Risk Management
For The
Oral and Maxillofacial
Surgeon

OMSNIC
DEFENDING THE SPECIALTY
OMS National Insurance Company, RRG, welcomes you to our program, “Risk Management for the Oral and Maxillofacial Surgeon.” OMSNIC is owned and operated by OMS, and we only insure OMS. For 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 Anesthesia, Implants, 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, closed claim summaries and other practice management resources in the OMSNIC Resource Center. 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
Chairman, OMSNIC Board

Michael Stronczek, DDS, MS
Chair, Risk Management Committee
The following live presentation is dedicated to the education and scholarship of the OMS community. It is meant to provide you with information regarding risk management topics. 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. This presentation does not modify the terms and conditions of your OMS National Insurance Company Professional Liability Policy. Please refer to your OMS National Insurance Company Professional Liability Policy for these terms and conditions.

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Topics

• Claims Data Overview
• Anesthesia Complications
• Implant and Nerve Injury
• Communication
• Wrong Tooth Extraction
• Failure to Diagnose
• Documentation
• Medication Related Issues
Course Objectives

• Enhance patient safety and prevent or reduce untoward events through the implementation of risk management strategies including the application of improved communication and documentation skills
• Understand the importance of implementing appropriate anesthesia management systems to improve patient safety
• Recognize issues that can contribute to wrong tooth extraction with a focus on reducing frequency
• Implement policies and strategies to help prevent delayed diagnosis or failure to diagnose claims
• Understand the relationship between medication and allergic reactions as well as the potential of drug addiction in some patients

Incident or Claim?

Incident
• Professional or bodily injury that an insured reasonably believes may result in a demand for money or services as compensation

Claim
• Demand for money or services as compensation for a professional or bodily injury

Contact an OMSNIC Claims Professional immediately if any of the following occurs:

• Death of a patient under any circumstances
• Any adverse occurrence that you believe may later result in a claim
• Contact by an attorney
• Demand from a patient
• Receipt of a subpoena or suit papers
• Contact by a peer or state review agency

800-522-6670
OMSNIC Advantages

- Stock Ownership
- New-to-Practice Discounts
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- Waiver of tail premium at any age after five years upon retirement
- Coverage for practices with reduced hours, such as Part Time, Consultation Only and Volunteer
- Free corporation/partnership coverage
- EPL and DPR defense only coverage
- Medicare/Medicaid Fraud & Abuse defense only coverage
- OMS Data Defense Coverage
- $1 million of free personal Excess (umbrella) coverage

ANESTHESIA

Overview

- Likelihood of an office anesthesia death during an OMS’s career: 1 in 18 surgeons
- Indemnity paid to date for all anesthesia related deaths in the office or hospital is approximately $20,000,000
- Trends
  - Capnography
  - CRNA
  - Dental Anesthesiologists
Capnography

As of January 1, 2014, the use of capnography will be mandated by AAOMS for all anesthesia procedures from moderate sedation to general anesthesia.

Capnography

• Measures expiratory CO₂ plotted against time
• In an open system, the actual CO₂ concentration may be skewed, but the continuous wave form gives evidence of a patent airway
• The loss of the wave form gives almost immediate evidence of respiratory compromise
• Pulse oximetry readings may go unchanged for several minutes before decreasing

Capnography Options
Case 1: Facts

- 21 year old Female
- Past Medical History  Non-contributory
- NKDA
- Weight 190  BMI 30.6
- No mention of the Mallampati Classification
- Dx: Impacted 3rd Molars
- Pericoronitis at 17 and 32
Anesthesia

- Returned 1 week later for extractions
- Initial Anesthesia Drugs
  - Versed® 5 mg
  - Fentanyl® 50 µg
  - Ketamine 40 mg total (2 doses of 20 mg given 5 minutes apart)
  - 2% Lidocaine with epi—9 cc injected locally
  - Propofol Pump

Complications

- After induction of anesthesia and the initial incision, the patient developed respiratory distress
- Airway obstruction led to bradycardia
- Attempts were made to control the airway with a bag-valve-mask
- As the O₂ saturation declined, the patient went into cardiopulmonary arrest

Emergency Management

- EMS called and assisted with CPR
- The patient was transported to the Emergency Room
- Resuscitation was unsuccessful
- The patient was pronounced at the ER
Complication - Airway Loss

- Anatomic Concerns
  1. BMI
  2. Mallampati Classification
  3. Neck size and mobility
  4. Oral Range of Motion
  5. Obstructive Sleep Apnea
- Recognition and Treatment

BODY MASS INDEX (BMI)

- What is a normal BMI?

BMI

- Patient BMI based on her reported weight was 30.6
- Actual BMI was 37.7 based on a height measurement of 63” and a weight of 213 pounds measured at the autopsy
- BMI is only one indicator of patient airway status. Consider the neck range of motion, neck size, presence of tonsils, etc. to accurately assess an airway
Emergency Management

- Equipment Failure: Bag/Valve/Mask was non-functional
- Succinylcholine given at 20 mg on 2 occasions
- Sub-intubating dose may have contributed to the development of bradycardia
- Staff preparedness was a concern
- EKG time stamp was from 10 years earlier complicating records

EMT Affidavit

- It appeared the physicians were not properly prepared for the emergency procedures that needed to be undertaken.
- In my opinion, paramedic personnel should have administered intubation and used a bag valve mask and endotracheal airway.
- Should have checked for a pulse as should be done when a patient is opioid per American Heart Association Guidelines.
- I asked the staff if there was a pulse, they responded "Yes, she's got a rhythm", however I immediately checked for a radial pulse and could not palpate. Then we immediately started CPR.
Outcome

- Coroner noted “the apparent cause of death is a cardiac arrhythmia and the manner of death natural”
- The cardio-vascular failure likely was a result of the compromised airway and subsequent hypoxia
- The toxicology reports showed the drugs given to be well within the therapeutic range
- Case was settled before trial for just under $3 million with defense costs at $64,000

Risk Management Tips

- Ensure redundancy in your emergency equipment
- Give every patient a complete airway analysis
- Prepare for the unlikely emergency. TEAM emergency preparedness is an essential aspect of every OMS practice

Case 2: Facts

- 20 year old male
- Presents for removal of three 3rd molars
- ROS is negative
- NKDA
- 68” 185 pounds
- BMI: 28.1
Anesthesia Medication

- 125 µg of Fentanyl®
- 6.5 mg Phenergan®
- 7.5 mg Versed®
- .625 mg of Droperidol
- 30 mg of Propofol
- 6 mg of Decadron®

Complications

- During the course of the surgery, the patient became agitated and was difficult to manage
- The patient ripped the monitors off while agitated
- Things continued to go downhill from there
Chart Notes

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</tbody>
</table>

Chart Note Highlights

• Unable to achieve pulse oximetry reading. O₂ Ready. No respirations detected. Patient ventilated with Ambu bag with O₂
• Unable to ventilate. Subseq intubated oral trach with ETT
• Gauze placed in LL to aid hemostasis. Tube was visualized. CPR started
• EMS Called. Tube was confirmed by EMS. CPR and ACLS protocol continued by EMS

Outcome

• Doctor rode in the ambulance with the patient to the ER
• EMS removed the ETT and replaced it with a Combi-tube during transfer
• The patient’s abdomen was noted to be distended when they reached the ER
• The patient was re-intubated and a bloody sponge was removed from the oropharynx
• Resuscitation failed and this young man expired
Settlement
$185,000 with $56,000 in defense costs before trial

Strengths
• OMS successfully intubated patient
• OMS managed hemostasis with gauze during emergency
• Unclear why the airway was suddenly compromised during transfer
• Unclear when the sponge was dislodged

Weaknesses
• Our OMS rode in the ambulance when ETT was switched to Combi-tube
• Chart notes did not indicate time stamped care
• Chart notes in the margin
• Sponge count was not documented or performed

Risk Management Tips
• Document emergencies with detailed notes and accurate time stamps
• Consider implementing an in-office sponge count
• OMSNIC recommends you transfer care to the EMS immediately upon arrival
  **Traveling with the EMS to the hospital may leave the patient under your control**

Case 3: Facts
• 53 year old female presented for extraction of # 1, 28

Patient’s past medical history:
• Sarcoidosis
• Asthma
• C-V Disease
• Hypertension
• 3 liters O₂ by nasal cannula at all times
• Recently admitted to hospital for pneumonia
Daily Medications

- Pred-Forte
- V-Fend (Antifungal)
- Prednisone (30 mg)
- Lasix
- Carvedilol (Coreg/Beta Blocker)
- Enalapril
- Potassium

Treatment

- Panorex taken
- Obtained informed consent
- OMS recommended surgery the same day as the consult
- IV placed and appropriate medications administered
- Shortly after sedation started, the patient had difficulty breathing and O₂ dropped to 81%

