Prioritizing Patient Safety

Reducing Risk through Closed Claim Analysis

Disclaimer

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The Fortress Difference

• Dentists involved at all levels
• Agents, attorneys familiar with dental practices and procedures
• Articles, documents and consent forms to address risks as they evolve
• Participate with dental associations and other groups advocating for dentistry
Incident vs. Claim

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

Reporting an incident memorializes the event for any future coverage. Doing so has no effect on premiums.

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

Contact Fortress @ 800-522-6675

- 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 regarding patient care
- Request for compensation or refund from a patient
- Any incident, adverse event or patient complaint that may later turn into a claim
Changes in dentistry that have the potential to affect risk

- Corporate Dental Practices
- Expanded scope for auxiliary staff
- Technology: EHR, CBCT
- Pain Management

Risk Management Goals

- Increase patient safety
- Reduce exposure to a claim
- Make a claim more defensible
- Minimize financial loss
Course Objectives

- Apply clinical risk management strategies to improve patient safety, mitigate associated risk factors, and reduce untoward outcomes and malpractice claims
- Implement strategies to help prevent failure to diagnose allegations
- Recognize the potential effect technology and applied risk management can have on mitigating and managing nerve injury
Case Review

Case Facts

• 42 year old man presents to private dental practice
• CC: “I need to have my wisdom teeth removed. I know you’ve been telling me this for a while”
• Previous visit 3 years prior: Exam and S/RP; Extraction of #1, 16, 32 treatment planned at that time

Patient Presentation

• History of hypertension
PATIENT SAFETY: IN-OFFICE ANESTHESIA

- Patient intake
- Patient selection
- Emergency Preparedness
- Discharge
- Postoperative Considerations

Patient Intake: Medical History

- Review for completeness
- Ask clarifying questions
- Specific notation of medications and/or allergies
- Previous experience with anesthesia
Patient Selection: Assessment

• Current medical conditions, allergies
• Current medications
• Previous history with anesthesia, local or otherwise
• BMI, Mallampati scores

Emergency Preparedness

- CPR
- Drills
- Checklists

Discharge and Postop Considerations

• Recovery Room Record
• Discharge instructions and medication lists in writing
• Escort Education
• Additional Caregivers?
• Follow Up Appointment
• In the event of an Emergency…
Clinical Documentation

Closer Look at Concepts

TREATMENT PLANNING
- Provide an indication for treatment
- Prioritize treatment based on dental/medical health
- Review on a regular basis, in accordance with your office policy
- Avoid unbundling services
- Refer when appropriate
ADA encourages dentists and patients to discuss dental treatment recommendations, including the need for diagnostic images, to make informed decisions together.
Day of Procedure

- Extraction #1, 16 and 32

Insurance codes and pricing in treatment notes

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Closer Look at Concepts
Documentation

• Comprehensive, including anesthesia
• Document contemporaneously with treatment
• Document legibly
• Avoid words, symbols or abbreviations which may be ambiguous
• Consistent format: SOAP
• Avoid fees in procedure notes
• Ensure notes are signed

Electronic Medical Records

Risks
• Templates
• Copy/Paste
• Cyber Security

Considerations
• “Lock” system
• Backups, Audits
• Log in and signature for each provider/staff
• Time Stamp/Meta Data

NEVER ALTER A RECORD

2 Days Post Op

• Patient seeks treatment at ER w/o contacting DDS
• Hospital admission note states:
  “swelling right submandibular and submental regions; subcutaneous emphysema, elevation of tongue, difficulty swallowing and breathing”
• Patient c/o “numbness” on R side chin
**Hospital Admission Consultation**

**Diagnosis:**
- Oropharyngeal edema
- Patient transferred to another hospital for OMS to perform I&D

**Past Medical History:** Significant for history of heart attack, hypertension, hyperlipidemia.

**Assessment:**
- A 43 year old male with the following:
  1. Status post extraction of teeth numbers 1 and 32
  2. Masticator space abscess, odontogenic abscess
  3. Right submandibular space cellulitis
  4. Right submental space cellulitis

