry socket treatment she c/o HA with pain in the rt. & lt. TMJ and pterygomasseteric sling
  - After local administration, the right molar area was irrigated and DRESSOL-X™ was placed in 28 & 32
  - Patient reported a HA before the procedure is done
  - OMS assumed it was related to her TMJ
  - She also had an area of ecchymosis in the rt. premolar area and inferior border of the mandible
  - X-ray taken & follow up scheduled

Day 6 Post-Operative X-ray
Post-Operative Office Visit

• POD #7, patient went to DDS office
  – DDS office refused to provide her post-op care. Instructed her to follow up at the OMS office
  – OMS office contacted the patient to come in, but her husband reported she was asleep
  – Rescheduled for the next day

2nd Post-Operative Office Visit

• POD #8, patient returned to OMS office
  – Packing was removed, socket irrigated and re-packed
  – Patient reported NO RELIEF (she thought her jaw was broken)
    • Recommended to follow up with TMJ Specialist

Post-Operative Complication

• The patient went to see the TMJ Specialist
  – X-ray showed mandible fracture in the area of the lower right molar extraction site
    • Verified by a second OMS

• Patient called requesting her records from OMS office
Outcome

• Patient had ORIF of right mandibular body fracture at the hospital
  – Discharged home the next day
• Followed up with TMJ Specialist for stretching exercises
• Patient on modified diet & Neurontin for extended time
• Claim was filed against the OMS

Pre-ORIF X-ray

Allegations

• Negligent extraction of 3 teeth
  – The teeth should not have been extracted
• Jaw fracture was not diagnosed in a timely manner resulting in delayed treatment
• Further surgery required to treat jaw fracture
Case Study Analysis

**Strengths**
- Documentation of care was excellent

**Weaknesses**
- Teeth were “perfectly healthy”
  - Should they have been extracted?
- Low suspicion for jaw fracture
  - TMJ r/t pain
- Non-diagnostic radiographs by the original treating OMS

**Outcome:** Settled at mediation

What Can We Learn From This?

- Make sure there are valid indications for all proposed treatment plans
- Fully address patient’s post-operative complaints regardless of how insignificant they may seem to you
- Make sure all imaging is of diagnostic quality

Case Study: Deep Cervical Infection

- 29 year old man referred for extraction of three third molars
- History: Patient prescribed PCN by referral
- Examination:
  - Tooth #16 severely decayed
  - Tooth #17 distoangular, creating chronic periodontal defect distal to #18
  - Tooth #32 mesioangular, causing bone loss distal to #31
Plan: Extract teeth #16, 17 & 32; prescribe pre-op antibiotics

Procedure: Extraction

- After consult:
  - 1 week later Amoxicillin 500mg QID prescribed
  - 5 weeks later Amoxicillin prescribed again
- Extraction of teeth #16, 17 and 32 occurred 6 weeks after the consult visit
  - Informed consent was obtained pre-procedure
  - #17 and #32 were difficult to remove
  - No immediate complications
  - Amoxicillin 500mg prescribed post-op

Post-Operative Complication

- POD #5 the patient returned c/o moderate swelling and limited jaw opening
  - Exam revealed the patient “looked good for 5th day after difficult removal”; trismus
  - Flagyl 250mg & syringe given, moist heat prescribed
- POD #7 the patient went to the referring DDS office c/o worsening pain
  - Recommended to return to the OMS office for possible alveolitis
Post-Operative Complication

- POD #7 patient returned to OMS office
  - Patient reported increasing pain, swelling, nausea, and limited jaw opening
  - Exam revealed he was progressing well; Phenergan prescribed for nausea, fluid increase and moist heat recommended
- POD #12 patient calls the office c/o a “scratchy throat”
  - No additional records related to this phone call

Outcome

- POD #13 the OMS receives a call from an ENT
  - Patient’s blood sugar was in excess of 600
    - Undiagnosed insulin dependent diabetic
  - Patient in respiratory failure
  - Patient admitted with deep cervical infection
    - Had 3 surgeries
    - Hospitalized for 11 days (released in good condition)
- Claim was filed against the OMS

Allegations

- Failure to diagnose and treat post-operative infection
  - Resulting in the development of a deep cervical infection and the need for 3 additional surgeries
- Failure to follow up with patient with indications of developing infection
Case Study Analysis

**Strengths**
- Informed consent obtained
  - Included the risk of infection
- Infection is a well-known surgical complication
- Post and pre-operative antibiotics were prescribed and dispensed
  - Amoxicillin
  - Flagyl

**Weaknesses**
- No records of temperature
  - Patient presented to hospital with a fever of 102
- No medication dispense log
- Failure to notice patient was not getting better
  - Prescription for Phenergan
  - “throat pain”
- Staff did not relay information