Anesthesia Delivery

- Versed® 2.5 mg
- Robinul® .2 mg
- Decadron® 8 mg
- Ketamine 25 mg
- Brevital® 30 mg
Treatment

- Heart rate initially increased from 106 to 125
- BP increased from 127/82 to 160/110
- $O_2$ decreased to 69%
- Flumazenil administered and the heart rate came down and the $O_2$ went up to 78%
- OMS extracted tooth #1
- Saturation went down again
- CPR was started and the EMS were called

Outcome

- Patient expired
- Case settled for $350,000
- Defense costs were $10,000

Medical Examiner’s Report

- Enlarged heart
- Pulmonary Edema
- Pulmonary Emphysema
- Liver congestion
- Splenomegaly
- Nephrosclerosis

- Cause of death listed as hypertensive C-V disease
ASA Classification

<table>
<thead>
<tr>
<th>ASA Physical Status</th>
<th>Description</th>
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<tbody>
<tr>
<td>1A</td>
<td>A normal healthy patient</td>
</tr>
<tr>
<td>2A</td>
<td>A patient with mild systemic disease</td>
</tr>
<tr>
<td>3A</td>
<td>A patient with severe systemic disease</td>
</tr>
<tr>
<td>4A</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
</tr>
<tr>
<td>5A</td>
<td>A moribund patient who is not expected to survive without the operations</td>
</tr>
<tr>
<td>6A</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
</tr>
</tbody>
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Risk Management Tips

- Consider a medical conference with the treating MD when patients present with a complex medical history
- Be prepared to handle medical emergencies in your office
- Classify your patient’s ASA status and choose your anesthetic technique wisely

IMPLANTS
Case 4: Facts

- 60 year old male; smoker (2pk/day)
- Presented for evaluation to remove #20/site preservation/subsequent implant placement
- CC: “tooth infection”
- Dx Loose #20

Case 4 Clinical Notes & TX Plan

Pre-Extraction Panorex
Extraction

• OMS removed #20 with site preservation
• Very little information on the chart regarding the actual procedure
• 1 week post-op patient presents to GP who notes #20 extracted. Refers patient to OMS for #18 extraction due to subgingival caries

Extraction

Complications

• No referral provided by GP or requested by OMS
• GP had wanted #18 removed; endo already started on #19
• OMS offered to place implant at #19 without charge as a gesture of good will
Implant Placed at #19 and #20

1. I hereby authorize [Redacted] and assistant to treat the condition described.

2. The procedure offered to treat the condition has been explained to me and [Redacted] understood the nature of the procedure to be performed.

3. I have been informed of possible alternative methods of treatment (if any), including:

   [Redacted]

4. [Redacted]

5. [Redacted]
Implants Post Op

- 2 days post op patient claimed lower left lip numb
- OMS says P-A during procedure did not show the 1st implant too deep (Panorex was lost)
- Another panorex taken - showed implant is too deep
- OMS removed #20 implant and placed a shorter fixture
- Prescribed Medrol® dosepack

Post Op Panorex

Panorex: Shorter Fixture
Neurosensory Exam

12/4/1
F/u

Pt was treated well.

Results of NS exam?

2 pts

Dee 1/A. Weld nerve pbs

Rx: None. Doc Rx 'n 2 B discussed.

Sample Exam Form

Clinical Findings:

- Touch (brush)
- Pressure (blunt)
- Pain (pin prick)
- Temperature (ice, ethyl cl)
- Two-point discrimination and localization
  - Normal = mm
  - Test = mm

Dictated Note

Apparently there was a miscommunication. Tooth #19 had a large filling in the mesial. Patient stated he had a root canal in that tooth, but still had symptoms and a dull aching pain. I spoke with his general dentist, who said they would try to save tooth #18. Patient told him he could have implant in #19. According to my understanding, on August 23, tooth #19 was extracted, because the patient was in pain, but the thought #20 should be extracted.

There was confusion because there was no note from his dentist, plus the fact that the patient had been constantly coming back for pain in tooth #19 and that appeared to be the problem. On October 9, 2005, I evaluated #19 for an implant, after waiting and it appeared there was adequate bone.
Outcome

• Suit filed claiming WTE and substandard implant placement with resulting nerve damage
• Settled prior to trial
• Indemnity $132,500
• Defense costs $14,000

Issues

• No referral provided or requested
• PA taken during procedure was lost
• Consent form was not complete
• Detail of NS exam was not documented
• Sparse documentation compared to lengthy dictated note can appear suspect

Risk Management Tips

• Use diagram charting to document initial NS exam, and any subsequent examinations
• Fully complete consent forms – no blank spaces
• Patient and doctor signature is essential
• Document thoroughly and consistently
• Inconsistencies in your charting style could be suspect
• Make and document referral to an experienced micro surgeon within 3 months of the initial injury
  – Use referral forms
Risk Management Tips

State Dental Practice Acts:

• Require documentation of the decision making processes that determine treatment planning
• A similarly trained practitioner should be able to read the patient’s record and understand how decisions were made and discuss the patient’s care

General Documentation

• Patient Chief Complaint
• Examination
• Diagnosis
• Treatment planning
• Alternative treatment options
• Anesthesia discussed
• Patient choice documented

Dental Implant Case Details

• Implant length and diameter
• Location and angulations
• Restorative plans
• Need for bone and tissue grafting
Detailed Operative Notes

- Incisions
- Where placed
- Bone quality and quantity
- Anatomic defects influencing fixture placement
- How/where augmentation was done
- Use of surgical guide
- Complications

Case 5: Facts

- 60 year old male in good health
- Failing bridge #18-20
- Bridge sectioned, #18 removed, #19 ridge deficiency grafted with ramus graft
- Implant subsequently placed at #18, #19
- OMS used surgical guide provided by referring GP

Detailed Treatment Plan

1. Local anesthesia
2. Remove bridge distal to tooth #20
3. Extract tooth #18
4. Evaluate ridge width of site #19. If inadequate ridge width due to resorption of the alveolar process, additional graft.
5. Buccal bone graft to reconstruct buccal alveolar plate #19
6. Place trial implant
7. One screw to secure graft to implant
8. Four to five month graft healing
9. Template constructed by
10. Two implants into sites #18 and 19
11. Postoperative panoramic x-ray
12. Four month integration of implants
Detailed Treatment Plan

13. Reverse manipulation to confirm integration
14. Postopacryl to confirm occlusion
15. Curettes as per

It is possible that after sectioning the bridge, there may be adequate bone remaining without grafting. If that’s the case either I will place an implant in the #8-9 site slightly to the lingual, and if possible, an implant into the mental bone adjacent to mentally sign #8. If bone is inadequate in the #19 area, and/or if I don’t feel I can get good initial stabilization of an implant into pocket #19, I will graft and then come back.

Informed Consent

CONSENT FOR SURGERY AND ANESTHESIA

[Blank]
give not consent for the oral and
maxillofacial surgery to be performed. Implant

18, 19 will local anaesthesia

has been explained to me in the following terms:
place implant
on lower left 18 & 19 molars
which are acute

and I understand what is to be done. This is my consent to the oral surgery described above, and to any additional/alternative procedures that may be deemed necessary by

Dictated Op Note (Letter)

Today under local anesthesia I placed implants into the lower left quadrant by:

I found the bone graft to have healed very nicely. I removed the crown which had covered the bone graft in the past.

Using your surgical template I placed two implants as follows:

• #19 - 3.3 PN Miltex tapered 4 mm in diameter x 11.5 mm in length. I placed the healing abutment on which is 5.0 mm in diameter x 3 mm in height to be a two-piece provisional. There was excellent initial stabilization in the type II bone.
• #18 - 3.3 GN Miltex tapered 4 mm in diameter x 11.5 mm in length. I placed the healing abutment on which is 5.0 mm in diameter x 3 mm in height to be a two-piece provisional. There was excellent initial stabilization in the type II bone.

I placed multiple block split sutures and preserved all trimmed tissues.

In the recovery room I gave [patient’s name] postoperative instructions and prescriptions for pain, Paracetamol and pain relief for 5 days, and to continue the Chlorhexidine which [prescribed] began this morning.

I plan to remove the abutments in one week and in three months to evaluate the implants for integration.

