



# THE ART OF SELF DEFENCE

REDUCING RISK IN RESTORATIVE DENTISTRY

ALSO INSIDE

**10** CHAPERONES  
DON'T PRACTISE UNAIDED

**12** DIGITAL DENTIST  
INNOVATION IN ORAL HEALTH

AN MDDUS  
PUBLICATION

**MDDUS**  
UK INDEMNITY, ADVICE & SUPPORT



## Welcome to your SoundBite

THE media has been filled with headlines recently relating to allegations of inappropriate behaviour – so what better time to reflect upon the arrangements you make in practice for chaperoning? MDDUS dental adviser Rachael Bell sets out the many advantages of working alongside a chaperone – or chairside assistant – in her article on [page 10](#).

Expanding your professional skillset is a natural way to move forward in your dental career, but how do you do it safely? MDDUS early practitioner adviser Laura McCormick offers guidance on minimising your risk on [page 5](#).

It comes into effect in May 2018, but is your practice ready for the GDPR? On [page 6](#), risk adviser Alan Frame highlights key points of this new data protection regulation that will cover all personal information – both patient and employee.

Children can be accompanied at your practice by a wide range of relatives, friends and other

carers. Determining who has the right to consent to their treatment is not always straightforward. MDDUS head of dental division Aubrey Craig offers advice on [page 4](#).

An episode of the BBC show *The Apprentice* sparked an idea for a smartphone app in dentist Ben Underwood. He tells *SoundBite* about his innovative ideas to improve oral health on [page 12](#).

On [page 8](#), dentist and GDC expert witness Gordon Boyle considers ways of reducing clinical risk in restorative dentistry. Managing patient expectations and working within your competence are among his key lessons. Our case study on [page 14](#) continues this theme by highlighting the case of a patient who is unhappy with the appearance of a crown and complains about gum recession.

• Doug Hamilton  
Editor

## EFFECTIVE ANTIBIOTIC USE CAN HALVE SUPERBUG INFECTIONS

PROGRAMMES to ensure effective use of antibiotics can halve the number of hospital infections caused by multidrug-resistant bacteria.

Research published in *The Lancet* found numbers dropped even further when infection control measures such as good hand hygiene were followed.

Commenting on the findings, NICE said healthcare professionals should select the dose, length of treatment and type of administration (for example, tablets or injection) that is right for the person and the infection. This stewardship, they said, helps to fight resistance because it preserves the usefulness of antibiotics.

NICE deputy chief executive Professor Gillian Leng said: "It can be hard work, but this new research shows the difference we can make when we work together."

Inappropriate use of antibiotics, such as taking them for viral conditions like flu, or for mild infections that may clear up without treatment, is known to fuel resistance.

## ANNUAL GDC RENEWAL FOR DENTISTS

ANNUAL GDC registration renewal for dentists has opened with a final deadline of 31 December.

Dentists who do not renew by that date will be removed from the register and not allowed to practise.

**The GDC is reminding dentists to complete three simple steps:**

1. Declare and/or confirm you have indemnity
2. Pay your Annual Renewal Fee (ARF)
3. Make your CPD statement, if required.

This can be done online at [www.egdc-uk.org](http://www.egdc-uk.org), by post or by calling 0800 197 4610. Dentists will be declaring CPD under the current scheme for the final time before enhanced CPD is introduced in 2018.

## DENTAL SERVICES IN ENGLAND RATE HIGHLY

A NEW report by the Care Quality Commission (CQC) has revealed that nearly nine out of 10 dental practices in England inspected by the regulator have complied with all five of its key standards.

Out of 1,131 practices inspected in 2016/17, 88 per cent were found to be safe, effective, caring, responsive and well-led. These findings emerged from the CQC's annual *State of Care* report.

**The CQC found that:**

- 100 per cent of inspected practices met the tests for 'caring' and 'responsive' to their patients' needs and preferences
- 99 per cent were found to be 'effective' in achieving good health outcomes
- 96 per cent were found to be safe
- 89 per cent were considered to be well led.

Community dental services fared particularly well with 88 per cent achieving ratings of good or outstanding.

The CQC has been collecting data on primary healthcare services since 2011 and inspects around 10 per cent of dental practices each year.

Mick Armstrong, Chair of the BDA, said: "The latest CQC report represents another ringing endorsement for good practice in our profession, in spite of the huge challenges we face."



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## "FURTHER IMPROVEMENT" IN PERFORMANCE AT GDC

THE General Dental Council has shown further improvement by meeting all but one of the 24 standards set down by the Professional Standards Authority (PSA).

A PSA review found that in the year up to July 2017 the dental regulator met all four standards for education and training, all four for standards and guidance, and all six for registration.

It failed to meet just one standard for fitness to practise, which related to information security.

The improvements follow significant changes in the regulator's leadership, processes and organisational culture in response to PSA criticisms of their handling of a whistleblowing incident in 2013. The GDC's *Shifting the balance* report, published in January, set out a three-year strategy to achieve a "better, fairer system of dental regulation".

Last year the GDC did not meet the PSA standard for prioritising serious complaints when concerns were raised about how long it was taking to make decisions about interim orders. But this year they were found to be making decisions more quickly and assurances had been given about their risk assessment process.