**Subsequent Treatment**

- OMS performed I&D right masticator space abscess
- Due to oropharyngeal edema patient admitted to ICU
- Patient again c/o “numbness” R side

**2 weeks post-extraction**

OMS follow up after hospital visit

“In terms of the V3 anesthesia, I reviewed the Panorex today showing the socket of #32 closely approached the inferior alveolar neurovascular bundle. This was likely secondary to extraction of #32. I recommend no treatment except observation over three months.”

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[Image of Panorex showing the socket of #32]
Summary of Treatment and Subsequent Issues

- Extraction #1, 16, 32
- ER visit 2 days postop with submandibular swelling
- I & D in hospital
- Follow up with OMS 2 weeks post-op

Plaintiff Expert Affidavit: Allegations

(a) Negligently removed a impacted #12 in the right mandible that was anatomically malposed and adjacent to the inferior alveolar nerve canal and the lingual surface of the mandible; and,

(b) Failed to evaluate, diagnose or refer to a specialist an impacted tooth that presented a significant extraction risk; and

(c) Introgenically and negligently damaged the right lingual nerve; and

(d) Caused anesthesia and dysesthesia to the claimant’s lower right lingual nerve.

Four Elements of Medical Negligence

In order to prove medical negligence, plaintiffs will have to demonstrate four essential facts:

1. A duty of care existed between the medical professional and the plaintiff
2. The professional violated the standard of care
3. The defendant’s medical negligence caused the plaintiff’s injuries
4. The plaintiff’s injuries resulted in compensable financial damages
Plaintiff Deposition

“After the anesthetic wore off he felt numbness running along his jawline to his chin and on the right side of his lower lip. For the most part the symptoms are now located on the right side of his chin…He does not have pain but the numbness will intensify if he talks a lot or chews a lot. ….He still has embarrassing moments when he will either spill while trying to drink or have food on his lip or chin unbeknownst to him”

Case Evaluation

• Progression of post-operative infection and swelling threatened patient airway leading to the admission to hospital emergency room and lends drama to the case
• No long-term effects related to the infection, but nerve injury has resulted in numbness to lower lip on the right side and tingling on the lower chin

LACK OF DOCUMENTATION LED TO SETTLEMENT

“Known risk” Argument

• Doctors have a duty to educate patients of known risks of a procedure or course of treatment
• If a patient, once properly informed of possible risks, would have elected not to go through with the procedure, the doctor may be liable for medical malpractice if the patient is injured by the procedure
INFORMED CONSENT PROCESS

DISCUSSION
CONSENT FORM
DOCUMENTATION

INFORMED CONSENT DISCUSSION

The informed consent discussion should occur between the treating doctor and the patient or the patient’s legal guardian.

WHO CAN CONSENT FOR A MINOR?

• Parent
• Legal Guardian
• Emancipated minor

Discussion Points:
• Divorce, Custody Issues, Medical Consent
• Relative escorting patient (Grandparent or Sibling)
INFORMED CONSENT DISCUSSION

1. Patient specific
2. Diagnosis
3. Proposed treatment, including anesthesia options

INFORMED CONSENT DISCUSSION

4. Risks and potential complications of treatment and anesthesia
5. Risks of refusing treatment
6. Treatment alternatives, including no treatment

INFORMED CONSENT DISCUSSION

7. Pre-existing medical/dental conditions
8. Pre and post operative instructions related to treatment
9. Opportunity to ask questions
Informed Consent is a Communication PROCESS

Patients who believe they have been well informed regarding their condition and who have had their questions answered by members of the dental team are more compliant with treatment recommendations.