Once again, thank you for being so helpful during this case. It is very nice to see that you are so flat and doing so well. If there is any further assistance, please feel free to contact me at the office at any time.
Post Op Images

Post Op

• OMS documented that patient is healing well, stated that he would call restorative GP regarding angulation of implants

Angulation

• OMS discussed angulation dilemma with restorative GP, custom abutments discussed
• Patient was upset, restoring GP referred patient to periodontist for evaluation
• Periodontist opined that implants were improperly placed and would need replacement due to functional and hygiene considerations
Periodontist Treatment

- Removed the implant, grafted the areas, and replaced implant
- Noted that according to the patient, the surgical guide was not used by the OMS during the original surgery

Second Implant Post Op Image

Outcome

- Lawsuit filed claiming substandard implant surgery and placement by OMS
- Defense verdict at trial
- Defense costs $83,000
Strengths and Weaknesses

Strengths
• OMS documented use of surgical guide provided by GP
• Good documentation of treatment plan, informed consent
• Defense expert supported implants could be restored with custom abutments

Weaknesses
• Angulation of implants could be difficult to restore
• Patient stated that OMS did not use surgical guide
• Subsequent treater (periodontist) was not supportive of OMS treatment

Importance of Communication

• OMS contacted referring GP immediately following surgery to discuss concerns about angulation of implants
• OMS discussed concerns with patient, offered to remove implants and replace at no charge
• OMS communication with GP and patient gave the impression to the jury that the OMS had the patient’s best interests in mind

Risk Management Tips

• OMS managed a difficult outcome very well through good communication, offering an immediate solution to improve the outcome
• Documentation of surgery and informed consent was comprehensive
• Good communication and documentation can make less than ideal cases more defensible
COMMUNICATION IN THE OMS PRACTICE

Introduction

- Lack of communication is one of the most common reasons patients file lawsuits
- Studies estimate 80% of malpractice claims are attributed to the failure to communicate and/or lack of interpersonal skills

Poor Communications = $$$

- Negligence based on alleged inadequate post-op care and management - $725,000
- Alleged failure to diagnose squamous cell carcinoma - $225,000
- Alleged failure to advise of biopsy results - $175,000
- Wrong tooth extractions - 388 claims ('08 to '12) - >$3 Million
Communication Challenges

- Low health literacy
- Patient perceptions and expectations
- Lack of staff training

Types of Communication

- Verbal
- Non-Verbal (body language), emotions
- Tone

Types of Communication

- 56% facial cues
- 36% non-verbal
- 8% words

Active Listening and Communication

• According to “How Doctors Think,” doctors interrupt patients within the first 18 seconds of conversation
• Look at the person, show interest
• Lean in
• Affirm- “If I understand you correctly…”

“People don’t care how much you know, but they know how much you care by the way you listen.”
- Robert Conklin
  Author & Educator

Ask Questions

• Determine what is important to the patient
• How much do they already know? (Internet info, Google)
• How much do they want to know?
• Don’t assume they know “the obvious”

Explain and Educate

• People versus NY Times
• Use visuals to help clarify
Add a Little Empathy

• Empathy goes a long way
• Not only when an untoward event occurs

Building The Relationship

• Website
• First contact with staff and OMS
• Set expectations including fees, finance issues, appointments
• Make the patient part of the process
• Inform of any delays, complications, deviations

Invest in Staff Training

• Ongoing staff training is critical in establishing consistency and supporting patient safety
• Regular staff meetings- set the tone for the day, address any issues promptly
• Policies and procedures to support consistency- include clear instructions on handling phone calls- chain of command
• The time to train is before an untoward event
End Note

• If you don’t listen or answer patient’s questions effectively, you may be listening to and answering an attorney’s questions instead.

WRONG TOOTH EXTRACTION
Closed Claims Statistics

• 70% of closed claims are dentoalveolar
• 61% of dollars paid by OMSNIC have been for dentoalveolar claims
• 11% of closed claims are WTE
• Over $19 million dollars paid in indemnity and defense costs for WTE claims
• $15,000+ is the average indemnity + defense costs paid for WTE claims

Case 7: Facts

• 29 year old patient presented to Orthodontist for initial evaluation and records
• Ortho diagnosed Class II malocclusion
• Referred patient to OMS for jaw surgery consultation
• Referral letter included mandibular advancement consultation but no mention of extractions

OMS Diagnosis

• OMS diagnosed crowding and need for mandibular advancement; consent dated and indicated removal of teeth #1, 5, 12, 16, 17, 21, 28 and 32
• Consent not signed by patient
• Letter from OMS to Orthodontist listed treatment plan for extraction of 8 teeth and mandibular advancement
Ortho Treatment Plan

- Two weeks later at Ortho treatment conference, patient refused surgery; compromised result discussed in detail
- Detailed letter from Ortho to OMS discussed the nonsurgical treatment plan and requested removal of teeth #1, 5, 12, 16, 17 and 32
- Letter received and filed in patient’s chart at OMS office

Extractions

- 6 months after consult, the patient returned to OMS office for extractions
- Assistant had patient sign and date the consent form that was completed at initial consult
- OMS extracted #1, 5, 12, 16, 17, 21, 28 and 32 under IV sedation

Post Op

- 5 days post-op, patient returned to Ortho
- Notes #21 and #28 extracted
- Only treatment plan possible now requires surgery
- Patient called OMS office, staff member returned the call instead of the OMS
- The Ortho was notified the patient was contacting an attorney
Outcome

- Case was settled for near the estimated costs for the surgery
- Defense costs $11,000

Risk Management Tips

- The patient, OMS, and all referring dentists must have a clear understanding of the proposed treatment on the day of surgery
- Independently evaluate and document the facts leading to the diagnosis and proposed treatment on the day of surgery
- Obtain a written referral if another dental professional is involved
- Only the OMS can obtain informed consent
- Screen phone calls appropriately. Return calls directly when best to do so

Case 8: Facts

- 19 year old patient
- GP diagnosed caries #19, patient elected extraction
- Patient given original PA radiograph, (in envelope labeled #30) no written referral
- OMS exam form stated “ref for ext of #30” and “grossly carious #30 s/p endo tx w/ PA pathosis. Ext #30 as referred”
Extraction

- Consent signed for extraction of #30
- Same day surgery under IV sedation
- OMS extracted #30
- In PAR patient told OMS wrong side, escort confirmed the pain was on the left side
- OMS took PA radiograph of #19 area which was identical to original PA brought by patient in envelope labeled #30 by referring GP office

Extraction

- OMS called GP who confirmed #19 was to be extracted, noted staff error labeling envelope
- The next day, OMS extracted #19 under IV sedation
- Detailed note documented (for the first time) #19 and #30 sensitive to percussion, had previous endodontic treatment and stainless steel crowns

Issues

- No written referral from GP
- OMS seemed to be directed by the mislabeled radiograph envelope, not by a thorough examination and discussion with the patient
- OMS and staff did not identify dimple on PA radiograph for orientation
- OMS made a more detailed note after the error was found
Outcome

- Case was settled
- Defense costs $0
- Handled by OMSNIC Claims Supervisor

How Can You Decrease the Frequency of WTE Claims?

- Independently diagnose and confirm treatment with the patient
- Carefully review radiographs
- Perform Time Outs
- Document your thought process
- When in doubt or disagreement, defer the procedure
- Obtain referrals and consult with other dental professionals involved in treatment

Empower Your Staff

- Have staff prepare surgical charts using appropriate check lists to confirm:
  - Appropriate radiograph(s) are available
  - Appropriate consults and labs are available (if appropriate)
- The schedule:
  - Agrees with what was planned
  - Agrees with the consent form
  - Agrees with the written referral
  - Agrees with the prosthesis (if appropriate)
Empower Your Staff

• Assign staff to obtain necessary items and/or confirm proposed extraction/treatment
• If there is a time gap between the consultation and treatment, reconfirm the treatment plan with the referring dentist and the patient
• Ask the patient if the treatment plan has been changed since their initial visit
• Staff meetings and morning huddles can be used to coordinate the surgical schedule

Empower Your Staff

• Make sure that your staff knows that they should do anything to prevent a wrong tooth extraction (or any other surgical error)
• It is easier to explain to the patient why your staff yelled “stop” if they were in doubt about what you were about to do than to explain to the patient why you removed the wrong tooth

Written Referral

• Develop “Referral Booklets” for referring GPs and a “proposed treatment form”
• Email or fax proposed treatment form to the other dental professional requesting return written confirmation
• Have staff call other office and follow-up to obtain written referral
RISK MANAGEMENT FOR THE ORAL AND MAXILLOFACIAL SURGEON

BREAK

FAILURES TO DIAGNOSE

CLAIMS HISTORY

- Delayed or failure to diagnose 4% of overall claims
  - Cancer
  - Infection
  - Fracture
  - Osteomyelitis
- $16 million paid in indemnity through 2012
- Small percentage of overall claims but very expensive
Case 9: Facts

- Middle aged woman referred to OMS by GP for biopsy of lesion on tongue
- Biopsy performed, but never sent to lab
- Patient scheduled for follow up appt., but cancelled it and said she would call back to reschedule
- Patient never called to reschedule, no follow up by office

Second Biopsy

- Patient later claimed she called for results of biopsy but was told by staff, “no news is good news, wait to hear from us”
- 14 months after original biopsy, referring GP called to ask for pathology report
- Office called patient, asked her to come back for a second biopsy
- Specimen harvested, but arrived at the path lab more than a month later