The report also noted the GDC has changed its registration appeals process following concerns over how it was coping with a large volume of submissions. The time taken to resolve these appeals has now reduced from an average of five months to three.

The report stated: "The GDC's performance this year represents a further improvement since last year, when it met all but three standards in fitness to practise. We are pleased to note that the GDC has been able to build on the improvement that we reported on last year."

## "BAD APPLES" AND OTHER PERPETRATORS BEHIND PROFESSIONAL MISCONDUCT

AN analysis of professional misconduct amongst health and care professionals by the Professional Standards Authority (PSA) has found that not all perpetrators are simply "bad apples".

Researchers from Coventry University examined 6,714 fitness to practise determinations from the PSA database covering doctors, nurses, social workers, paramedics and others. They identified three different types of perpetrator: the self-serving "bad apple", the individual who is corrupted by the falling standards of their workplace, and the "depleted perpetrator" struggling to cope with the pressures of life.

Cluster analysis was used to identify how different kinds of misconduct group together for the different professions and the researchers also looked in more detail at cases involving sexual boundary violations and dishonesty.

The aim of the research was to offer a more nuanced multi-dimensional perspective of wrongdoings and offer recommendations to aid regulators and employers to improve detection of perpetrators and ameliorate the occurrence of these behaviours within health organisations.

In analysing cases of misconduct the researchers found examples of a typical group of "bad apple" perpetrators characterised by premeditated and strategic wrongdoing often involving either multiple offences against the same targets, or across multiple targets.

In addition they also identified "bad barrels" arising in poor workplace environments, which included inappropriate sexual talk/behaviour within an informal organisational climate, or collectives which supported, for example, faking qualifications and references for staff members.

A third group comprised individuals subject to the influence of stress and strain in misconduct. The researchers cite recent studies showing that stress can increase an individual's "moral disengagement", which then increases subsequent levels of "deviance".

Lead researcher Professor Rosalind Searle said: "The findings from the study have much broader implications and go beyond the regulatory process. We look forward to discussing them widely, looking at how they can be used to support preventative interventions in future by regulators, employers, and others."



## MALE DENTISTS "OVER-REPRESENTED" IN FTP CASES

AN analysis of GDC data has found that male dental professionals were more likely to have been involved in a fitness to practise (FtP) case than their female colleagues, as were older (over 30) registrants.

These are just two findings from the first in-depth analysis of FtP data commissioned by the GDC, aimed at "assisting the organisation with its reform to become a better, fairer and more efficient regulator".

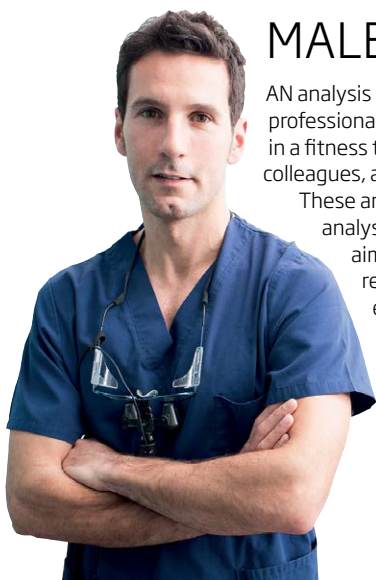
The analysis, carried out in 2016 by Plymouth University Peninsula Schools of Medicine and Dentistry, also found that dentists were significantly over-represented at all stages of the FtP

process compared to other registrant groups.

Dentists coming onto the register having qualified in an EEA country were more likely to be involved in an FtP case, but those entering via the Overseas Registration Exam were less likely to be involved compared to their UK qualified counterparts.

The odds of having been involved in an FtP case were 22 per cent higher for dental professionals identifying as 'Asian' or 'Other' compared to those identifying as 'White' but the researchers are careful to note that there are significant gaps in this data as it was provided on a voluntary basis.

The GDC says the report reveals some important insights into the types of FtP cases and the dental professionals appearing but it is "just one source of information in a complex landscape, and is not, on its own, able to establish the factors that are causing these findings".



# PARENTAL RESPONSIBILITY

Do you know who has the right to make decisions about children's dental treatment? **Aubrey Craig** offers some advice

**E**STRANGED parents, foster carers, close family members – the question of who exactly has the right to consent for dental treatment in children is often a complex one that can be difficult to judge. At MDDUS, we have dealt with a number of calls from members seeking advice on this topic.

Before delving into the finer details of each case, remember the basic principle that, generally, only a person with what is known as 'parental responsibility' can consent to a child's dental treatment (assuming the child does not have the capacity to give consent themselves).

Parental responsibility cannot be transferred by those who hold it but they can authorise others to act on their behalf. As in most situations, any emergency treatment can be provided without consent.

Common scenarios we encounter include a child being brought to the practice by a father who does not live with them or by a foster parent or relative and there is uncertainty in determining who holds parental authority to consent.

Sometimes parents still retain responsibility for the child even when they are being cared for by someone else. Indeed, it is often the case that the foster parent or person attending with the child does not know whether or not they have parental responsibility.

It can be a complex area and, if doubts exist, we would advise caution and even withholding non-emergency treatment until written consent is provided by a responsible parent.