INFORMED CONSENT FORM

- Signed in the office, prior to any treatment and prior to administration of any sedatives/narcotics
- Patient and procedure specific
- Include type of anesthesia elected
- Outline potential risks

INFORMED CONSENT DOCUMENTATION

DISCUSSION DETAILS

+ SIGNED CONSENT FORM

FILE IN PATIENT’S CHART
INFORMED CONSENT IS NOT A DEFENSE TO NEGLIGENCE

Written and signed informed consent is not mandated by many state Dental Practice Acts; however, written signed informed consent creates a rebuttable presumption of valid consent.

In the defense of dental professional liability claims and licensure actions, one fact remains as true as ever: if it is not documented, then it didn’t happen.
69 year old woman visits corporate dental practice with a focus on esthetic results after years of dental neglect

Chief complaint: “I’m not happy with my smile”
MEDICAL CONSULTATION

Provide any relevant information that a PCP or specialist would require to comment on a patient’s prognosis:

- Planned procedure
- Expected procedure duration
- Anticipated anesthetic and/or medications
- Anticipated bleeding, if any
- Post-operative healing expectations

Example:
A mutual patient, Miss. Smith, is scheduled for extraction of her LL and LR 1st molars with immediate placement of two dental implants, under local anesthesia with N₂O₃. Expected procedure length is 2 hours and moderate bleeding can be expected. Expected immediate post operative healing time is 5-7 days. Given the patient’s history of hypertension, please provide any suggestions for management of Miss Smith’s hypertension, including alteration to current medications.

What’s the Risk?

Given this patient’s medical history and the proposed treatment plan of multiple extractions and implants, what information do you communicate to the PCP to ensure patient safety?
DDS Plan

• Patient referred to OMS contracted with this practice for extractions and implants
• All pre-surgical forms and consents are completed at the general dental practice location and forwarded to the OMS
• Patient given prescriptions for Peridex, Clindamycin and 20 tabs of Vicodin in preparation for surgery

Referral Communication

Closer Look at Concepts
**PROPER REFERRALS**

• **Timely**
  
  Delayed referrals may result in allegations of failure to diagnose or failure to refer.

• **Legible**
  
  Avoid miscommunication or confusion by ensuring all written referrals are legible.

• **Accurate**
  
  Verify all information and requests noted on referrals.
PROPER REFERRALS

- Informative

Patient demographics and identification

- Informative

Date of the referral

- Informative

Evaluation and treatment completed to date
PROPER REFERRALS

• Informative

Copies of diagnostics performed

PROPER REFERRALS

• Informative

Desired evaluation or care the specialist is requested to complete

PROPER REFERRALS

• Informative

Plan for care following the specialist's intervention
PROPER REFERRALS

- **Informative**
  
  Request for a consultation report and ongoing status reports

- **Discuss questions/concerns**
  
  - With patient and/or specialist
  - Include contact information on referral

- **Ensure compliance**
  
  - Consider assisting patient with appointment from your office
  - Discuss preferences for follow up with any referrals
Day of Procedure: OMS Office

- Documentation received from DDS office
- Medical history form
- Consent for treatment forms
- Pre-surgical forms
- Medical consultation
- OMS Visit
- Surgery proceeded: exts/implants
- Recommend 10 day follow up with DDS at franchise location
- Prescription written for 10 additional Vicodin – patient forgot meds at her home out of state

What's the Risk?: Opioids

Do you know the current regulations in your state related to opioid prescriptions and dispensing?
The responsibility lies with all healthcare providers to educate patients on effective and responsible pain management options.