2nd Biopsy Results

- Biopsy showed squamous cell CA
- Patient had partial glossectomy, modified radical neck dissection
- CA treated surgically with no further therapy
More Problems

- 5 months after the second biopsy, OMS sent the patient to collections for an unpaid bill
- 6 months after that, OMS received a request for records
- The office never located the patient’s treatment record

Issues

- Patient alleged first biopsy would have been positive for CA
- Having lost the biopsy specimen, there was no way to refute the allegation
- Patient was sent to collections without review

Outcome

- Case was settled for $1.8 million
- Defense costs were $22,000 - somewhat limited by early settlement
Risk Management Tips

• Log pathology reports
• Manage biopsy specimens
• Notify all patients of results, even if negative
• Review all patients being sent to collections
  – Do not allow staff to send patients to collections without your approval
• Ensure policies and protocols exist and are followed to prevent lost records

How To Manage Biopsy Specimens

• Biopsy Log
  – Log specimens sent out of the office
  – Send by a service that is trackable
  – Log pathology specimens received
  – Check regularly for specimens not yet received
  – Date stamp pathology reports
  – Have the doctor review and sign the pathology report
  – Report results to patients
• Have a “tickler file” to prevent biopsy patients from being lost to follow up

Case 10: Facts

• Consult with middle aged female with a Hx of Hodgkin’s lymphoma referred by GP for XO teeth #s 1, 2, 15, 16, 17, 32
• Extractions 3 days later
• 1 week post op visit: Numb on right side
• F/u 2 weeks
• 2 weeks post op: Patient calls – jaw popped last night, now has excruciating pain
Diagnosis

- Patient seen in office next day, c/o pain, exam normal, nothing seen on Pano
- Patient seen again in office next day. Pain last night, feels ok today. Assessment: osteitis. Return 3 days
- One week later: continued pain
- Exam: DDx severe osteitis, fracture #18 or root exposure #18
- Extracted #18

Continued Follow Up

- 2 days after extraction, patient improved, no pain
- One week later: IAN paresthesia on right resolving
- 2 week f/u, continued numbness, plan to observe
- 4 week f/u, improved, slower healing of #17/18

One Month Later

- Patient called, unable to open mouth, c/o pain, swelling, popping. Pano showed osseous changes in left mandibular angle area
- Recommended debridement, IMF, possible need for ORIF
- Patient requested second opinion
- Patient’s husband cancelled f/u appt, not seen again
Final Diagnosis

• Mandibular osteomyelitis, possible ORN
• Underwent debridement and 40 HBO dives

Is There a Fracture?

Radiation Issue

• Patient checked “yes” on radiation treatment to face, neck, jaw, mouth or throat
• Should this have been considered when planning treatment for complication?
Allegations and Outcome

- Failure to diagnose mandibular osteomyelitis, possible ORN
- Settlement demand for $850,000
- Case ultimately dismissed by the patient

Risk Management Tips

- Obtain and review radiation therapy treatment summary whenever possible
  - Mantle radiation as used in the past did not include the mandible as part of the radiation field
- It is important that our records thoroughly document our thought process because subsequent treating clinicians will often put forth flawed theories of disease and/or complications
  - Highly unlikely that this patient had ORN

Case 11: Facts

- Middle aged female referred by GP to evaluate lesion on FOM present for 2 months
- Chart Notes: "3 mm x 5 mm ulcer ant FOM adjacent submandibular duct punctae"
- DDx was non-healing traumatic ulcer vs. neoplasm
- Tx plan included baseline photographs, soft diet, refrain from EtOH and smoking for 6 weeks, biopsy if lesion persisted at that time
Clinical Considerations

- The patient has a history of tobacco and EtOH use
- The anterior FOM is a high risk site for SCCa
- Biopsy has a low morbidity and high diagnostic yield
- Why not biopsy the lesion and remove guesswork from the diagnostic process?

Six Week Follow Up

S – Patient “feels better” with tenderness at #27
O – Significant decrease in size since last visit. Fibrinous callous
A – Traumatic ulcer, healing slowly secondary to repeat trauma, EtOH and tobacco
P – Patient advised to maintain soft diet. Decrease EtOH and tobacco as much as possible. Avoid trauma to site, return in 1 month after bridge complete
14 Weeks After Initial Presentation

S – OMS stated that she had “no complaints re: FOM since permanent bridge cemented”
Now complains of tenderness on facial #29 and mobility #29, no chills, fever, dysphagia

O – Ulceration, edema facial gingiva #29, #29 +1 mobility, deep probing on DL
Panorex— + bone loss distal #29

A – Diagnosis: “Periodontal disease with acute exacerbation #29”

P – “Recommend follow up with GP re: #29”

Panorex at 14 weeks

STOP!!

• 59 yo female with a long history of tobacco and EtOH use
• She had been followed for several months
• Whatever pathologic process that was ongoing for several months had not resolved
• The panorex taken 14 weeks after initial presentation showed a radiolucent lesion of the anterior mandible
6 Months After Initial Presentation

S- C/o several week history pain lower right. Cannot localize to a tooth, endo done on #27 to treat pain. No improvement
O- #28 trace mobility, #27 non mobile
  - Positive ulceration returned/worsened in floor of mouth overlying ridge anterior to submandibular gland duct
  - possible expansion of soft tissue anterior to ridge
  - Tender to palpation, negative submandibular/submental nodes
A- Ulcer anterior floor of mouth, possibly area of previous ulcer
  - highly suggestive of malignancy
  - not clear whether or not previous lesion even totally resolved
P- Incisional biopsy

Diagnosis

• Diagnosis: Squamous cell carcinoma, well differentiated
• The patient underwent treatment of her cancer
• Patient alleged delayed diagnosis and treatment

Issues

• The OMS made thorough and detailed records but for some reason had a low index of suspicion
• The patient kept her follow up appointments
• A more timely biopsy to establish a definitive diagnosis would have:
  – Helped the plaintiff to get treatment sooner
  – Helped our OMS defend himself against the allegation of delayed diagnosis leading to delayed treatment
Outcome

• Case settled for $620,000
• Defense costs: $126,000

Risk Management Tips

• Biopsy early
• Always follow up with a patient
• Hindsight is 20/20, but one can certainly question the approach of following a patient for 6 months before biopsy and submission of a specimen for pathology

Case 12: Facts

• 33 year old woman referred for consultation on symptomatic, carious, non-restorable #17
• Extraction without complications
• Patient discharged with pain meds, 1 week f/u appt
• Patient developed severe pain and discomfort in jaw and area of extraction
Clinical Course

• Patient seen post op #’s 3, 8, 10 for pain
• 10 days later: Healing well, pain meds prescribed, treated for dry socket
• 2 days later: Patient returned feeling much better. No sign of infection or discharge
• Instructed in oral hygiene, smoking cessation

Clinical Course

• 3 weeks later: Patient’s husband called – Patient had excruciating pain. Pain meds prescribed
• Seen next day – pain lessened. Films taken – no sign of foreign body, fracture or impingement
• Referred to pain management specialist

Documentation of Call
Clinical Course

- Patient returned the next day—still had pain—again advised to reduce cigarette usage, see neurologist
- Next day, patient’s PCP called—patient had left facial swelling. CT scan showed possibility of granuloma or abscess, but no fracture
- Patient seen next day by another OMS in the practice, panoramic film showed radiolucency

Diagnosis

- Osteomyelitis, admitted to hospital
- IV antibiotics administered in hospital for 5 days, through central line for another 37 days
- Subsequent CT scan showed a non-displaced clear fracture through the extraction site
- Patient transferred care to another OMS, fracture healed and infection resolved

Allegations

- Negligent performance of extraction causing fracture
- OMS ignored complaints of pain
- Failure to diagnose injuries
- Damages:
  - Pain and suffering
  - Permanent scarring
  - Inability to cook, clean, perform spousal activities or socialize
Discovery

• Patient had a long history of reliance on pain medications
• Patient received an Rx for Prednisone from another provider but did not advise OMS
  – It could have reduced the inflammatory process and masked its appearance for diagnostic purposes

Case Strengths

• Records are extremely complete
• Husband’s inappropriate behavior toward staff and doctor did not help his wife’s case
• Patient was not forthcoming about medication usage
• Patient claimed OMS ignored her complaints of pain – records show each complaint was appropriately addressed
Outcome

• Our expert witness from a local university supported the insured's care
• Patient could not secure an expert
• We refused to make an offer, forcing plaintiff to proceed with case
• Patient voluntarily dismissed the case

Risk Management Tips

• Document carefully and completely
  – Outline patient complaints and steps taken to address them
  – Use quotes to show inappropriate patient or family behavior
• This type of documentation can help defend a case as it did here
Elements of a Good Record

