DPSF | DENTAL PATIENT SAFETY FOUNDATION

Patient Safety Listed PSO Organization

P0198

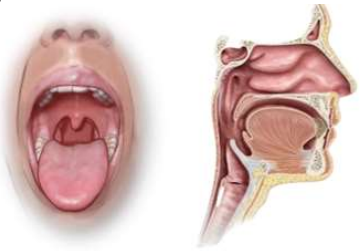
# Shared Learning

from the Dental Patient Safety Foundation Reporting Tool

"What gets measured gets managed" is the DPSF philosophy to encourage reporting. All received information about patient 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 2026.1: Object Lost Beyond the Oropharynx

**Situation:** The Dental Patient Safety Foundation has become aware of multiple incidents where teeth, teeth parts or foreign dental products fall back in the throat of a patient (awake or sedated) and become lost or not immediately retrievable. In some cases, these events were dismissed with the hope that the object was swallowed and will pass uneventfully.



**What we learned**:

1. One can never be certain of the location of the foreign body based solely on the presence or absence of patient signs or symptoms.
2. All patients should be immediately referred to an immediate or emergency care facility for appropriate radiographs and medical referral. There are no exceptions to this practice.
3. All objects that are aspirated must be retrieved.
4. Some objects that are ingested should be retrieved (per a gastroenterologist or general surgeon). In some circumstances, objects may be allowed to pass (expectant management,) however elimination is never guaranteed unless radiographically documented.
5. Small objects or objects that are not radiopaque may not reveal on plain films or CT scans.
6. Objects that become lodged in the alimentary canal may not be symptomatic for many weeks.

### Objects that have been aspirated or ingested:

- Teeth, parts of teeth, metal or plastic restorative material
- Gauze, cotton rolls
- Implants parts – screws, wrenches
- Scalpel blades, endodontic files, burs
- Broken instruments

### Recommendations to improve patient safety and quality of care

1. Competent oropharyngeal partitions
2. Keep strict track of small objects
3. Tether instruments if possible

### What are Patient Safety Events?

**Incidents** – events that reach the patient, whether or not harm occurred
**Near Misses (close calls)** – events that do not reach the patient
**Unsafe Conditions** – circumstances that ↑ the probability of an incident / near miss

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.

**Reference:**
Huh, J. Foreign body aspirations in dental clinics: a narrative review. J Dent Anesth Pain Med 22:161-174, 2022.

www.dentalpatientsafety.org
112 E. Burlington Ave. Ste 507 LaGrange, IL 60525