Potential Areas of Alleged Liability

- As the legal requirements change, expect to see an increased number of Professional Regulation investigations
  - Prescribing/dispensing without consulting PDMP
  - Prescribing/dispensing beyond 3 day or 7 day limit

Prescribing Practitioner v. Dispensing Practitioner

- A prescribing practitioner writes a prescription for a patient to have filled elsewhere
- A dispensing practitioner not only writes a prescription, but provides the medication to the patient from office inventory
- There may be different levels of liability depending on whether a HCP is dispensing medication
Screen for Potential Drug Abuse

- Ask the questions openly and honestly
- Watch for signs and symptoms of substance use disorders (SUD)
- Use your Prescription Drug Monitoring Program
- Involve responsible family members and PCPs
- Discuss existing prescriptions with referrals

Additional Considerations

- Continue to educate your staff on acceptable prescribing practices
- Secure all prescription pads when not in use
- Consider a direct prescribing plan so no paper RX pads are available
- Consider alternative medications and treatment modalities

Fortress Patient Safety and Risk Management
Opioid Resources

- Informational Guide Regarding Opioids
  (for practitioner use)
- Educational Form for Patients
  Regarding Opioid Use
6 days later

- Patient calls DDS office and states that she has swelling near her neck
- Percocet mailed to patient’s home

What’s the Risk?

What conversations would you have with a patient who has increased swelling in the neck area? What recommendations would you consider for this patient?

Do your patients know how to contact you after hours?
2 weeks postop

- Patient seen in hospital by ENT
  - CC: Swelling in neck
- ENT unable to reach OMS; ENT phones general DDS to inform him of patient presentation with swelling and apparent infection
- I & D performed

DDS Follow Up with OMS

- General DDS emails OMS
  - Relays ER visit details
  - No CT scan as patient has not yet been seen in DDS office for follow up
2 days after hospitalization
• Patient presents to DDS office
• CT scan: lingual cortical bone perforation noted at apices of implants 23 and 26

2 days after hospitalization
• DDS notifies OMS of perforations by phone and sends CT scan via email
• OMS states “all looks good….perforations will not cause submental abscess”

“Took postop CT scan today. All mandibular implants have perforated through the lingual cortex. If you think it’s fine, it’s your call. I just heard there is a higher chance of submental abscess with perforation through lingual cortex…”

I feel you should be the one taking care of the postop complications, so that she knows you’re actively involved in this to take care of her...she was extremely displeased with the service received from your office...please make sure you sit down with any future patients of ours prior to any sedation and after the procedure to make them feel emotionally comfortable...

I did everything I could in my position to smooth out the situation”
OMS Email Response

“Perforation of lingual cortex doesn't mean anything. Check the appliance, her occlusion and make sure she is on Keflex and Flagyl 500mg each QID……. Be very apologetic(duh) but you know what I mean. Let me know what happens…”

Result of Post Op Visit to DDS

Patient asks DDS for 2nd OMS referral
Refuses to see treating OMS

6 weeks post surgery

Patient seeks 2nd opinion from another OMS:

- Swelling appears to have resolved extra orally
- Firmness and fullness anterior floor of mouth, tender to palpation
- 23/26 visual mobility, percussion positive
- Mandibular posterior implants and maxillary implants WNL
- Radiolucency 23/26 on CBCT, loss of lingual plate
What's the Risk?

What information do you gather and from whom when a patient presents for a second opinion or who may be upset with care rendered by a previous provider?

Justifiable Criticism

• Do you have all of the facts?
• Patient condition prior to treatment?
• Communicate with previous providers

One day later

• 2nd OMS removes 2 implants at 23 and 26 sites
• Recommend 10 day follow up

Patient fails to show for follow up appointment and 2nd OMS calls patient’s son when he is unable to reach patient. Son states that patient can not travel far for just a follow up visit and that she is not very good about answering her cell phone or VM.
10 weeks post surgery

• Patient presents to general DDS
• Severe pain UL implant area
• CT scan and PA's: reveal possible osteomyelitis
• Patient sent back to 2nd OMS for evaluation

10 weeks post surgery

• Patient sees 2nd OMS
• Two draining fistulas near posterior implants
• Diagnosis: consider aggressive osteomyelitis
  —recommend evaluation at University medical center nearby

Follow Up

• Patient seen at University and treated for osteomyelitis
• 3 months later, scans show healing
Result