- Information about the patient’s condition, the treatment rendered, and the rationale
  - History
  - Physical findings
  - Assessment / Differential Diagnosis
  - OMS thought process
  - Informed Consent
  - Treatment / Procedure notes
  - Follow-up
- Legibility

Privacy/Security

- Health care providers must take reasonable steps and precautions to protect patient information in paper or electronic charts
- HIPAA HITECH requires encryption of email sent with any identifiable patient information

HIPAA Series in the e-Learning Center

Documentation – Paper Records

- Each page should have a patient identifier and each entry should be dated and signed
- Month/day/year should be used for all entries
- For anything dictated, do NOT use “dictated but not read”
Preprinted Forms

• Ensure all blanks are filled in
• If blanks are not filled in, explain why (such as deferred, refused, n/a)
• If a question doesn’t apply to all patients, consider a way to make it relevant for all
  - DENSE PREGNANCY? YES NO
• Redesign forms with questions that may no longer apply to your practice patterns

Documentation – Electronic Records

• Check to ensure that updates to electronic record systems do not alter information in record
• Review records to ensure that misinformation is not repopulated in charts (i.e., from templates)

ALL 202 - EMR course available in the e-Learning Center

Pre-Populated Template

Subjective/History of Present illness: []
Objective: []
Blood Pressure taken today:
Oral mucosa within normal limits
Pharynx Clear
No cervical lymphadenopathy or masses
Example of Pre-Populated Statement

Objective:
Head and Neck Exam: No facial asymmetry. The neck is supple without any lymphadenopathy or masses appreciated.

Blood Pressure taken today: 139/76

Intraoral Exam:
The oropharynx is clear. She is completely edentulous and the dentures do fit rather loosely. 3 small 2 x 2 millimeter ulcerated areas right buccal mucosa with erythematous borders. The areas do not appear to be in an area that would be irritated by the denture. No erythema or ulcerations appreciated under the tongue or on the mandibular ridge.

This template should be deleted

Patient History Forms

Should include the following:

- All medical conditions
- Medications/Herbals/Vitamins
- Birth control prescriptions
- Daily aspirin
- Bisphosphonates History
- Any medical or dental problems not addressed on form
- TMJ symptoms

Patient History Forms

- If patient leaves things blank (e.g., medication allergies), ask them to fill it out
- Ensure all history forms are signed and dated by patient
- Forms should be reviewed and signed by the doctor
- Update information (medications, etc.) at every appointment
Documentation

- Progress notes should contain only clinical information
- Information on billing, insurance, etc. should be housed separately (e.g. on the other side of the chart)
  - Information should only be in progress notes when it impacts care (for example, “patient refuses care due to lack of insurance/funds/etc.”)

Document Objectively

- Do not use subjective comments (e.g., “Patient is obviously angry,” “Patient is obnoxious,” “Patient doesn’t know what he’s doing”)
- Use objective terms
- For difficult situations:
  - Take time to compose thoughts before writing anything
  - Use quotes from patient (e.g., “Patient screamed “expletive” and hung up”)
Documentation

• Document good news as well as bad (i.e., patient has had complete relief of pain)
• Use patient quotes to document status
  – Feeling better, feeling worse, etc.
• Warning labels
  – Allergies – can use on outside of chart (HIPAA myth says no)
  – Name alert (put on outside of chart if there are two patients with identical names)

SOAP Notes

• Can easily note patient’s condition and what the OMS assesses and plans
• Can be reviewed quickly for an overview of the patient’s clinical course
  – Can prevent ordering tests that have already been performed
  – Can remind OMS/staff of what yet needs to be done

Sample SOAP Note

SOAP Note

Subjective: Pt presents for 3 month BG check. Pt doing well, no problems
Objective: Checked healing, tissue pink
Assessment: Normal post-operative course.
Plan: Took pain. Pt scheduled for implant 3/31/12

Assistant: [Signature] (electronic signature) Tue., Mar. [Signature]
Differential Diagnosis

- Document thought process/how you arrived at DDx
  - Example - Patient has non-painful swelling on roof of mouth next to broken down tooth - infection vs. neoplasm?
- Document the treatment plan, alternative course(s) of treatment, next course of action
- Ensure another OMS could follow your thought process

Diagram of lesion/exam

Treatment

SOAP Notes

Informed Consent

- An educational process, not a piece of paper
- Note the consent discussion in the progress notes
  - Need not be long
  - Need not iterate information from consent forms
- Consent forms must be signed by patients after discussion with OMS
Documentation of Safety Issues

• Surgical Time Out
  – Expanded Time Out Checklist is now at www.omsnic.com
  – Can adapt to your practice

Time Out Checklist

Patient Name:_____________________ Allergies/Adverse Drug Reactions:____________
Date of Birth:__________________________________________ Date of Surgery:________________________
Surgeon:________________________ ______________________________

PRE-OP CHECKLIST

RN/ASSISTANT

Patient Identity Confirmed
Procedure and Surgery Site Confirmed with patient/parent/legal guardian
H&P Reviewed (Patient medically optimized for procedure)
Pre-op Antibiotics / Steroids Given (if applicable)
NPO confirmed

Escort (name/relationship) ____________________________________________
Radiographs available, up to date, and properly labeled
Consent Accurate (NOT Outdated) and signed

Patient Examined (Heart and Lungs; nasopharyngeal airway)
Appropriate monitors in place (EKG/ O2/CO2/BP)
Instruments and tray set-up appropriate for procedure
Emergency Cart Readily Available/ O2 + Suction on

IMMEDIATELY PRIOR TO PROCEDURE

Time Out: Patient identity/procedure & consent confirmed

BEFORE DISCHARGE

Patient appropriate for transfer to recovery
Post-op instructions given (verbally and written)
Prescriptions reviewed with escort and/or patient
Discharge Criteria Met

OMS SIGNATURE, DATE, TIME ____________________________________________
RN/ASSISTANT SIGNATURE, DATE, TIME ______________________________
Other Methods

- Note in Progress notes
- Note in Operative record
- Be able to demonstrate what actions were performed if no checklist is used

Surgical Documentation

- Anesthesia
  - If a claim arises, your records will likely be compared to ones used in a hospital setting
  - Use a timed log that shows when and how much medication was given, vital signs

Consents reviewed/signed
ASA Classification
Monitors
NPO Status
Timed Grid for medications
Continued record

Notes time surgery completed

Surgical Documentation

• Surgical details
  – Surgical Time out performed
  – Incision – what kind, how
  – Use of surgical drill
  – How tooth was extracted (whole, in pieces, etc.)
  – Unusual findings
  – Surgical guide used? If not, why not?
    • Implant Case

Surgical Prep

Procedure/Changes in planned procedure

Precautions: Throat Drape

Post op instructions/ Follow Up
Post-Op

- Discharge criteria met
- Home care instructions
- Document escort
- Return appointment
- DO NOT FILL IN DISCHARGE INFORMATION AHEAD OF TIME

Staff Documentation

- Should be concurrent, dated and signed
- Information should *not* be added in the margins or in between notes
- Keep an updated log of staff names and signatures
Examples of Staff Documentation

Sample 1

Quick Note
Spoke with pt. reviewed post op x-ray. pt doing well, they will call with any questions or concerns. Pt seems he is in normal
condition, he is taking his lisinopril. I suggested he supplement that with duphaston if that is not enough. Advised him to call if
this does not work for him.

Sample 2

Quick Note
L/M on machine to check on pt. Advised pt to call with any questions or concerns.
Assistant: GT

Note Created By [redacted] on Fri, Mar. 12, 2010, 8:33:28 AM

Documentation of Phone Calls

• Claims can arise from lack of documentation of calls
• Each call should be documented in the patient’s chart
• Establish clear protocols for handling phone calls
  – What to communicate to OMS
  – After hours calls
  – Medication requests

Risk Management Tips

• Document telephone calls. In particular:
  – Calls that come in outside of office hours
  – More than one call from the patient or family (no matter how many are made or received)
  – Advice and instructions given to patients (e.g., bring patient to office/hospital, suggested medications, or general instructions [ice, tea bags, etc.])
  – A patient’s refusal to adhere to instructions and why
Risk Management Tips

- Phone records are now easily available, making it possible to verify calls from doctor or patient
  - Can benefit doctor or patient

Patient Compliance

- Document specific failure to comply ("advised Patient to stop smoking, could prevent healing")
- Document continued failure to comply ("Patient still smoking, warned to stop")
- Document all steps you take to get patients compliance
  - Phone calls
  - Letters and other correspondence
  - Notice of Non-Compliance Letter

Patient Compliance

- If patient continues to be non-compliant, determine whether you will agree to continue to treat, or dismiss from your practice
- Send "Notice of Non-compliance letter" that advises patient of needed care, consequences of not having care
- If continued non-compliance, consider dismissing patient
Notice of Non-Compliance Letter