**Outcome:** Defense verdict

What Can We Learn From This?
- Temperature measurement should be considered if infection is suspected (in addition to giving antibiotics)
- Medication logs are required if an office is dispensing medications
- “Increasing pain” a week post-op is indicative of a problem
- Accurate and timely communication between the staff and OMS is paramount to quality patient care

OMSNIC Office Risk Assessment
- Available in the e-Learning Center
- Complimentary
- A series of questions that represent the most frequently encountered risk management issues
- Helps identify areas in your practice that could benefit from additional risk management strategies
- Provides a comprehensive report specific to your practice with recommendations to help improve practice habits to improve patient safety and reduce risk
NERVE INJURY
If you damage a nerve, is it negligence?
Nerve Injury Claims
- The number of claims have remained stable
- Attorneys are getting more aggressive with these claims
  - They are following similar claims around the country to focus on trends
- Significant increase in indemnity payments
  - Lingual nerve injuries especially

We Need To Be Cognizant Of These Concerns

Radiographic Imaging: 2 Dimensional vs. 3 Dimensional
- Can you get more clinical information?
- Can you get more accurate linear measurements?
- Can you see anatomic structures in all dimensions?
- Is the x-ray exposure acceptable?
- If you have a cone beam scanner, should you use it at all times?

Legal Concerns
- Necessary to read the entire scan to avoid missing pathology
- Can be used to prove the appropriateness of surgery
- Can be used to prove errors in surgery as well
- Where do you stand?
Case Study: Apicoectomy

- 35 year old woman referred for evaluation for apical surgery
  - Previous root canal #30
  - Bone loss noted at distal root of tooth #30
- Examination:
  - Tooth non-mobile
  - Buccal fistula present/Percussion pain
- Differential Diagnosis:
  - Failed RCT vs. Fractured root

Pre-Operative X-ray

Bone resorption distal root of #30

Procedure: Apicoectomy

- Local Anesthesia was administered
- At the start of the procedure, a 1 cm laceration occurred on the mucosal side of lower right lip
  - Laceration was sutured immediately
  - The patient was notified of this laceration
  - The surgeon was unsure of how this happened
- Apicoectomy was performed
  - Root Fracture was ruled out
  - Abscessed tissue was removed, the root tip shaped and a retrofill completed
Discussion Question
When an unexpected injury occurs to your patient, what is the best way to manage the complication?

• Inform the patient of the complication immediately and/or his or her escort if the patient is under anesthesia
• Follow up with a call from the OMS the night of surgery
• Schedule the patient for a follow up appointment to reevaluate the injury and healing

Post-Operative X-ray

Radiographic Findings
• Periapical was taken after surgery
  – Could not visualize the IAN
  – Retrofill and surgical result were difficult to see
  – No evidence of a root fracture noted
Post-Operative Complication

- The referral DDS was informed of the lip laceration the day of surgery
- Patient canceled follow up visit with OMS
- A week later DDS advised the OMS
  - Laceration was barely visible, but patient now complaining of a numb lip
  - OMS contacted the patient and asked to reevaluate the area but the patient never returned
- The surgeon and treating DDS did not communicate after this discussion

Outcome

- Patient followed up with another OMS one month later
  - **Complaint:** Paresthesia of the right lower lip
  - **Exam:** Anesthesia in the right lip down to the chin
  - **Diagnosis:** Right IAN injury with anesthesia
  - **Plan:** Nerve exploration recommended but the patient declined

Allegations

- Sustained laceration of right lip not associated with the planned surgery
- Suffered damages including numbness and pain to her lower right lip. Patient said she had constant drooling which was “embarrassing”
- Permanent traumatic neuropathy of the right IAN
Case Study Analysis

**Strengths**
- Informed consent form signed detailing potential for nerve injury
- The insured followed up with the DDS after patient failed to follow up
- DDS noted laceration was "barely visible"

**Weaknesses**
- No pre-op discussion about nerve injury as possible complication
- Injury could be the result of the laceration to the lip or from the apicoectomy or from the local anesthesia
- Limited documentation detailing laceration
  - Notes lack detail
  - Little information on the surgical flap

Outcome: Settled prior to trial

What Can We Learn From This?

- Potential risks and complications should be discussed even if they seem unlikely based on the diagnosis and anatomic finding
- Document the clinical findings, discussion and treatment related to inadvertent injuries
- Operative notes should include the anesthesia administered even if it is only local (i.e. dosage in mg, # of carpules, etc.)

Case Study: Implant Surgery

- 32 year old man referred to OMS
- Past Medical History: Non-contributory
- Examination:
  - Fractured tooth # 19
  - Severe bone loss with 1+ mobility
  - Panorex available
Diagnosis & Treatment Plan

- Diagnosis: #19 non-restorable
  - Options discussed with patient including no replacement, partial denture, bridge, or implant restoration.