• Patient files suit against DDS, corporation and original OMS

Allegations: Improper performance, deviation from standard of care, negligence

Expert Witness Testimony

• Poor documentation of events
  – No pre-surgical work up in OMS office
  – No OMS imaging to confirm implant location/angulation/prognosis
  – Lack of documentation of conversations with general DDS
  – Type and size of implants not noted in records

Expert Witness Testimony

• Poor communication with patient
  – Informed Consent obtained by DDS, not OMS
  – Not informing patient of lingual perforation
  – Follow up post op; patient not accepting calls/VM

• Recognition of lingual plate perforation at surgery and removal of implants may have reduced risk of infection
Case Evaluation

• Case settled prior to trial
• Both DDS and OMS participated in a financial settlement

What Do We Learn From This?

• Proper referrals
• Responsibility for patient safety and care lies with all providers
• Communication is key

Practice Model Considerations

• What does your schedule look like each day?
• When considering sedation, what pre surgical work up is completed?
• When referring to other providers, how do you communicate what you know?
• How is consent obtained for treatment?
Practice Model Considerations

- What role do your staff play?
  - What directives are they given for scheduling?
  - How do they support the informed consent discussion?
  - How are phone calls triaged?

BOD/Peer issues: will focus on the treating DDS

Case Review
Patient Presentation

- 64 year old woman
- Med Hx: HTN, diabetic, thalassemia minor, social drinker, never smoked, father died from lung cancer
- Patient of this dental practice for over 10 years
- Inconsistent periodontal recalls

OMS Visit and Follow up at DDS

- Ext #17 at OMS office
- Follow up at DDS office
  - Pain at #17 after extraction
  - DDS notes possible infection post op
  - Amoxicillin prescribed
7 months post extraction-Patient visits OMS

CC: Intermittent throbbing pain at #17 site
• Exam: well healed socket, tender at DB #17
  – Diagnosis: Periodontitis
  – Plan: Prophy, re-evaluate for bone graft

Another year later- Patient visits DDS

CC: Pain at #17 site
• Prophy, Exam & Panorex:
  6 mm open defect at #18 with furcation involvement
• DDS notes “possible pathology” in chart; does not disclose to patient

Closer Look at Concepts
Documenting Patient Compliance Related Issues

• Missed Appointments
• Lack of adherence to recommended treatment (Non-Compliance)
• Informed Refusal
• Dismissal or Termination of Care

Compliance Related Letters

• Missed appointments
  – Used as an alert and reinforcement
  – Document all attempts to communicate with the patient

• Patient Non-Compliance
  – Emphasizes the importance of following treatment recommendations
  – Lays the ground work for future action
    * Include a time frame for response
    * Informs patient of potential impact on Dr-Pt relationship
Dismissal Letter

• Generally **NOT** the first letter sent to the patient who has exhibited non-compliant behavior
• Sent at a safe stopping point in course of treatment
• If the patient is a threat to you/your office = grounds for immediate dismissal

Dismissal Letter

General Components:
• Considerations for Emergency Care
• Includes a release for records
• Objectively explains reason for termination
• Provides resources to find a new OMS
• 3 copies made and sent

What’s the Risk?

• Documentation reveals that DDS noted “possible pathology”
5 days later - Patient visits Periodontist

- Endo/perio lesion
- Poor prognosis #18
- Refer back to OMS for extraction

OMS Visits

- Extraction #18, graft placed
- 2 weeks post extraction #18: “healing w/o evidence of infection; IAN paresthesia onset: “cranial nerves test normal”

6 weeks post extraction #18
OMS Differential Diagnosis:
Osteomyelitis vs. Delayed healing

- OMS prescribes Amoxicillin (no cultures)
- Referral to PCP: evaluate diabetes

Is there more to your differential diagnosis at this point?