- Should include the following:
  - Concerned about care
  - What care is needed/recommended
  - Consequences of not obtaining care
- Don’t “soft pedal” consequences
  - Patients may claim they didn’t comply because “it wasn’t that important”

Notice of Non-Compliance Letter

- Send via regular and certified return receipt mail to last known address
- If patient refuses certified letter, has to sign to refuse it
- Courts have held that if the certified letter reached the patient, the regular mail letter also was delivered

Patient Dismissal

- May choose to dismiss patient depending on response to non-compliance letter
- Should be at a good “stopping point” in treatment
- Dismissal Letter to include:
  - Reason for dismissal
  - Will continue to provide emergency treatment for 30 days
  - Referral source to find another treater
  - Will provide records with appropriate authorization
- Send letter certified, return receipt requested
Patient Dismissal

- When dismissing a patient for failure to comply with recommended treatment, it is important to restate:
  - Diagnosis, treatment provided, treatment needed
  - Risks of not continuing treatment
  - Objective reason why the relationship is being terminated
- Sample Patient Non-Compliance™ and “Withdrawal from Care” letters at omsnic.com

Record Release

- Patients have always been able to obtain a copy of their chart with appropriate authorization
- HIPAA rules specifically allow patients to obtain a copy of a written or electronic record
- Cannot refuse copies due to outstanding bills
- When records are legitimately requested, ensure timely release of them
  - Can potentially prevent upsetting the patient or attorneys taking further action (what is being hidden by refusal to release?)

Documentation of Paresthesia

- Important to document it at first mention by patient
- Document extent and severity
- Follow with serial documentation (use forms provided by OMSNIC)
- Document resolution, or referral for possible treatment
Medications

- Must be legally documented:
  - Name
  - Dose
  - Route
  - # Given/# Refills
  - Pharmacy Telephone #
- Use Medication flow sheets to track medications

Medication Allergies

- Ensure that patients fill in medication allergies on health history forms
- If they forget, don’t fill it in for them – give form back to them to fill in
- Use allergy stickers on charts
  - Include date sticker was made
  - If new allergies are discovered and added, include date information was added to sticker
- Ensure they are checked before prescriptions are called in

Medication Allergies

- Note details of allergies
  - Some patients will claim allergies who only experience mild complications such as upset stomach
  - Others may claim strange “allergies” that may be true
Documentation of Medications

Documentation suggestions:
• Specify dose and strength using the metric system
• Always use leading zeros (e.g., 0.25 vs .25)
• Never use trailing zeros (e.g., 1 vs. 1.0)
• Use a black ballpoint pen (not felt-tip)

Test Results: Staff Responsibilities

• Office policies for handling test results should be in place, reviewed with staff and followed
• Follow sample from harvest to relaying information to patient
  – Biopsy Log available on omsnic.com
• Work with office systems and tickler files to ensure all patients are contacted in a timely manner

Amending Paper Charts

• Do not white out, obliterate, scribble over or cross out incorrect information.
• If something is written in error while still writing, draw a single line through and write the correct word.
Amending Charts

- To correct an error in a previous note in a paper chart, draw a single line through it, write “error,” add initials and date
- Write a new note, *dated the day it is written*, to indicate correction
- Since previous notes in EMRs are locked, make correction the same as for paper charts by adding a new note *dated the day it is written*.

Adding Additional Information

- To add additional information to any chart:
  - Make a new entry in chronological order
  - Date it the day you are writing it
  - Note the additional information
  - Sign it

Never alter a record
Falsification of Records

• Generally sufficient to show actual malice
• Sends the wrong signal to jurors, can shatter credibility
• Can give rise to a spoliation of evidence claim, which is subject to criminal, not civil prosecution
• In states where tort limits have been enacted, if a jury finds the records were falsified, an amount in excess of the tort limit can be awarded
• Punitive damages can also be imposed (usually not covered under malpractice insurance)

“I never met anyone who was sued who wished they had documented less.”

—Lewis N. Estabrooks, DMD, MS
Chairman, OMSNIC

10/24/2013
MEDICATION RELATED ISSUES

Devastating Medication Error

• 8 y/o presented for extractions
• Post surgery, patient tearful and complains of headache, nausea
• IV Fentanyl and Phenergan given, patient has seizure
• 2nd bag of IV hung by assistant
• Patient admitted to ER, unresponsive, continued to seize. Eventually placed in medically induced coma.
• CT showed subarachnoid or cerebellar intraparenchymal hemorrhage

What happened?

• RN placed order for D5W and D50W prior to procedure
• Surgical Assistant unpacked the boxes and didn’t realize D5W never arrived
• Outside packaging was removed when unpacking and stored on the same shelf
• Patient received 850ml of D50W, blood glucose was 2178
• Significant cognitive problems
Case 13: Facts

• 57 y/o presents with painful #2 for extraction

Previous Medical History

• Patient seen in OMS office 3 years previously

Medical History For Present Procedure
Anesthesia Record: Previous Procedure

Office Note 2/20

HISTORY OF PRESENT ILLNESS: The patient had been seen for extraction 2/20. The patient has no history of dental pain before this. She was exposed to another patient for a period of two days associated with the upper right maxillary. The pain is severe. She has been experiencing it for the past two days. She has been taking ibuprofen. She is in pain today.

PAST MEDICAL HISTORY: Hip replacement, emphysema, history of hepatitis A and C, and left lumbar surgery.

MEDICATIONS: Aspirin, ibuprofen, and ibuprofen.

ALLERGIES: Complete blood count, and latex gloves.

DIAGNOSIS: History of smoking one-pack cigarettes per day, however, the patient no longer smokes.

PHYSICAL EXAMINATION: Multiple decayed teeth noted. Tooth #1 had gross decay and was extensively tender to percussion. There was no related pathology noted through the radiographs taken. There was no tenderness. Tooth #1 was sensitive to percussion. Removing all calculus was not required.

X-RAY: Pericoronitis. Tooth #1 gross carious decay.

ASSESSMENT: Gross decay with acute severe pain associated with tooth #1.

PLAN:
1. Removed the above findings in detail with the patient and husband.
2. Recommended follow-up consultation for extraction of tooth #1. Anesthetic options reviewed and local anesthesia would not be possible due to the patient's medical history.
3. Recommended follow-up consultation for extraction of tooth #1. Anesthetic options reviewed and local anesthesia would not be possible due to the patient's medical history.

Office Note 2/21

Telephone Conversation:

The patient called and asked me through answering service. The patient had an extraction yesterday with general anesthesia. She did not have any pain or swelling. She complained today that she had red, puffy facial swelling and sudden edema. In addition, she has a rash on her chest. She does not feel that she has had any rash before the past two years. She develops. She also told me that she has had three years of pain for the past three years. She end up with a systemic reaction of swelling and redness. Therefore, her reaction to the use of Caracalam. However, because of the possibility of an allergic reaction, she advised me to take ibuprofen. She also told me that she has been taking ibuprofen in the past without difficulty.

In the past with her previous reactions, she has taken ibuprofen, and she advised me to take ibuprofen today. If her symptoms worsen, she will call. She will also call her physician.
Outcome

- Claim not filed

Risk Management

- Closely scrutinize patient’s health histories and old records
- Ask questions to detail pertinent positive answers
- Clearly mark all allergies on charts and document the nature of the allergic reaction to determine the severity
- Ask patients to review or complete a new health history at each visit
Case 14: Facts

• 62 y/o patient presents for extraction of # 16 & 17

Medical History Form

Are you allergic or have you acted adversely to:

Yes No Local Anesthetics

Yes No Selsa Drugs

Yes No Barbiturates, sedatives, sleeping pills

Yes No Iodine

Yes No Penicillin

Yes No Other antibiotic

Yes No Aspirin

Yes No Codeine or other narcotic

Yes No Other

Procedure Note and Prescribed Medications
Office Dispensed Medications

AMOXICILLIN
500 MG
15 CAPSULES

Complications

• Pruritic rash over the entire body; no respiratory difficulty or tongue swelling.
• Treated by physician family member with Benadryl and Medrol DosePak; and seen in local ER.

Outcome

• Indemnity: $5,000
• Defense Costs: $2,238
Risk Management Tips

• Allergies should be clearly and boldly marked on the chart
• Ensure correct medication is dispensed – implement a check system (medications verified by two staff members)
• Be familiar with your state dispensing laws
• OMS can be liable for acts and omissions of staff! This is serious business.