Surgical Plan

- Phase 1: Extract and graft the site
- Phase 2: Place implant for future crown restoration
- Risks, benefits, and alternatives discussed
- 1 page basic surgical consent form signed

Consent: Nerve Injury Risk (Focused)

**Nummness** - There may be a loss of function of a sensory nerve in the area of surgery resulting in tingling, numbness, or pain of the lip, chin, gums, teeth, or tongue. Such loss of function may be accompanied by drooling on the affected side and alteration of taste perception or speech. These effects do not occur often, and their occurrence is unpredictable. These symptoms may persist for weeks or months while the nerve returns to normal function. In some instances, such loss of nerve function and accompanying symptoms can be permanent.
Procedure: Extraction

Phase 1

- Tooth #19 extracted under IV sedation
- Site grafted for implant placement
- No complications noted

Post-Operative Evaluation

3 months post-extraction:
- Extraction site #19 “healing well” (good ridge form)
- Clinical findings and restoration options discussed once again.
  - partial denture, bridge restoration, or an implant with fixed crown
- Risks of possible nerve injury discussed a 2nd time
  - NOTE: The IAN is clearly diagrammed on the film but no measurements are noted
- Scheduled for implant placement in 1 month

Post Extraction X-ray

Vertical bone loss shown
Expected with a severely infected tooth
Discussion Question
The OMS identified the appropriate anatomic structures. What other measures are necessary to safely place an implant?

• An accurate vertical bone measurement is essential
• You must calibrate the panoramic film to get an accurate measurement.
• The cone beam scan does not require calibration
• 3-D views give more accurate anatomic knowledge

Procedure: Implant Placement
• 4 months post-extraction:
  — 5 page informed consent form signed
  — Nerve injury section is less focused as previous

Surgical Complications
Such possibilities include but are not limited to, infection, tissue discoloration (black), alteration in taste and smell, tingling, increased sensitivity of the lips, tongue, chin, cheek or teeth which may last for an indefinite period and may be permanent. Also possible are injury to teeth if present, loss of bone, bone

• A 5 x 13mm implant was placed
  — No evidence the panorex was calibrated or a numerical measurement was taken

Post-Operative Complication
• 14 days later, patient returns complaining of lower lip paresthesia
• No post-op phone call was made to the patient
• This is the 1st communication with the patient after surgery
• Panorex taken to evaluate the site
Recommendation & Treatment

- Plan: Remove the implant immediately
  - Patient delayed the implant removal by 6 days
- When patient returned, implant was removed
  - During removal patient had sensation consistent with a neural injury
  - The 5 x 13 mm implant was replaced with a 6 x 10 mm implant
  - A post-operative panorex was taken

Post-Operative X-ray
Outcome

• Patient returned 10 days post-op
  – Sutures were removed
  – Site was “healing well”
  – Neuro Exam: + directional sense & hypoesthesia of the mental nerve distribution
• Patient returned twice over the next 2 months
  – Neuro Exam: + directional sense, partial resolution of hypoesthesia and pins and needles sensation
  – Plan: Follow up with general dentist in 3-4wks for restoration & in 6wks for re-evaluation of neuro exam

2 Months Post-Operative X-ray

A request for records made 1 month later

Allegations

• Negligent placement of a dental implant injuring the mandibular nerve
• Permanent paresthesia with “pins & needles” sensation to the left lip, chin and gums
• No referral for microsurgical evaluation/repair
• IME Findings: “dense paresthesia of the mental nerve distribution, left side... [objective improvement is unlikely although subjective improvement likely due to adaptation]”
2 Dimensions vs. 3 Dimensions

Cone Beam Scanner

- Cannot see this detail on the panorex
- It appears the implant is within the confines of the nerve canal
- This information can be used to support your care or prove there are potential damages

Cone Beam Scanner

- In this case, the implant length is appropriate
- The preparation clearly damaged the nerve canal
CONE BEAM CT FAQ

Q: If I take a Cone Beam CT of a patient who is NOT mine (e.g. as a favor to a referral), who's responsibility is it to read the image?

A: The interpretation of the entire image is ultimately the responsibility of all parties involved, and should be accomplished by the party or individual who is well trained and skilled to do so.