Two months post extraction
OMS notes firm wound, swelling persists
- No culture or biopsy
- IAN paresthesia issues persist
- Diagnosis: osteomyelitis
  - referral to infectious disease specialist
Two weeks later
Infectious Disease Consult
• Symptoms started nearly two months ago
• Wound hasn’t closed
• Patient has lost a total of 20 lbs since extraction #18, 2 months ago
• CT scan: bone demineralization consistent with osteomyelitis
• Treatment recommendation: Unasyn by IV

2 months post consult with Infectious Disease
ER visit
• CC: Jaw pain, bleeding
• History of abscess, infection, osteomyelitis
• On Unasyn via PICC line

Oral cancer will not always look like this
One month post ER visit:
Referral to 2nd OMS in a university setting

Exam: large swelling firm left cheek, with interincisal opening limited to 30mm. Obvious necrotic wound.
Radiographs: sub CT scans

Diagnosis: osteomyelitis, neoplasm, left cheek

Treatment Plan:
• First reference to neoplasm in patient chart

2nd OMS Chart Notes

• “…delayed diagnosis of 7 cm mass…facial asymmetry, palpable doughy rubber mass…absence of pus, fever, erythema”
• “…CBCT reveals large osteolytic lesion, left mandible; bone loss on buccal, lingual into neck of condyle, coronoid process…”

2nd OMS Chart Notes

• “…periodontist identified that the back molar needed to be removed due to significant bone loss. This is concerning to me along with the continued numbness in lower lip and chin as representing not an osteomyelitis but a malignant tumor…slow growth over 6 months is inconsistent with an osteomyelitis…rubber like consistency is more consistent with a tumor…”
2\textsuperscript{nd} OMS Chart Notes

- “Biopsy confirmed suspected diagnosis of SCC”
- “…somewhat neglected carcinoma…”
- “…carcinoma had been untreated for over 6 months…progressed into masseter muscle, internal pterygoid muscle and temporalis muscle…”

Documentation

- Justifiable criticism
- Remaining objective

Surgery

- 2\textsuperscript{nd} OMS performed jaw, neck resection, reconstruction with titanium plates
- Followed by chemo and radiation
- Several ER visits for pain, weakness, complications

9 months later, patient died after recurrence and metastasis to brain and lungs
Lawsuit: Named Defendants
Alleged negligence by General DDS, Periodontist and 1st OMS

Failure to:
– Perform oral cancer screening
– Biopsy & culture of non-healing wound
– Refer for cancer screening
– Correlate symptoms & timely diagnose cancer on two separate occasions

Case Evaluation
Plaintiff Claimed:
- Delayed diagnosis caused medical expenses, suffering, death
- Failure to consider & rule out tumor on two occasions

Case Evaluation
Defense:
• Initial diagnosis of periodontal disease supported by imaging
• No clear suspicion of tumor by anyone until three months prior to diagnosis
• Defendant OMS claimed bone graft obscured diagnosis
• Causation: rapidly developing SCC; delay in diagnosis unlikely to change outcome
Case Evaluation

For General DDS
• Prepopulated EMR entries after diagnosis of SCC still state infection, no further reference to SCC

For all Defendants
• Incomplete workup for lingering infection
• Lack of cancer screening exam
• No CBCT or diagnostic evaluation to rule out neoplasm

2nd OMS Called as Expert
• Could not support the defense
• Symptoms inconsistent with osteomyelitis
• Defendants focused too narrowly on infection, delayed further workup and diagnosis of SCC, nothing was done to rule out other causes

Litigation Considerations
Failure to diagnose infections and cancer cases
• Disfiguring or catastrophic damages do generate sympathy

CASE SETTLED BEFORE TRIAL DUE TO CHALLENGES IN DEFENSE
What do we learn from this?