While the law is recognised in all UK jurisdictions, there are some subtle differences as to who holds parental responsibilities (PR) between countries. In each nation, a birth mother automatically has PR unless this has been removed by a court. Likewise, an unmarried father can be granted a PR order by a court or can obtain a PR agreement with the child's mother. But there are differences.

In Scotland, the Children (Scotland) Act 1995 defines who has parental responsibility and the right to consent to a child's treatment. A father will have PR if he was married to the mother at the time of the child's conception or after. An unmarried father will have PR if his name appears on the child's birth certificate and

the child was born on or after 4 May 2006.

In England and Wales, the law differs slightly in that a father will have PR only if he is married to the mother at the time of the child's birth. An unmarried father will have PR if his name appears on the child's birth certificate and the

child was born on or after 1 December 2003.

In Northern Ireland, a father will have PR if married to the mother at the time of the child's birth or after – if living in Northern Ireland at the time of the marriage. An unmarried father will have PR if his name appears on his child's birth certificate and the child was born on or after 15 April 2002.

In the case of same-sex parents who are civil partners, both have parental responsibility if they were civil partners at the time of the treatment, e.g. donor insemination or fertility treatment. For non-civil partners, the second parent can get PR by either applying for it if a parental agreement was made, or becoming a civil partner of the other parent and making a PR agreement or jointly registering the birth.

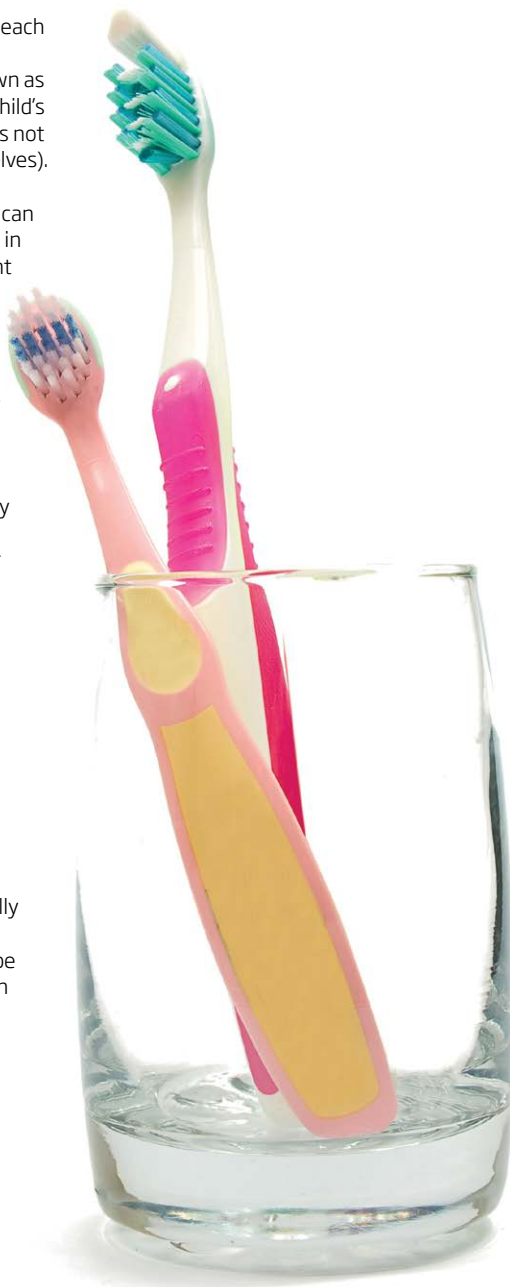
There are also legislative differences in the UK that affect children and young people and their rights to consent on their own behalf.

In Scotland, competent patients, even if under 16, can consent in their own right and parents do not simultaneously have a legally valid proxy. A decision by a competent young person under 18 to refuse treatment is likely to be binding and legal advice should be obtained in complex cases. It may be helpful to encourage the young person to discuss the matter with a parent/carer. Be sure to ask the patient's permission before discussing treatment options with a parent/carer.

Any patient aged over 16 who lacks capacity in Scotland is subject to the Adults with Incapacity (Scotland) Act and all medical treatment must comply with the terms of this act. Someone who "has care" of a child cannot act in a way contrary to the known wishes of the parents – thus if a carer attends with a child and treatment is required, parental wishes should be ascertained.

In Northern Ireland, the situation is similar to England although there is some ambiguity about the status of someone with parental responsibility being able to consent for a competent young person who refuses consent.

On these rare occasions such cases will likely need to be referred to the court. Currently there is no specific legislation regarding young people aged 16-17 who lack capacity and common law principles (those from case law and precedent) must be followed.



**Aubrey Craig is head of dental division at MDDUS**

YOU have just looked at your appointment book for the day ahead and that complex treatment you had booked in for Mr Brown for 45 minutes has been reduced to 30 minutes as reception have squeezed in an emergency patient. You can feel your stress levels rising and your day hasn't even started.

If you did have the time to stop and think before Mr Brown sat down, you could have carefully reviewed your treatment plan. Instead you feel rushed. Are you competent to carry out this treatment safely and to the appropriate standard? Are you confident that the training you went on last month gave you the necessary skills?

This can be a common dilemma for dentists who are looking to broaden the range of treatments they offer and expand their professional skillset. So the question is: "How do we start to move forward and develop our skills safely?"