Case Study Analysis

Strengths
- Three informed consent forms were signed that identified nerve injury as a complication
- OMS removed the implant after report of hypoesthesia
- Patient delayed the implant removal by 6 more days

Weaknesses
- No calibration or bone measurements are noted
- No immediate post-op panorex taken on the day of surgery
- 1st post op at 2 weeks
- No referral to micro surgeon
- No documentation to support delay in implant removal
- OMS advised there would be a "return" to normalcy

Outcome: Settled during mediation

What Can We Learn From This?
- Accurate x-ray calibration and bone measurements are necessary when a crucial anatomic structure is at risk
- Consider post-procedure imaging
  - Early recognition of the problem is essential to follow up and correct any errors
- Refer to a specialist early rather than late
- Document subjective findings as well as potential causes for delay
Case Study: 3rd Molar Extraction

- 16 year old Spanish-speaking man referred to OMS by Orthodontist
  - Expose and upright the two lower 2nd molars and extract 4 impacted wisdom teeth prior to braces
- Health History:
  - Mild asthma
  - Herniated disc L4/L5

Examination & Diagnosis

Clinical and Radiographic Findings:
- Lower 3rd molars mesioangular and impinging on the 2nd molars
- Upper 3rd molars high in the alveolus and near the sinus

Diagnosis:
- Mesioangular impaction of # 31
- Vertically delayed eruption of # 2, 15 & 18
- Roots of second molars are mature
Pre-Operative X-ray

Procedure: Extraction

• Consultation and surgery the same day
• Informed consent:
  – Discussion included the patient, his mother, and the office’s Spanish-speaking dental assistant and the OMS
  – A Spanish translated Consent Form was signed by the patient’s mother and witnessed
• Procedure: #1, 16, 17, & 32 extracted under IV sedation & #18 & 31 were exposed

Post-Operative Complication

• At the 1 week follow up patient had left lingual anesthesia and loss of taste
• Plan:
  – Return to office in 1 week
  – Possible referral for lingual nerve repair
  – Continued observation
• Patient returned for follow up 1 month later
  – No progress or recovery noted
  – Referred to a micro-surgeon for evaluation and possible treatment
Referral Letter

Dear Dr.

underwent extractions of teeth #1, 16, 17, 32 and exposures of teeth #18, 31 on . He reported for post op care on and reported loss of sensation to the left lingual region as well as loss of taste. I advised him to return in a week for a lingual nerve evaluation, however, he was lost to follow up. reported to the office today with similar complaints of numbness as well as frequent tongue biting. I am referring him for a lingual nerve evaluation/possible repair. Please keep me informed as to his progress .

Post-Operative: Microsurgery

• 1½ months later (10 wks. after extraction) the patient saw the microsurgeon
  – Diagnosis: left lingual nerve hypoesthesia
  – Plan: reassess in 1 month; possible spontaneous improvement
• Patient returned in 1 month (14 wks. after extraction)
  – Neuro Exam unchanged (+ left tinel sign)
  – Plan: microsurgery in 2 weeks
• Patient underwent exploration and repair of his left lingual nerve

Outcome

• Patient reports no improvement of symptoms after months of follow up with microsurgeon
  – Microsurgeon unable to locate the distal nerve
  – The proximal nerve was sutured to prevent neuroma formation
• Patient continued orthodontic treatment as originally planned
• Patient filed suit against the OMS
Allegations

• Negligent extraction of a wisdom tooth and elevation of the adjacent tooth
• Severed lingual and related nerves
• Loss of taste and sensation of his left tongue
• Unsuccessful lingual nerve repair due to scar tissue

Cone Beam Scan

Jury Verdict

• The Plaintiff’s expert was a general dentist who frequently removes teeth
  – The expert did not create a focused argument supporting the injury to the lingual nerve
• The Defense expert pointed out:
  – The anatomical concerns with the 2nd and 3rd molars and the potential for a lingual nerve injury
  – The appropriate referral to a micro-surgeon
  – OMS treatment was within the Standard of Care
• During deposition, the patient appeared to have minimal deficit associated with this injury
Case Study Analysis

**Strengths**
- Good panorex showing definite delayed eruption of teeth
- Patient delayed return visit
- Timely referral to a microsurgeon
- Informed consent process was excellent
  - Use of a qualified interpreter
  - Use of a Spanish form
  - Signed by OMS & witness

**Weaknesses**
- Lingual nerve damage
- No post-operative films to evaluate treatment

Outcome: Defense verdict

What Can We Learn From This?

- The need for surgery should be clinically evident and documented
- With nerve injury, early diagnosis and referral is essential... but even with early referral, treatment may not be successful
- A translated Informed Consent form and interpreter are ideal for patients who do not speak English
- Consider OMSNIC Resource: “PATIENT EDUCATION FOR THE CARE AND TREATMENT OF SENSORY NERVE DISTURBANCE”

Informed Consent

In the REALWORLD
Schloendorff vs. Society of NY Hospital

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.”