• Patient Assessment
• Consider biopsy and/or imaging
• Oral Cancer Screening
• Communication
• Documentation
• Referrals
• Patient Compliance

Closer Look at Concepts

Oral Cancer: Documentation

1. Document patient specific symptoms and complaints
2. Complete exams on a regular basis
3. Document all exam findings
   (size, location, consistency, color)
4. Re-check progress in 2 to 4 weeks for suspicious lesions
5. Assume a cancer diagnosis unless and until it is ruled out: refer to specialist for consultation, biopsy or monitoring
6. Document when a suspicious lesion is gone
Oral Cancer Cases

In CA and infection cases: communication and documentation are critically important

Records must tell a complete, accurate story of your care, patient compliance, progress and results

Consider a high level of suspicion

• Considerations: timely diagnosis, referrals and care

Fortress Pulse: Topics for Consideration

• Online orthodontic treatment
• Service animals
• Consent while under the influence
• CBCT reading, patients of record?
• Online reviews
• Photos and recordings in office-HIPAA

Online Orthodontic Treatment

Q: My patient has undergone orthodontic treatment via an online service, despite my referral to an orthodontist in the area. The patient is now presenting to my office with complaints of pain on biting due to this treatment provided by the online service and claims that because they are a patient of record, I must treat the symptoms. What are my obligations?
Referrals and Communication

- If you are unable to communicate with the provider, you are unable to determine the treatment plan
- Adjustments to tooth structure to accommodate occlusal interferences are not reversible
- Recommend evaluation by an orthodontic specialist

Service Animals

Q: My patient claims that her service animal needs to accompany her to her dental appointments. Am I obligated to allow this?

Q: I would like to bring my dog, who is licensed as a support animal, to my office. I believe this will help to calm some of my patients. Is there any liability related to this?

WHAT IS A SERVICE ANIMAL?

An animal that has been individually trained to do work or perform tasks for an individual with a disability. The task(s) performed by the animal must be directly related to the person’s disability. The animal must be trained to take a specific action when needed to assist the person with a disability. (i.e. a person who has epilepsy may have a dog that is trained to detect the onset of a seizure and then help the person remain safe during the seizure). Emotional support, therapy, comfort, or companion animals are not considered service animals under the ADA. However, check with your State or local governments to see if they have laws that allow people to take emotional support animals into public places.
What questions can staff ask to determine if a dog is a service animal?

In situations where it is not obvious that the dog is a service animal, staff may ask only two specific questions: (1) is the dog a service animal required because of a disability? and (2) what work or task has the dog been trained to perform? Staff is not allowed to request any documentation for the dog, require that the dog demonstrate its task, or inquire about the nature of the person’s disability.

SUPPORT ANIMAL CONSIDERATIONS

- INFECTION CONTROL
  - Cleanliness of the animal
  - Transmission of disease
- SAFETY FOR PATIENTS
  - Accidental bites
  - Accidental bumps/positioning
- ALLERGIES
  - Potentially unknown, may lead to liability

Consent While Under the Influence

Q: A patient presented for extractions and asked to visit the bathroom prior to consent and receiving anesthesia. The patient returned and a strong alcohol odor was noted on his breath and he was very boisterous. A dental assistant who had suspicions about the patient’s behavior, checked the bathroom and noted that three small empty bottles of alcohol were now in the trash bin. Do we have to treat this patient?
CBCT Reading

Q: I have purchased a CBCT and some dentists in my building will send their patients to my office for JUST a scan. Is it my responsibility to read that scan or can I just send the patient with a copy of the scan as long as they sign a release?
Online Reviews

Q: I have received a negative online review and would like respond because this patient is lying about events. What should I do?

SAMPLE ONLINE RESPONSE

We appreciate your feedback. Our office strives to provide an excellent experience, and we work hard to constantly improve our practice. In order to protect the privacy of our patients or potential patients, we do not address specific comments made online. Please contact our office to discuss any concerns that you may have.

Photos and Recordings in Office

Q: Parents of some of my patients have started to take videos of what they consider to be funny moments for their kids in our dental office. Is this ok?
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.

THANK YOU
Patient Safety and Risk Management Department
800-522-6675
dds4dds.com