The General Dental Council's *Standards for the dental team* states that "you must provide good quality care based on current evidence and authoritative guidance" and that "you must work within your knowledge, skills, professional competence and abilities." It makes it clear you must only carry out a task or type of procedure if you are appropriately trained, competent, confident and appropriately indemnified. So how is this possible when you are carrying out a procedure for the first time?

The starting point of learning any new skill is identifying what it is that you want to achieve. As dentists we are responsible for our own professional learning and development. Indeed, we will all have to comply with the GDC's new enhanced CPD (ECPD) scheme which comes into effect in January 2018.

Under ECPD, dentists will be expected to use a personal development plan (PDP) to identify new skills they wish to learn; to plan the CPD they will need to attain this; and review the anticipated outcomes and timeframe in which they wish to achieve

## How can dentists develop their professional skills safely?

**Laura McCormick** offers some advice

this. The days of going on a course solely to catch up with your friends have gone.

The question now is where do you start? Undertaking additional training to further develop our skills not only enables us to provide better patient care, it also increases our professional satisfaction. But before you jump straight into drafting a PDP, take some time to honestly reflect on your current skills and knowledge and compare that to where you want to be. Carefully consider your next step and be aware of the pitfalls of being overly ambitious and trying to expand your skills too far and too soon.

Dentists have a wide range of training options to choose from: perhaps you are interested in learning about sedation techniques or would like to provide particular aesthetic treatments? Once you have identified an area which requires a new skill, the next step is to plan your CPD and find an appropriate training course to meet your needs. This requires some care and attention as the quality and scope of courses varies wildly. Some may be sponsored by companies while others are independent.

Regardless of which type of course you choose, there are a few essential elements for keeping yourself right when developing additional skills. Consider:

- Who is taking the course? What is the experience of the speaker and are they affiliated with any companies?
- Is there an exam/assessment at the end of the training course? Is there ample opportunity to practise the clinical skills you have just learned? Consider whether

the course allows enough time for you to realistically learn the skill being taught to an acceptable professional standard.

- A good training course will provide ongoing support after completion. A mentor may be appointed who can offer assistance with pre-treatment case assessment and pre-op planning. They may also be available to watch you carry out the procedure and provide a post-treatment appraisal. Once you and the mentor agree that you are confident and competent enough to start going solo they will provide ongoing support and advice.

It is up to the individual practitioner to demonstrate the adequacy of their training. A portfolio of your work provides a record of treatment undertaken and the outcomes achieved but it should be more than just a compilation of photographs. Include reflective commentary on each of the cases and an appraisal by the mentor. This way it will support and demonstrate the type of learning undertaken and can also provide valuable supporting evidence should your competency be called into question.

So before you start Mr Brown's complex treatment, be mindful that you are not overreaching yourself for the benefit of your career or overriding what is in the patient's best interest. Learning and developing new skills is a vital part of being a dentist and ultimately patients benefit from having a happy enthusiastic clinician.

**Laura McCormick is a dentist and early practitioner adviser at MDDUS**



**MOVING FORWARD**

# PREPARE YOURSELF

**S**O, WHAT is the GDPR and what do you need to know about it? The European-wide General Data Protection Regulation is a comprehensive overhaul of existing data protection law, which hasn't been updated since the Data Protection Act (DPA) came into being in 1998. The Information Commissioner's Office (ICO) has described it as the "biggest change to data protection law in a generation". Now is the time to start preparing to ensure compliance.

First, make sure everyone who processes personal data in the practice is aware the law is changing and of its likely impact.

## All personal data

The GDPR will apply to all 'personal data' being processed, meaning information that relates to an identifiable living person. This definition is broad, and as well as patient information it also relates to employees' personnel records including sickness absence, performance appraisals, recruitment notes and any other information held about your staff. It will apply whether your practice is private, NHS or a combination of both.

As a starting point, consider:

- What categories of personal data do I currently process?
- What do I do with that personal data?
- Why do I do it – what is my legal basis for processing it?
- Is it necessary for me to be processing or retaining all the personal data that I have (the more personal data you have the greater the risk of a breach)
- Who am I sharing that personal data with?

## Privacy notice

This information would form the basis for your 'privacy notice', a new requirement under GDPR, which should document what personal data you hold, where it came from and who you share it with. An important data protection principle is that any processing of personal data must be fair and transparent and data controllers will be obliged to inform their patients and employees about exactly what

GDPR is coming. Now is the time to start preparing for the big change in data laws

they do with the personal information they hold and process. The privacy notice should be concise, intelligible and easily accessible. If it becomes too unwieldy, you can consider splitting it into separate notices or presenting it on your website in the form of videos or blogs. The important thing is to be transparent and provide accessible information. Start reviewing your current data processing activities now and familiarise yourself with the requirements of privacy notices.

The processing principles under the new GDPR all existed under the DPA but some have been developed further. The ICO has said that if organisations have been complying with best practice under the DPA they "probably won't have too much work to do". But as data controller you will have to demonstrate compliance and are accountable by law. (See our checklist opposite for further details.)

