



Shared Learning

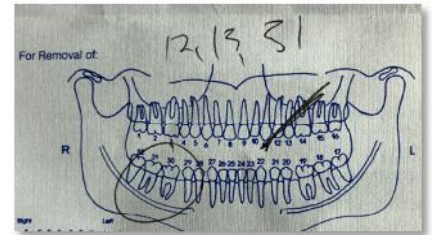
from the Dental Patient Safety Foundation Reporting Tool

“What gets measured gets managed” is the DPSF philosophy to encourage reporting. All received information about patient safety events (unsafe conditions, near misses or adverse events) are contextually de-identified (full confidentiality is preserved), aggregated, analyzed and abstracted by selected experts from our DPSF committees. Reports are generated and disseminated as the only means to learn from our errors. The information in these peer-reviewed reports is provided for its educational value only, and does not purport to establish any legally binding standard of care. Feedback is encouraged.

Case 2017.12: Wrong Site Surgery

Situation: A 44 y/o female was referred on an emergent basis to a specialist for extraction of three teeth as indicated. Undated bitewings were sent with the patient, which necessitated a panorex radiograph, provided at no charge to the complaining patient. Examination confirmed that #12 and #13 were non-restorable, and that pain in the lower right quadrant was due to equivocal discomfort on the distalmost tooth. No attempt was made to contact the referral source, as the surgeon was distracted, in a hurry, and not particularly pleased to manage this situation from an infrequent referral source. Teeth #12, 13 and the most posterior tooth on the lower right quadrant were removed. On return to the dentist, he contacts the specialist indicating that #32 was extracted and not #31, which was clearly indicated on the referral slip due to a lingual fracture and poor restorative prognosis.

What we learned: In cases or of previous extractions and drifting of teeth, any currently used numbering system can become unclear, especially in the absence of obvious pathology. In spite of common knowledge that wrongful tooth extraction is the most frequent claim against dental surgeons, the frequency of this claim has not improved.



Welcome to the inaugural DPSF safety report, generated by information received on the reporting tool. Future reports will be released on a monthly basis and catalogued on the website. We encourage frequent reporting of unsafe conditions, near misses and adverse events as the only means to close the gap between knowing how to prevent these occurrences and taking the necessary action to do so! Please visit our website.

The DPSF Board of Directors

Recommendations and action:

Referral sources should actively engage and educate their patients regarding planned procedures at outside offices, facilitating a proactive stance to ensure successful completion of desired treatment. Referral forms should be clear and complete. Verbal communication can be most helpful, especially when difficulties are anticipated. A request for a current panorex or other films should replace the transmittal of dated or anatomically insufficient radiographs.

Subsequent treaters should resolve any treatment plan ambiguities with both patient and referral sources, and treatment should be deferred until all uncertainties are eliminated. This includes verbal and visual confirmation with each patient. Staff can assist by demanding a “time out” confirmation of impending treatment, and adhering to check lists. A workplace environment where staff are encouraged to speak up without fear of retribution should be continually reinforced. Distractions, divided attention and production pressure are conducive to error.

Additional reading:

Saksena A, Pemberton MN, Shaw A, et. al. Preventing wrong tooth extraction: experience in development and implementation of an outpatient safety checklist. Br Dent J 2014;217:585.
Worsley B, Willis B. Preventing Wrong Tooth Extraction. Today's FDA 2015;27:45.

www.dentalpatientsafety.org

16011 S. 108th Ave. Orland Park, IL 60467
833.216.7931 708.460.7919