More than a piece of paper

The **PROCESS** of communication between a patient and doctor that results in the patient’s authorization or agreement to undergo a specific treatment or procedure

American Medical Association, 1998

– The Discussion
– The Form
– The Documentation

Health Literacy

**Challenges**
- The Literacy Gap
  - A National Adult Literacy Survey:
    - > 44 million adults are “functionally illiterate”
    - ~ 50 million possess “marginal” literacy skills
    - 16 – 20% of high school graduates lack sufficient reading skills

**Recommendations**
- Simple language
  - No “dental jargon”
- Visual aids
  - Models
  - Imaging
- Ask follow up questions
  - “Was that explanation clear?”
  - “Does that make sense?”
  - “Is there anything that you need me to explain?”
Non English Speaking Patients

**Challenges**
- Inability to read or speak English
- Cultural issues

**Recommendations**
- Utilize a qualified interpreter & translated documents (if possible)
- Cultural sensitivity; Ask questions if you are unaware

Note: Spanish Consent Forms are available on the OMSNIC website

Blind and Deaf Patients

**Challenges**
- Blind:
  - Inability to see the form
- Deaf:
  - Inability to hear the discussion

**Recommendations**
- Blind:
  - Considerations for a verbal process
    - Utilize an aide (family, friend) if patient agrees
    - Verify their level of independence
- Deaf:
  - Sign language interpretation
  - Visual aids

Patients with Decisional Limitations

**Challenges**
- Dementia, Alzheimer’s, Brain Injury, Adults with Down Syndrome, etc.

**Recommendations**
- Clinical judgment
  - Does the patient have capacity to make informed decisions?
- Contact their PCP or DDS
  - How are they managing the patient’s challenge?
- Communicate with POA
  - What if they do not have one?
Minor Patients

Challenges

• Absent Parent/Guardian
  – Work, travel, illness, emergencies, etc.
  – Day of surgery escort?

• Child(ren) of divorce or Ward(s) of the state

• Emancipated minors

Recommendations

• Advanced consent/Post-pone tx
  – Not in the case of emergencies
  – Written and verbal consent
  – Identify a suitable escort

• Identify who has legal authority to consent on minor’s behalf
  – Mom vs. Dad vs. Both
  – Foster parent vs. Social Worker vs. Other identified guardian

• Ask for Declaration of Emancipation

Informed Consent FAQs

When should you re-consent?

A: Consider re-consenting when:
  Office policy mandates it
  Change in treatment plan
  Change in patient condition
  New information is obtained
Should an informed consent form be signed at consult or on the day of surgery?

A: The choice is yours, but remember, the form MUST be signed pre-procedure and before a sedative is administered or taken.

Can my patient’s minor child be used as an interpreter?

A: No; best practices and many state statues prohibit any minor person (under the age of 18) to act as an interpreter.

Can I perform a biopsy on a patient under GA if they signed a consent form for tooth extraction?

A: Remember Schloendorff vs. Society of NY Hospital?
Can my RN or Dental Assistant consent the patient?

A: No, he/she can assist with the process, but the doctor MUST take the lead.

When is my patient’s POA activated?

A: Nothing happens until the patient is determined to be unable to participate in medical decisions.

NOTE: Power of attorney documents have language included in them that indicate when the power of attorney takes effect.

Should the Informed Consent process be patient specific?

A: Stay tuned to Emergency Preparedness.
Case Study: Patient Selection and Monitoring Equipment

- 26 year old man referred for evaluation/extraction of deeply decayed #18
  - Patient reported difficulty eating
  - Weight: 181lbs  Height: 5' 2"
- Health History
  - Down syndrome
  - Heart surgery to correct atrial septal defect at birth
- Medications
  - Guanfacine

Pre-Operative X-ray
History

• Parents told the OMS that no other surgeon would treat their son due to his Down syndrome
  – OMS initially told the parents to wait and see if the tooth soreness would alleviate with time
  • Tooth soreness continued
  – Treatment Plan: Extraction of #18 with general anesthesia
• Medical consultation from Cardiologist
  – No need for pre-med before procedure

Initial Office Notes

Special Considerations

• In a patient with Down Syndrome, the following concerns are important to evaluate:
  – The patient’s airway should be thoroughly evaluated including oral cavity and neck range of motion, mallampati classification, history of OSA, etc.
  – Comorbidities including cardiovascular concerns
  – The patient’s ability to understand treatment and give consent
  – The patient’s candidacy for GA or in office IV sedation
Procedure

• #18 extracted under general anesthesia
  – 5mg Versed, 75mcg Fentanyl, 240mg Pentothal, 4mg Decadron
  – 2 carpules 2% Lidocaine w/epinephrine
• Surgery performed without complication

Page 2: Anesthesia Record

"Note: these times do not correlate with actual times because the ?? clocks are not set to real time"
Emergency Management

- Transported to recovery room
- OMS alerted and returned to the room
- CPR started; Defibrillator attached; No shock advised
- CPR began
- Patient bagged
- 911 called