Case 15: Facts

• 48 y.o. patient presents for extraction lower right molar under sedation / GA
Chart Notes

- “History of allergy to valium. Valium anti-convulsant. No rash”
- “GA with Valium, Sublimaze and Propofol”

Complications

- Patient had "extended post op multiple seizures" for 45 minutes and 911 was called
- Admitted to hospital
- Discharge Dx: seizure disorder vs. stress reaction
Outcome

• Demand: $150,000
• Case settled: $20,000
• Defense Costs: $3,735

Risk Management Tips

• Investigate allergies even if they seem unlikely
• Do not dismiss a patient’s assertion of an allergy
• When in doubt, treat as an allergy and avoid medication

Case 16: Facts

• 60 y/o for excision of a tongue lesion which had failed to resolve after a reasonable period of observation
• 20 second rinse with “toluedine blue”
• After 10 seconds the rinse was burning so badly it was spit out
• Solution was undiluted, and instead of 1% a 99% solution was administered
Photos Taken By PA

Post-injury Course

- Poison control called: rinsed with water, milk; chew Tums
- Sent home on topical steroid suspension; topical lidocaine; and acetaminophen with codeine
- Severe swelling face and tongue
- Daughter took to ER, admitted and hospitalized 8 days
- Three to four weeks of significant pain

From Hospital Discharge 1 Week After Incident

Pain:
1. Patient is to take long-acting morphine as well as morphine for breakthrough.
   Take 60 mg Dénor 30 milligrams orally twice a day
   NURSE 10 milligrams oral every 4 hours for breakthrough pain

Nutrition:
Patient uses inadequate protein/energy intake related to mouth pain and inability to tolerate a regular diet as evidenced by patient report of consumption of less than 50% of meals.

ENERGY INTAKE: Patient must consume 75% of meals and 3 oral supplements/day.

NUTRITION INTERVENTIONS:
1. Meals and drinks
   1. Recommend a pureed diet.
   2. Will order nourishments RD.

MEDICAL FOOD SUPPLEMENTS:
1. Patient will drink 2600 kcal brought from home TDD.

VITAMINS AND MINERAL SUPPLEMENTS:
1. Recommend a multivitamin with minerals daily.
At Follow-up One Month After Incident

accidentally exposed to full-strength glacial acetic acid and suffered extensive intra-oral chemical burns to her anterior hard palate, bilateral buccal mucosa, dorsal tongue, upper and lower labial mucosa, and soft palate. At her last appointment with us on 06/14/2009 she was no longer taking MB Contin and she reported regaining a sense of tasting sweet foods. However, she could not differentiate texture. She was not trim and a maximum interocclusal opening of 45 mm, she was able to protrude her tongue and lick her upper lip.

Outcome

• Consulted with and followed by Neurologist for loss of taste and smell, and speech pathology
• Continued treatment for tongue and other soft tissue injuries
• Permanent taste and smell deficiencies
• Demand: $325,000
• Indemnity: $225,000
• Defense Costs: $13,609

Risk Management

• Do not store full strength solutions in patient areas/operatories
• Clearly label solutions and concentrations
• Put alerts on full strength solutions
• Educate your staff on the importance of attention to detail
• You can be held responsible for the acts and omissions of your staff
Case 17: Facts

• 26 year old presents for extraction of multiple painful and infected teeth
• Seen in office several years previously for extractions, recovering IV drug user then.
• Patient says now “clean”
• OMS notes “track marks”

Treatment

• Undergoes extraction of 6 teeth
• Placed on antibiotics
• Prescribed Vicodin, #17 with one refill, for pain management
Outcome

• Patient expires from heroin overdose
• The patient’s family brings suit alleging relapse in patient’s addiction due to prescription of narcotic analgesics; and irresponsibility of the OMS to have prescribed a narcotic to a known recovering addict

Risk Management

• Discuss pain management with physician managing recovering addict
• Consider obtaining medical consult on patients with drug abuse history
  – Medical Consult form on omsnic.com
• Consider alternatives to opioids if appropriate
• Do not withhold appropriate pain management

Drug Seeking Behavior

• Gives medical history with textbook symptoms
• Emergency treatment required
• Non-opioid medications “don’t work for me”/requests certain medications, dosage
• After hour phone calls with no follow up appointment required
• Physical signs: unusual appearance, over/under dressed
• Out of town patients who lost/forgot Rx
Risk Management

- Involve your entire team
- Recognize and document suspicious behavior
- Obtain a thorough history of present illness
- Prescribe non-narcotic medications
- Proceed cautiously

CDC 2010 Report

- 2 million used prescription pain killer non-medically for first time within last year
- 1/3 of people > 12 years old who used drugs for 1st time began by using prescription drugs non-medically
- 70% from friends or relatives; directly, by purchase, theft
- 33% of all opiate prescriptions used non-medically
- 174 million opioid prescriptions in 2000
- 257 million in 2009
Drug overdose deaths increased for the 11th consecutive year in 2010, according to a new analysis published in the Journal of the American Medical Association. Leading the list of drugs responsible for these fatalities are prescription medications, especially opioid analgesics.

The analysis, conducted by the Centers for Disease Control and Prevention (CDC), found that 48,000 people died from a drug overdose in 2010—an increase from 40,649 deaths in 2009 and 16,849 deaths in 1999. Nearly 60 percent of the overdose deaths in 2010 involved pharmaceutical drugs, with oxycodone associated with roughly 75 percent of those deaths.
FDA announces new labeling rules for opioid painkillers, including oxycodone

The Food and Drug Administration on Tuesday announced that it will require stronger warning labels on OxyContin and certain other narcotic painkillers, known as opioids, as part of an effort to combat the rampant addiction and misuse that lead to thousands of deaths each year.

The agency said the labeling changes would apply to all extended-release and long-acting opioid painkillers. The most widely used of these include oxycodone, which can be found in OxyContin and similar drugs.

Washington Post, Sept. 10, 2013

In 2010, the CDC said, 16,651 died from overdoses involving opioids. That same year, the agency said enough opioid pain relievers were sold to medicate every adult in the United States with the typical dose of 5 milligrams of hydrocodone every four hours for a month — a 300 percent increase from barely a decade earlier.

Washington Post, September 11, 2013

Making Opioid Drugs Less Alluring

By Luke Westover

New York Times

Making the drug harder to get is one obvious way to reduce its appeal. Under the new rules, doctors can only prescribe OxyContin in the form of a pill, rather than the patch or the extended-release tablet. This makes it harder to obtain, as doctors are less likely to prescribe it. It also makes it harder to use, as the pain of taking pills is more intense than the pain of taking a patch.

Congress should act to continue the manufacturer of opioid resistant pills.

Wall Street Journal, January 14, 2013
She (Elaine Morrato, DrPH, MPH) voted in favor of the change because evidence presented at the meeting indicated that hydrocodone-containing products meet the criteria for a schedule II drug. These criteria include having a high potential for abuse, a currently accepted medical use with restrictions, and the potential to cause severe psychological or physical dependence. By comparison, schedule III drugs are those with low or moderate potential for dependence or abuse.
Methods. The authors participated in a two day meeting in March 2010 cohosted by Tufts Health Care Institute Program on Dental Medicine, Boston. The purpose of the meeting was to synthesize available opioid abuse literature and data from a 2010 survey regarding West Virginia dentists’ analgesic prescribing practices, identify dentists’ roles in prescribing opioids that are used nonmedically, highlight practices that dentists can implement and identify research gaps.

Dentists prescribe 12 percent of IR opioids in the United States, behind only family physicians, who prescribe 15 percent of IR opioids. Since the abuse of opioids largely involves IR opioids, we assume that dentists are prescribing opioids that are being used nonmedically.

Dental Tribune: “US Experts Hold Dentists Accountable For Drug Use”
- Published July 6, 2011
- 12% of immediate release opioids are prescribed by dentists
- Opioids most prescribed in dentistry include hydrocodone and oxycodone
- “Dentists write the third most prescriptions for immediate release opioids in the United States”
- “Left over tablets... are the primary source for prescription use initiation for children and adolescents”

More than 20% [of oral and maxillofacial surgeons] prescribe more tablets than would generally be necessary to control the postoperative pain after the removal of impacted third molars. This could be a source of drug diversion and nonmedical use by young adults and should be avoided.
ADA Webinars

Register for opioid prescribing webinars in 2013
ADA continues educating members on how to treat pain

ADA Update

Dextron’s role in preventing prescription drug abuse

Prescription Drug Abuse Facts
- Following growing drug problem in the U.S.
- National prescription drug abuse and misuse rates continue to rise
- Dextron can lead to serious or fatal consequences in the United States, either of only family pharmacists
- FDA regulates prescription opioids to help prevent abuse

The upcoming conference on Dextron and other prescription drug abuse prevention. The event will address steps on being an effective provider for an individual, and how pharmaceutical education is handled for the providers.

Conference on Dextron
![Image](image.png)

Dear Prescriber,

The Blue Cross Blue Shield of Massachusetts (BCBSMA) member named above has filed two prescriptions for short-acting opioids within the calendar month. Because you prescribed the extra doses, BCBSMA has discretionary authority to deny subsequent opioid prescriptions for the patient. If you have already submitted a refill request, please disregard this letter.