## Legitimate reason

To process personal data legally, you must show you have a legitimate basis for doing so. For example, you may need to process an employee's personal data to comply with a legal obligation such as sending information to the HMRC, or providing a copy of a patient record under a subject access request. It is vital everyone is aware they must have a legitimate reason to access patient records, otherwise they may be committing a serious offence.

## Monitoring employees

Another area to consider is the monitoring of your employees. Do you use CCTV in staff areas? Do you allow staff to make personal phone calls from the practice system or send personal emails from their business account? Can they access personal email accounts and online banking from their work computer? Why would you want to monitor these things? You could argue that you have a legitimate interest in protecting your business. And while you do have the right to protect your IT systems, you

also need to respect the personal privacy of your staff. A balance must be struck between the need for legitimate monitoring and the right to privacy.

## Individual control

The new GDPR will give individuals more control over how their personal information is used. New rights include the right to erasure (also referred to as the right to be forgotten) and the right to withdraw consent from companies using and storing their personal information. This could apply, for example, to a practice marketing database but not to dental records or essential employee information.

Subject access requests is another area that will see significant changes. Currently, the DPA enables data subjects to see and have a copy of the information that is held about them, and you currently have 40 days to comply with such requests. Once the GDPR is in place you will have to comply 'without undue delay' and within a maximum of one month. The existing fee structures will be abolished altogether.

## Breaches

The GDPR will also require data controllers to inform the regulator and data subjects within 72 hours of any "significant breaches" being discovered. The definition of "significant" has not yet been confirmed. Be aware that the penalties for breaching the GDPR and the loss of personal data can be high – up to four per cent of your gross annual turnover or €20m (whichever is higher). This will increase from the current maximum of £500,000 depending on the size of your business.

In conclusion, GDPR is set to become the definitive authority on data protection, offering the same protection to personal information across the EU and beyond. Britain's decision to leave the EU is not an escape clause as the UK Government says it will remain fully signed up to its provisions.

## Useful links

- ICO – [tinyurl.com/zqfmm48](https://tinyurl.com/zqfmm48)
- MDDUS GDPR checklist (login required) – [tinyurl.com/yd4ze796](https://tinyurl.com/yd4ze796)

*Alan Frame is a risk adviser at MDDUS*





## PRIVACY NOTICE

### WHAT TO INCLUDE

- Who is collecting the information  
– i.e. identify the data controller?
- What personal information do you hold?
- How is the information collected by you?
- Why is it collected, its purposes?
- How will it be used by you?
- Who will it be shared with?
- What will be the potential effect of this on the individuals concerned?
- Is the intended use likely to cause individuals to object or complain?
- What are you doing to ensure the security of personal data?
- Information about rights of access to their data

### PRESENTATION

- Use clear, straightforward language and avoid jargon
- Adopt a style that will easily be understood
- Don't assume that everybody has the same level of understanding as you
- Be truthful

# THE ART OF SELF

Dentist, practice adviser and GDC expert witness  
**Gordon Boyle** looks at key risks in restorative dentistry

**R**ESTORATIVE dental care can present numerous pitfalls as any dentist knows – but in my experience the key is to focus on the most elementary. The following lessons in “self-defence” should help minimise risk in restorative care and general practice as a whole.

## Lesson 1 - Good record keeping

Accurate, comprehensive clinical records are an essential component of safe care delivery and can be extremely useful in the management of a complaint or claim. Clinicians should aim to create an appropriate record at each stage of the care pathway from the initial presenting history to post-operative instructions. Excellent guidance is offered by the FGDP publication *Clinical Examination & Record Keeping* which is available online free of charge.

The production and secure archiving of study models, pre-operative wax-ups and photographs are an essential part of that record keeping process, especially in large restorative cases.

## Lesson 2 - Consent

With the exception of a routine examination (where implied consent may suffice), it is critically important that the patient's informed consent has been secured prior to every intervention. This requires sufficient discussion and explanation for the patient to understand the proposed treatment, viable alternatives, and the material risks, benefits and costs.

Make it clear in your notes that a conversation has taken place, including all of the options offered and the related risks and benefits. Supporting documentation could be a signed treatment plan for simpler courses of treatment or a more comprehensive document for more complex treatment plans.

However, the line between consensual dentistry and patient-led dentistry must never be blurred. In terms of restorative dentistry, a common pitfall within the consent process is where the patient wants to “go off-piste”. They persuade you to complete a treatment plan that you just don't quite feel comfortable with – the classic is a failed post crown that really should have been extracted and replaced with a bridge, a denture or an implant crown. Here, the dentist cannot rely on their consenting discussions, irrespective of how beautifully they were documented. The fact is that patients cannot consent to harm. The dentist should stand firm and decline to replace the post crown.

Managing your patient's expectations is crucial in the consent process. Many complaints arise when expectations

are unrealistically high. This is especially true of elective cosmetic procedures. Dentists should explain the limitations of treatments, including timescales and outcomes. The use of diagnostic wax-ups and clinical photography can go a long way to help.

## Lesson 3 - Know your limitations

Beware of being drawn into advanced treatment plans that are beyond your capabilities. Do not be afraid to stage your treatment plan and make full use of referral to colleagues at any stage of that plan. I have always found that experienced colleagues are more than willing to offer support and patients respect your candour when that is sought.