Outcome

- 5 minutes later, EMS arrived
  - Patient “ashen, cool, with no carotid pulse or pupil reaction”
  - Removed OMS monitors and placed their own
  - Patient in v-fib
  - 1 shock administered
- Patient transported to hospital
  - Pronounced dead
- Autopsy
  - Cause of death: Respiratory depression in the course of anesthesia
  - Contributory factor: Down syndrome

Allegations

- Failure to properly assess patient pre-anesthesia
  - Down syndrome patients have compromised airways
- Failure to properly maintain monitoring equipment
  - Improper times recorded and pertinent information missing
  - No SaO2 numbers recorded during or after surgery
Case Study Analysis

**Strengths**
- Informed consent indicates risk of anesthesia complications
  - Cardiac arrest, brain damage, death

**Weaknesses**
- Poor pre-op assessment
  - Wrong ASA
  - No head and neck exam
  - No Mallampati
  - BMI (33.1 Obese)
- Intra-op assessment poorly documented
  - Inaccurate time stamp
  - No SaO2 recordings

**Outcome:** Settled

**ANESTHESIA RECORD**

**What Can We Learn From This?**
- *Emergency preparedness starts with patient assessment*
- Monitoring equipment must be calibrated with correct time and date
- Monitors and printers must be in working order and have memory
- Patient monitors should not be removed/detached until patient fully awake and responsive
Case Study: Allergic Reaction

Informed consent obtained
- Discussion/ form signed
- Clindamycin 600mg administered

Extractions performed without complication

Post-op instructions given

Procedure

Post-Operative Complications

6 hours post-op
- Patient called office complaining of nausea, emesis and pain
- Appointment scheduled that evening at office

I.V. fluids given
- Toradol, Zofran, 50mg Demerol
- Allergic reaction immediately following administration of Demerol
- Patient's tongue and oral tissues doubled in size
- 911 contacted immediately
- Patient placed on full monitors
- Ventilation with an oral airway
  - Unable to intubate due to size of tongue
Emergency Management

- EMS arrives
  - Combitube placed
  - Benadryl administered
- Patient transported to hospital
  - Patient vomited around combitube
  - Combitube removed
  - Oral tracheal tube placed
    - Steroids and Epinephrine given
    - Pulseless electrical activity: CPR initiated
  - OMS followed patient to hospital
  - OMS spoke to patient’s family and ER doctor about incident

Outcome

- Patient admitted to hospital overnight
  - Prophylactic antibiotic therapy given to prevent aspiration pneumonia
  - Patient given large doses of steroids
- OMS returned to hospital the following day
  - Patient extubated
  - Discharged that evening
- OMS wrote a letter to referring orthodontist informing him of complication
  - Advised doctor to add Demerol as patient allergy

Letter to Referring Ortho

Dear Dr.[Name],

Early today, your patient underwent uneventful extraction of wisdom teeth and two premolars... At approximately 5 o'clock the patient contacted the office and said she was having issues with nausea and emesis. When the patient arrived, I started an IV, gave the patient additional doses of Toradil, Zofran, and a 50mg dose of Demerol. Ms. [Name] exhibited a severe allergic reaction following the Demerol administration... the patient was stabilized for transport to the emergency room. The following morning after large doses of steroids... the patient was discharged to home. Please update your records to indicate Demerol allergy on your patient chart.

Regards,
Case Study Analysis

**Strengths**
- Contacted EMS immediately
- Followed patient to hospital
- Spoke with ER doctors and family
- Wrote a letter to inform referring orthodontist of allergic reaction
- Entire office record well documented

**Weaknesses**
- Administration of Demerol
- Delayed administration of Benadryl
- May have tried other airway options

**Outcome:** No suit filed

What Can We Learn From This?

- Communication with family and other doctors (including ER and ICU physicians) can help to defuse a potentially bad situation
- EMS will not always arrive within minutes
  - Prepare for the unexpected
  - Be prepared to handle an emergency in the office while waiting for EMS

Prepare For The Unexpected

*Practice, Practice, Practice!*

- Assign staff specific roles during an emergency
- Use the actual equipment and drugs needed during drills so staff knows exactly where to find them
- Check and inventory crash cart and emergency equipment on a regular, rotating basis among staff
- Be willing to take suggestions and advice from your staff
- Staff Tip: Create surprise emergency drills that involve the doctor(s). After all it is the doctor(s) who will direct staff during an emergency
Sim Man in Your Office

- Real life simulation
- Utilizes your staff in your office
- Utilizes your equipment and expired drugs
- Staff and doctors have to open and prepare drugs for administration
- Can do scenarios in any location in office
- Let’s you see deficiencies in preparation, office layout, logistics, etc.
- Immediate feedback from independent observer
- Potential ACLS recertification

