# Wrong Tooth Extractions

## An excerpt from OMS Risk Management Study Guide

What would seem to be a largely preventable occurrence is still OMSNIC's second most preventable claim. The claims history shows that **as of 2005 there were 868 wrong tooth extraction claims costing $9.5 million dollars**. For a largely preventable claim, these numbers are very, very high. In reality, there are a small number of situations that will result in a wrong tooth extraction no matter what preventive procedures have been used. However, the majority of the cases are preventable.

The issue of wrong site surgery has been studied intensively, and JCAHO performed a Root Cause Analysis to determine how such problems occur and what can be done to prevent them. The root cause analysis determined that **there are several contributing factors to the problem. First and foremost is communication.**

It is necessary to conduct a preoperative assessment of the patient, and have procedures in place to verify the operative site. **Staffing issues** (too many, too few, not utilized appropriately) can add to the mix, and distraction factors can also cause problems. If telephone calls interrupt, or protocols are not followed, these types of distractions can potentially lead to errors. Another potential problem is the lack of availability of records. **If a patient chart cannot be found, or the referral slip is missing**, the entire process is thrown off kilter and can lead to errors.

Another issue is the **organizational culture of an office**. If only one person makes the determination of procedures to be performed and other opinions are not permitted, a different opinion that might prevent an error may be dismissed. If one or more emergencies have thrown off the schedule, subsequent appointments may be hurried to fit everyone in. In such situations, the same amount of care may not be taken to ensure that each procedure is checked and re-checked to ensure that it is the correct one being performed on the correct tooth.

Another issue that can cause potential problems is **unusual patient characteristics, such as missing or shifted teeth**. The potential problems in these situations are obvious.

JCAHO'S solution as determined by their root cause analysis was to take the following steps:

- Create and use a verification checklist including appropriate documents (records, etc.)
- Obtain oral verification of patient, surgical site and procedure in the OR by each member of the surgical team
- Monitor compliance with these procedures

Fortunately, JCAHO has supported the ADA's position exempting dental procedures from the site-marking requirement. Complying with the requirement would have been both onerous and difficult. JCAHO's solutions were designed for hospital environments. However, there are lessons to be learned from this analysis that can be applied to the oral surgery office.

**The first step is verification of the patient**. Confirm the patient identity by name and/or identifying number. The confirmation should be made by more than one person in the office.

The second step is to **verify the tooth/teeth to be extracted. Confirm the site with the patient. If necessary, confirm the site with the referral. This can be necessary if the referral form is missing or unclear. It can also be necessary if the referral form says one thing but the patient says another.** Confirm the site with the staff members involved. Patients sometimes change their minds as to the number of teeth they want removed, and may only tell the staff and not the surgeon.

Of course, it is important to verify the site with one's own dental/surgical judgment. This is a vital step when the information given is not consistent. **Xrays need to be confirmed as belonging to the patient and correctly oriented.** Claims have occurred when a nerve injury resulted from an incision into an area where no tooth was located, only to find that the x-ray was put up backward on the light box! **Make certain that the x-rays belong to the patient and are properly oriented**. Once the site has been established, actively (verbally) confirm it with at least one other staff member to ensure complete agreement. Having definitively confirmed the site, the procedure to be performed should then be verified. Again check the referral information. Ensure that the health history is available, and there are no precluding medical conditions. It is also necessary to ensure that prophylactic antibiotics have been taken if necessary. To easily check that all of the elements are confirmed, one can use a checklist including the following items:

- Intended operative procedure
- Intended operative site
- All records, imaging studies
- Informed consent document

Then, after everything has been verified, a quick "time out" should be taken IMMEDIATELY before the procedure, for the doctor and assistant to review the plan. Once the quick check is completed, the procedure can begin.

There are two other issues that can help to reduce the chance for errors. First, reduce handoffs where possible, e.g., have the same personnel move the patient whenever possible. Second, have a standardized abbreviation, acronym and symbol list and use ONLY the approved abbreviations, acronyms and symbols. This will ensure that everyone understands each part of the chart and reduces the potential for errors. Many of the suggestions in this section are easy to implement if not already done. It only takes a bit more attention, and the willingness to adhere to a set of protocols to reduce the incidence of a largely preventable error.