## Lesson 4 - Risk assess

When reviewing case files in negligence claims, I often find failures to record a risk assessment for all four disease processes in our realm: caries, periodontal disease, tooth wear and oral cancer. Placing and recording each of those in a high, medium or low risk category encourages more holistic patient care and leads us to attempt to bring those disease processes under control before proceeding. The absence of a recorded risk assessment raises questions as to whether an assessment was actually done and how appropriate your options for restorative treatment were.

## Lesson 5 - Take appropriate radiography

The FGDP's publication, *Selection Criteria for Dental Radiography*, outlines very succinctly when dental radiographs should be taken. Rarely when I am asked to look at a case do I have the opportunity to clinically examine the patient concerned. A picture paints a thousand words and good quality, appropriate radiography gives me as close an opportunity, clinically, to identify sound treatment choices.

The most common failing is that following, or in the absence of, a caries risk assessment, bitewing radiography is not carried out at appropriate intervals. The FGDP advise every six, 12 or 24 months for high, medium and low risk adults. Although there is a sound argument for some patients to lengthen these timeframes, there is a tendency to push these way beyond the guidance which can be difficult to justify.

We are duty-bound to justify and write a report on every radiograph we take with good reason to identify absence or presence of disease and, in this context, to give evidence to support restorative treatment options.

## Lesson 6 - Vitality test

I doubt there is a practice in the land that doesn't have ethyl chloride and some cotton wool pledgets at hand. Whether a





# -DEFENCE



*"Many complaints arise when patients' expectations have not been managed and are unrealistically high"*

tooth is vital or not is a crucial factor in its care. While a vitality test is not 100 per cent accurate, it offers a guide as to the state of the pulp. Performing and recording this simple test, especially prior to more advanced restorative procedures, supports your diagnosis and restorative treatment options.

## **Lesson 7 - BPE**

Failure to diagnose and treat periodontal disease has become, I believe, the biggest cost to indemnity providers and ultimately dentists. I still come across failure to perform regular basic periodontal examinations (BPEs) indicating periodontal disease or health, the foundation of any restorative care.

Recent guidance states that a BPE should be carried out at every routine examination, and scores of three or four should lead to further examination, active treatment and resolution before proceeding with any restorative option.

## **Lesson 8 - Educate yourself in CAD/CAM**

With the growth of CAD/CAM dentistry (of which I am an advocate) there is a risk that you may start to look at every case and think of it as the "only option" rather than just "one option".

Education to utilise the benefits of CAD/CAM dentistry is not as developed as the technology itself and there can be confusion as to what can be achieved. Some may see these as low quality destructive crown machines when in reality they can produce minimally invasive restorations, the quality of which matches the gold standard. The world of adhesive dentistry is rapidly evolving with new materials constantly appearing but it remains unforgiving in terms of basic technique. Staying abreast of new developments is just as important as focusing on the basics.

The pitfall is to invest only in the technology and not in the education required to utilise the benefits. All of the above lessons apply just as much, if not more, to evolving techniques over traditional dentistry. Your treatment options may have to be justified not only to a critical patient but also possibly to an 'expert' witness who, ironically, may have limited experience in this field.

The pitfalls of restorative care are more than just hard clinical technique. Acquiring and applying 'softer skills' has the mutual benefit of improved risk management and ultimately better patient care.

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**Gordon Boyle is a dentist in Glasgow and Scottish practice adviser for Denplan, with an interest in restorative CAD/CAM dentistry. He also works as an expert witness in GDC proceedings and litigation cases**

## Dental adviser **Rachael Bell** explains the many benefits of working alongside a chaperone or chairside assistant

**A** LLEGATIONS of inappropriate behaviour have not been far from the headlines in recent months, so what better time to reflect upon the arrangements we make in dental practice for chaperoning?

The English word 'chaperone' was first recorded in the 15th century and originally meant 'hood for a hawk', later referring to 'an older woman who protects a young unmarried female.' The dental surgery is hardly like a scene from *Pride and Prejudice*, with a dental nurse awkwardly listening in to what is going on whilst pretending to be invisible – or at least it shouldn't be.

The term chaperoning is commonly used when we think about protecting patients and ourselves from accusations of 'boundary transgressions'. But the role of chaperone – or what is commonly referred to in dentistry as a chairside assistant – encompasses a far greater range of responsibilities.

### Appropriate support

Aside from the practicalities of delivering care to an upper 7 unaided, and providing an extra pair of hands so we have a chance of reaching old age with our backs intact, chairside assistance provides for: a second person in medical emergencies; a witness to what is said and done; reassurance for the patient; and physical protection for both.

The rise in dental litigation should have sensibly seen the end to practising dentistry unaided, and yet we take calls daily from members of the dental team querying whether they can work alone. Traditionally, hygienists and therapists have been expected to work without a designated dental nurse, and often business reasons are quoted for the lack of chairside assistance being provided. Whilst we live in the real world where staffing comes at a cost, the financial practicalities of running a business have to be balanced against the risks of working unassisted.

The General Dental Council's *Standards for the dental team* states that "you must be appropriately supported when treating



patients". Their use of the term 'must' means this is non-negotiable. But what do they mean by 'appropriately supported'? One might imagine that a nurse only popping in to clear away instruments for the LDU was not the intention behind their drafting. The *Standards* go on to say "you should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting." The only circumstances they say this doesn't apply are when:

- Treating patients in an out-of-hours emergency
- Providing treatment as part of a public health programme
- There are exceptional circumstances.