Case Study: Patient Selection

- 44 year old man referred to OMS by general dentist
  - Evaluation of severely decayed teeth
  - Weight: 330lbs  Height: 6’ 4”
- Medications
  - Metoprolol 50mg, Lisinopril 40mg, Hydrochlorothiazide 25mg, Niaspan 1000mg, Pravastatin 40mg, Amlodipine 5mg, Aspirin 81mg.
  - Multi vitamin, B-12 1000mg, Folic Acid 400mg
- Health History
  - High blood pressure
  - Shortness of breath/fatigue

Fatigue, high blood pressure, short of breath (able to walk up stairs without difficulty)
Pre-Operative X-ray

Examination

- Comprehensive Exam
  - 10 teeth non-restorable
  - Treatment Plan: Extractions with general anesthesia

- Consent signed
  - Potential complications related to anesthesia administration were not listed
Procedure

- Teeth extracted with general anesthesia
  - 5mg Versed, 100mcg Fentanyl, 20mg Brevital, 25mg Ketamine
  - No complications
- Patient transported to the recovery room

Anesthesia Record

Description of Incident
Emergency Management

- Recovery room
  - SaO2 and pulse started to drop
  - Nasal cannula oxygen increased from 2L to 10L
  - 911 called
  - AED placed and CPR started
  - Emergency medications: 0.4mg Atropine x 2, 0.4mg Narcan x 2, 0.1mg Flumazenil x 2, 1mg Epinephrine

Outcome

- EMS arrived
  - Patient pulseless/apneic
  - Patient intubated
  - CPR continued
  - Emergency medications: 4mg Narcan, 2mg Atropine, 300mg Amiodarone
  - AED advised shock
- Patient transported to hospital
  - Patient later expired
- Autopsy
  - Cause of death: Cardiac arrhythmia due to cardiomegaly and focal myocardial fibrosis

OMS Staff Deposition

- Surgical assistants revealed that several statements made by OMS were inaccurate
  - Anesthesia record completed after OMS learned of patient death
  - Patient was not placed on nasal cannula until after respiratory distress
  - Patient not placed on EKG or pulse oximeter until after surgery
    - OMS did not keep pulse oximeter alarm on
    - Blood pressure never recorded
  - OMS did not alert EMS that patient was not breathing
    - Patient described as “unresponsive” only
Allegations

- Failure to evaluate patient as high risk for sedation
- Failure to obtain complete medical history
  - Obstructive sleep apnea
- Failure to fully evaluate airway
- Failure to utilize monitoring equipment
- Failure to maintain emergency airway equipment
  - Did not establish artificial airway
- Falsification of dental records

Case Study Analysis

**Strengths**
- Death due to a pre-existing condition
- Informed consent used

**Weaknesses**
- No medical consult
- Use of Ketamine in hypertensive patient
- Failure to monitor patient during procedure
- Insufficient resuscitation attempts
  - Airway not maintained
- Falsifying records

**Outcome:** Case settled

What Can We Learn From This?

- Medical consultations can provide additional insight for patient with comorbidities
- Proper monitoring can allow for early intervention
- Ensure that medications used are not contraindicated with patients health conditions
  - E.g. Ketamine for hypertensive patients
- In an emergency, correct communication is essential
- Records must be contemporaneous
- Consider OMSNIC Resource: “Medical Consultation Request Form”

**NEVER ALTER A RECORD!!!!**
What Else to Consider

• If you have elevator access, will the elevator accommodate a stretcher?
• What is the response time of the EMS?
• Will room size and layout allow for efficient emergency management and equipment?
• Does everyone in the office know their role?
• Are you prepared to deal with an office fire?
• Are you prepared to deal with power failure?

Emergency Management Resources

• Visit www.omsnic.com to view/download
  – OMSNIC Office Emergency Training Program
  – Anesthesia Record
  – Crash Cart Checklist
  – Emergency Record
  – Recovery Room Record
• Visit www.aaoms.org for the Office Anesthesia Evaluation Resources

Documentation

The Whole Truth...
...Nothing but the Truth

Spoliation: the material alteration of a document so as to render it invalid

Examples:
– Notes in a margin
– Suspiciously missing records or pages of a record
– Altered entries (scratch outs, write overs)
– Changes to dates

NOTE: The health record is a LEGAL document

Common Charting Omissions

1. Health history is not clearly documented or updated
2. Assessment of patient is incompletely documented
3. Treatment plan is not documented or not clear
4. Objective findings are incompletely documented
5. Subjective complaints are not documented
6. Telephone conversations with patient are not documented
7. Informed consent & refusal is not documented

Adapted from the ADA CMIRP Malpractice Survey
Top Errors in Record Keeping

Where the Story Begins...

