DPSF | DENTAL PATIENT SAFETY FOUNDATION

Patient Safety Listed PSO Organization

P0198

# 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 p atient safety events (unsafe conditions, near misses or adverse events) are de-identified contextually (confidentiality is fully protected under federal law), 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 2020.4: Flawed EMR: Accept/Resolve Error/Shame ASAP

**Situation:** A 42 y/o female presents for removal of wisdom teeth with deep sedation. Patient, procedure, NPO status, BMI, and Mallampati classification were documented. The surgeon entered the room, introduced self to patient's parent, confirmed procedure, glanced (didn't look) at the health history, which revealed only that the patient was taking methimazole (surgeon was unfamiliar with this medication). There were no other positive entries on the document. Escort was dismissed, monitors applied, normal VS noted, IV placed and 2mg midazolam was administered. **After this**, the doctor "became aware" of 2 facts: 1. the patient was last seen ***8 months ago*** and 2. the patient was being treated for hyperthyroidism. Scrambling to "back-track and cover up", the doctor became aware of suboptimal patient compliance with her endocrinologist as confessed by the now sedate patient. The hyperthyroid "box" on the screening health document was NOT checked. Rather than cancel the case and face criticism/shame, the surgeon completed the case then noted a gasping patient with a heart rate of 255 bpm. Treatment measures were immediately instituted which terminated the sudden supraventricular tachycardia.


**What we learned**: Rather than face criticism and shame, the surgeon inappropriately proceeded with the case. Lucky for him, there was no patient injury, only a "close call". EMR is imperfect, and may be challenging to populate by lay patients who are unaware of its significance. In addition, a patient's health status can change, especially in an 8 month interval. There is no substitute for a deliberate and thorough verbal confirmation of a health history check list. It is as equally important to update histories as it is to confirm procedures, record pre-op vital signs, etc. It appears that the surgeon proceeded instead of aborting the case and admitting cognitive error to avoid shame. This could have resulted in severe patient injury.


**Recommendations:**

1. Always check for recent changes in health histories, just prior to treatment.
2. Become aware of and compensate for disruptive challenges during busy patient flow, by purposely slowing the pace and requesting team cross-checks of all actions.

The DPSF encourages 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.

**Additional reading:**

Adibi, S. Medical and Dental Electronic Health Record Reporting Discrepancies in Integrated Patient Care. JDR Clin Trans Res 20: 1-6, 2019

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