The GDC define exceptional circumstances as "not routine and could not have been foreseen", pointing out that "absences due to leave or

training are not exceptional circumstances."

The use of the word 'should' in the GDC's guidance above does mean that there may be circumstances when a dentist could treat a patient unassisted. Any practitioner would be expected to be able to demonstrate that they considered the particular patient, procedure and their own skills and experience before making the decision to work alone. That said, the GDC specifically indicate that they use the word 'should' when explaining how you will meet the overriding duty which is that you must be appropriately supported.

One of the overarching principles of the *Standards* is that dentists should "put patients' interests before your own or those of any colleague, business or organisation". Using financial circumstances to justify the non-provision of chairside assistance could put the practitioner in breach of this.

### Patient safety

Patient safety is paramount to the GDC who



# CHAPERONE

*“The rise in dental litigation should have sensibly seen the end to practising dentistry unaided”*

colleagues in a way that is in patients’ best interests

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18 (staffing) and regulation 12 (safe care and treatment).

The CQC is clear that if inspectors found dental care professionals working alone, not in exceptional circumstances, they would be concerned. In addition, where chairside support from a dental nurse was not available, they would expect to see a risk assessment which has taken into account the medical emergency scenario for either the patient or the DCP. Their key question is: “How are risks to individual people who use the services assessed, and their safety monitored and maintained?”

## Self-defence

Lastly, aside from complying with the relevant regulators, the presence of a chaperone can be helpful to a clinician when faced with accusations of misconduct. Whilst comprehensive records are crucial, who can honestly say their notes fully reflect everything that was said? Patient complaints frequently also include allegations about a clinician’s manner or attitude. In these instances the supporting witness statement of your dental nurse can be key. Clearly if they aren’t in the room, then you are very much on your own as records say little about a clinician’s demeanour.

The actress Greta Garbo once famously said that she “wants to be alone”. When work is hectic we may sympathise, but the days when that was either wise or safe may well have passed.

**Rachael Bell is a dental adviser at MDDUS**

state: “You must not provide treatment if you feel that the circumstances make it unsafe for patients.” They are clear that there must be at least one other person available within the working environment to deal with medical emergencies when you are treating patients. It is for the individual practitioner to check, risk assess and decide whether the other person in the practice is appropriately trained for this purpose.

When deciding whether you can safely treat a patient alone, consideration must be given to how you would cope should a medical emergency arise. After all, we can’t always predict who will become unwell. Consider also how accessible the other person is. If you have to leave your patient, pass through doors and potentially go up or downstairs to summon assistance, what happens to the patient in the meantime? Clearly your second person needs to be rapidly accessible to fulfil any idea of patient safety.

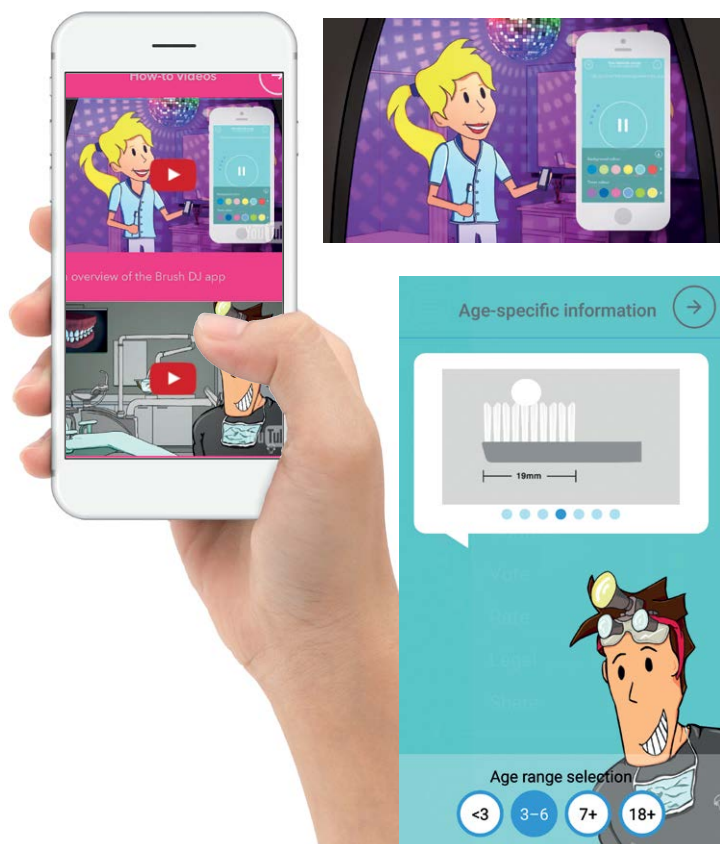
## Clinician safety

Assault and aggressive/threatening behaviour is thankfully rare, but it does happen. By working in an isolated environment without assistance, you may be placing yourself and/or your employee in an unnecessarily vulnerable position. How often do you leave a dental nurse alone with a patient? They are vulnerable to both allegations of inappropriate behaviour and potential assault. Where the dental care practitioner (DCP) is an employee, you may also be breaching your duty as an employer to look after their safety and wellbeing (under the Health and Safety at Work Act).