Common Omission: Health history is not clearly documented or updated

How to Prevent the Omission:
1. Ensure that all questions/blanks have a response
2. Consider signing at initial review
3. Subsequent reviews should be documented in chart or on the health history
   • “Reviewed health history, no changes per patient”
Setting the Scene: The Role of the OMS

**Common Omissions:**
- Assessment of patient is incompletely documented
- Treatment plan is not documented or not clear
- Objective finding & Subjective complaint are missing

**How to Prevent these Omissions:**
1. Use consistent documentation formats (SOAP)
2. Document your thought process
   - Write what you see and your plan to address the problem

The Role of Your Staff in the Narration

**Common Omission:** Telephone conversations with patients are not documented

**How to Prevent the Omission:**
- Office Policy & Protocol
  - Identify the how, what, when and where
- Supply staff with the tools
  - Access to the patient’s record
  - User name & Password

It’s a TWO WAY STREET

Documenting Your Patient’s Response

- **Common Omissions:** Informed consent and/or refusal is not documented
- **How to Prevent the Omissions:**
  - Use Procedure Specific Informed Consent forms
  - Document the informed consent process in the record
  - Document patient compliance in the record
  - Consider the use of Informed Refusal forms and Compliance related letters
Patient Compliance Issues

- Missed Appointments
- Lack of adherence to recommended treatment (Non-Compliance)
- Informed Refusal
- Dismissal or Termination of Care
- Use a formal letter or form to document these non-compliant behaviors
- Consider OMSNIC Resource: Compliance Related Documents

General Guidelines

- Communication with the patient before sending a letter
- Patient specific
  - Identify the specific non-compliant issue & recommendations
- Make 3 copies of the letter
  - Patient’s record
  - Mail (regular and certified)
- Document supportive information in record

Missed Appointment Letter

- Used as an alert and reinforcement
- Sent to a patient who has missed 1 or more appointments
  - Appointments have not been rescheduled
    - Document all attempts
- General Components:
  - Identifies the number and type of appts missed
  - Emphasizes the importance of continuity of care
  - Lays the groundwork for future action
    - Include a timeframe for response
    - Informs patient of potential impact on Dr-Pt relationship
Non-Compliance Letter

- Used as a warning or notice
- Sent to a patient who has exhibited behavior inconsistent with recommended behavior
  - Smoking cessation
  - Referral to a specialist
- General Components:
  - Specifically identifies the noncompliant behavior
  - Outlines the potential health consequences
  - Reiterates recommendations
  - Informs patient of potential impact on Dr-Pt relationship

Dismissal Letter

- Used to end the doctor-patient relationship
- Generally NOT the first letter sent to the patient who has exhibited non-compliant behavior
- Sent at a safe stopping point in course of tx
- General Components:
  - 30 days of Emergency Care
  - Includes a release for records
  - Objectively explains reason for termination
  - Provides resources to find a new OMS

Informed Refusal of Treatment Form

- Supports the doctor-patient discussion related to recommended treatment that the patient *clearly* refuses to adhere to
- General Components:
  - Is not a letter and should not be mailed to pt.
  - Requires patient signature
  - States the recommended treatment
  - Outlines the risks of refusing treatment
Common Dictation Errors

1. **Words, symbols, or abbreviations** are ambiguous
2. Lack of **signatures** or illegible signatures
3. **Illegible** documentation

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What Does That Mean?

**Common Errors:** Words, Symbols, or Abbreviations are ambiguous

**Especially dangerous with prescriptions**

**How to Prevent the Errors:**

1. Use only universally accepted shorthand
2. Occasionally ask your Office Manager or assistant if what you wrote was clear

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Whose Note is This?

**Common Error:** Lack of signatures or illegible signatures

– Especially in a group practice

**How to Prevent the Error:**

1. Make it a habit to sign all entries
2. Write your name if your signature is difficult to read
3. Keep a signature log
4. In EMR, create individual accounts that identifies all user entries
What Does That Say?

**Common Error:** Illegible documentation

**How to Prevent the Error:**
1. Take your time
2. Utilize a staff member to dictate when appropriate
3. Consider type written chart notes (EHR)

Electronic Health Records

- **Beneficial**
- **Risks**
  - Templates
  - Copy & Paste
  - Cyber Issues
- **Considerations**
  - “Lock” system
  - Backup system daily
  - Conduct audits of the system
- There are a number of different EHR Systems
- **General Principles:**
  - All staff documenting should have a log-in and “signature”
  - “Time Stamp”
    - Meta-Data
  - Do NOT delete/alter notes
  - Amendments/Addendums should maintain the original note

Documentation: The Story of Patient Care
Questions?

Thank You.

Need to Contact OMSNIC?

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