For a prior authorization request to be approved, you will be asked to certify that the evidence-based guidelines described below have been met. Approved prior authorizations will apply to all subsequent opioid prescriptions for the duration of the authorization.

Blue Cross Blue Shield of Massachusetts developed its opioid management policy to address the risk of addiction and the public health challenges of system-wide supply and abuse. The company’s use of guidelines for initiation of chronic opioid prescribing as described in our medical policies:

- The assessment of a treatment plan, including a clear diagnosis, explicit goals, and explanation of benefits treatment options
- The use of informed consent and a formal assessment of addiction risk
- The completion of a written agreement between prescriber and patient addressing issues of prescriptive management, diversion, and the use of other substances.
- An accountable prescriber group and the use of one pharmacy or pharmacy chain by the patient.

For more information, visit the Blue Cross Blue Shield of Massachusetts website or contact the Blue Cross Blue Shield of Massachusetts member services department.

- Call the Blue Cross Blue Shield of Massachusetts member services department.
- Visit the Blue Cross Blue Shield of Massachusetts website.
- Use PrescribeIT, our web-based tool found at https://prescribeit.bluecrossma.org.
- Use the Perioperative Drug Preauthorization Form to request authorizations. If the member has a cause for the prescription, please indicate that on the form and the member will be excluded from the prior authorization requirement.
Monitoring By Pharmacies

CVS Caremark is conducting a review of patient claims. This is to ensure that benefits are being administered according to the terms of coverage outlined in the patient’s CVS Caremark service plan. The patient’s record was identified through a claims review for inpatient medication utilization patterns which may indicate inappropriate or unsafe medication use or drug interactions. The data was then reviewed and identified as a high-risk patient based on one or more of the following criteria:

1. Inpatient medication list inconsistencies
2. High-cost medications
3. Drug-drug interactions
4. Drug allergy
5. Drug toxicity

We are forwarding a copy of your patient’s medication profile, which includes medications that were dispensed under the above patient’s beneficiary ID number during a recent 12-month period. The list includes all medications dispensed, whether or not they were dispensed for the patient’s illness.

Based on this information, please review the following on the attached response form:

1. The identified patient is your patient?
2. The identified medications were prescribed by you?
3. The identified medications are medically necessary due to a specific diagnosis (please provide diagnosis)
4. If other medications are prescribed, please write them here

Your cooperation will greatly assist us in our ongoing review of this patient’s drug utilization as we work to ensure appropriate and safe management of this patient’s medication usage. Please respond via FAX at (866) 443-0263 within 7-10 days. We hope this information is helpful and thank you for your assistance.

Clinical Services
CVS Caremark

Under the Controlled Substances Act, pharmacists must evaluate patients to ensure that appropriateness of any controlled-substance prescription. In addition, state boards of pharmacy regulate the distribution of opioid analgesics and other controlled substances through the discretion of pharmacists.

NEJM, Sept. 12, 2013

AG sanctions dentist

Hudson | Prescription privileges suspended after discrepancies found.

By Patrick Madden

A Hudson dentist has been suspended from prescribing controlled substances, including oxycodone, for 30 days by the state Board of Dental Examiners. The board found that the dentist had written more than 400 prescriptions for oxycodone in 2012 and had not consulted a pain management expert before prescribing the drug.

The board also found that the dentist had written more than 200 prescriptions for oxycodone in 2013 and had not consulted a pain management expert before prescribing the drug.

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Dentist | Office investigated after tip from local pharmacist

The office of Dr. Robert T. Brown was investigated by the police after a tip from a local pharmacist.

The police were called to the office of Dr. Brown after a tip from a local pharmacist who said that the dentist had prescribed a controlled substance for a patient without a valid medical reason.

The board also found that the dentist had written more than 200 prescriptions for oxycodone in 2013 and had not consulted a pain management expert before prescribing the drug.

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Recommendations From The White House and CDC Paper

- "Amend Federal law to require practitioners (such as physicians, dentists...) ... be trained on responsible opioid prescribing practices as a precondition of [DEA] registration"
- "Require drug manufacturers to develop effective educational materials and initiatives to train practitioners on the appropriate use of opioid pain relievers"
- "Work with ... medical and healthcare boards to encourage them to require ... continuing education programs to include instruction on the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse"

Massachusetts Online Prescription Monitoring Program

The Massachusetts Online Prescription Monitoring Program (MSPM) is a secure website that supports safe prescribing and dispensing. The MSPM allows authorized prescribers to view the prescription history of a patient for the past year.

To obtain information regarding the MA Online PMP click on the following link: Prescription Monitoring Program (PMP) or contact the Drug Control Program at drug.control@state.ma.us

Mandatory Education Requirement for All Prescribers

As of January 1, 2011, pursuant to MGL. 266. Section 18b, all prescribers, upon initial application for a Massachusetts license to practice dentistry and subsequently during each renewal period, must complete education relative to:

- Effective pain management
- Identification of patients at high risk for substance abuse
- Counseling patients about the side effects, addictive nature and proper storage and disposal of prescription medications

Documentation Of “Counseling” Patient Re: Opiates

Treatment:

1. Others

Begin after surgery: Relief capsule, 500 mg, 1 cap(s), orally, 4 times a day, 7 days; (c) 28, Refill 0

Begin after surgery: Vicodin tablet, 300 mg 5 mg, take 2 tabs, orally, every 6 hours if needed for relief pain x 14 days; 45 Refill 0

We reviewed carefully issues surrounding use of narcotic medications keeping dosing to the minimum needed for control of pain and not to drive, make any important decisions or drink alcohol while on these agents and to use if any is absent that also cannot return to work while still on these agents. Side benefits: alternative of medications reviewed in detail.
3 CA Bills Would Help Fight Rx Abuse

The Los Angeles Times (9/16, Glover, Girion, 3.07M) reports that last week, California legislators “passed an ambitious slate of reforms aimed at giving authorities better tools and broader powers to crack down on doctors who recklessly prescribe narcotic painkillers and other commonly abused” medications. The three measures now await signature from Gov. Jerry Brown. One bill would “require coroners to report to the medical board overdose deaths involving prescription drugs” to see if such deaths could be linked back to a specific physician’s practice to detect any reckless prescription patterns. A second measure would beef up the state’s prescription medication monitoring program, while the third proposal would prevent physicians “from stonewalling investigators by failing to turn over dead patients’ records or by repeatedly postponing interviews.”
Governing Agencies

- OSHA (sterile technique; safe needle/IV practice)
- CDC (spread of disease; public health)
- FDA (use of “approved” vendors)
- DEA (controlled substance logs, med disposal)
- BORID / BORIM (who can administer drugs)

Summary

- Continued monitoring of prescription narcotic analgesics
- Always provide appropriate treatment and patient pain management
- Document your decision-making process when prescribing medications
- Be aware of changing regulations/Board of Registration requirements
Conclusion

• Look at your procedures/process with improvement in mind
• Put needs/concerns of patients first. Always act with their best interests in mind
• Good documentation is one of your best defenses in a claim or lawsuit
• Risk Management is a collaborative effort

“Learn from the mistakes of others. You can’t live long enough to make them all yourself.”
- Eleanor Roosevelt

OMSNIC ONLINE
RISK MANAGEMENT RESOURCES

www.omsnic.com

Policyholders:
User ID: Policy number
Password: Begin with last 4 SSN, then create your own

Staff & Others:
Register with Guest User Registration
Risk Management Updates Webpage

OMSNIC Q&A

• Each issue of the Monitor will feature specific questions from our policyholders
• Focus on questions where there appears to be some ambiguity
• All questions will be archived on the website
• Submit questions to rm@omsnic.com

OMS Legal Desk Reference
Coping With Litigation

OMSNIC Resource Center

Login to www.omsnic.com and click “e-Learning Center” on the left to access the complete library of OMSNIC online risk management education.
Office Risk Assessment

- Available in the e-Learning Center
- Complimentary Risk Assessment to help identify areas in your practice that could benefit from additional risk management strategies
- Asks a series of questions that represent the most frequent risk management issues
- Provides a comprehensive report specific to your practice with recommendations to help improve practice habits to improve patient care and reduce risk

Sample Page From Risk Assessment Report

Office Emergency Training Program

- EMG 101 - Diagnosis and Management of Airway Issues
- EMG 102 - Diagnosis and Management of Allergic Reactions
- EMG 103 - Diagnosis and Management of Cerebrovascular Accidents (CVA)
- EMG 104 - Diagnosis and Management of Cardiac Issues
- EMG 105 - Diagnosis and Management of Loss of Consciousness
Contact OMSNIC

800-522-6670
rm@omsnic.com
www.omsnic.com

QUESTIONS?

References

• http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf
• http://www.ada.org/7541.aspx
• http://www.cdeworld.com/courses/4516