The Care Quality Commission (CQC), which regulates primary care dental services in England, has published a series of useful *Dental mythbuster* guidance articles, of which number 13 relates to lone working. It states that when inspectors judge whether or not lone working is safe they consider:

- GDC *Standards* Principal 6: Work with





# THE DIGITAL DEN

App developer and dentist **Ben Underwood** talks to *SoundBite* about his hi-tech approach to improving oral health

**D**ENTIST Ben Underwood is at home looking after his newborn daughter who is just 10 weeks old. Although his first child, she is not his only 'baby' as Ben is the creator of award-winning dental app, *Brush DJ*.

As baby Hannah sleeps in his arms, the new father explains how the idea came to him while watching an episode of the hit BBC show *The Apprentice*. As Lord Alan Sugar challenged the candidates to develop an app, an idea was sparked in Ben's mind.

The premise was simple: create an app to encourage good oral health using music as the hook to motivate tooth brushing for an effective length of time; and so *Brush DJ* was born. Fast-forward six years and it has been downloaded over a quarter-of-a-million times in almost 200 countries.

## Constant process

Achieving this success was not easy. It took six months of hard work and considerable personal financial investment – including recruiting a local

app developer – to turn the idea into a reality.

Ben says: "Think of it like building a house – but not quite as expensive. There are a lot of things to consider and plan. Then once it's built, it is a constant process of updating and improving based on user feedback."

"It's the positive feedback that keeps me working away on it, because I am definitely not doing it for the money!"

## Seal of approval

The NHS generally takes an average of 17 years to bring an innovation into widespread use, but *Brush DJ* has defied the odds to become the first (and currently only) dental app to be accepted into the new NHS Digital Apps Library. Ben also has the backing of the Chief Dental Officer for England Sara Hurley and the British Dental Association (BDA), as well as having attracted NHS funding to further develop his app.

Proud of his achievement, Ben admits it has been harder work than he first thought: "Did I ever think about giving up on the app? Yes and no. All innovators go through what's known as the 'hype cycle', where everything



PHOTOGRAPHS: BEN UNDERWOOD

# TIST

is very exciting in the beginning and expectations are high. But then they hit the 'trough of disillusionment' when you think 'this is never going to scale'. There are many barriers to innovation in the NHS, but also some amazing people who will enable it."

## Hi-tech motivation

Available for both Apple and Android devices, *Brush DJ* has to date been downloaded more than 313,000 times worldwide and translated into 14 languages: "It is very exciting," Ben says. "Tooth decay is not just a UK issue, it is a global problem and so it's exciting the app is reaching people far and wide. But there is still a long way to go."

He is passionate about his app and insists technology has an important part to play in modern dentistry. "People are spending so much time with their smartphones, using apps for everything from shopping and banking to social media and dating. If you are trying to engage people and grab their attention to promote evidence-based oral health, an app can help".

In the dental surgery where Ben works as an associate, he sees tech-savvy children as young as four using mobile devices. It is those youngsters and their parents that he wants to target and motivate in a bid to get everyone brushing effectively. Seeing the first-hand impact of preventable tooth decay on his young patients inspired him to take action.

He explains: "Extractions due to tooth decay are the biggest reason

children aged five to nine are admitted to hospital for a general anaesthetic (GA) - and this is for a preventable disease. Having a GA is traumatic and also incredibly expensive at around £1,000 per operation. This is money that could be better spent elsewhere in the health service."

He recalls sitting in on a recent assessment session in which a two-year old child needed nearly all of her teeth extracted under GA. "It's appalling," he says. "Imagine how devastating that was going to be - not for the surgeon doing it or the parents, but for the child who will wake up in pain.

"We don't need to find a cure for toothache - we know the cause and the cure, and we know we can prevent it, but we have to get the message across in a way people will hear it and be motivated to act on it."

## Innovator

Now a fellow of the NHS Innovation Accelerator (NIA) programme, which earned Ben a funding boost to further develop his app, he was among a handful of health professionals (and the only dentist) to be selected by the NHS to join the elite team two years ago.

Now in its third year, the programme has around 40 innovators, from sole traders like Ben to multinational companies like Boots who have inventions or the capability of developing their ideas.

And it really does 'accelerate', as Ben points out: "You can get a warmer reception when you knock on the door of someone high up in the NHS, rather than just turning up and telling someone 'I have developed this...'"

As an NIA fellow he has both mentored and inspired other innovators. His advice to young or established dentists who are reading this and have an idea is to contact the Academic Health Science Network (AHSN) in England or Scottish Health Innovations Ltd (SHIL) who can provide help and support.

Just like raising a newborn baby, developing an app demands a lot of patience, time and money. It also requires continual nurturing. So how does a busy dentist balance his career with his app development, NHS Innovation Accelerator commitments and fatherhood? "I don't watch much TV," he laughs.

When he is not treating patients, trying to change behaviours and revolutionise modern dentistry, Ben enjoys running, cycling and gardening. "I think you need to regularly do sport of some description," he says. "It helps both physically and mentally."

When asked about his plans for the future, Ben says his immediate priority is Hannah. "The app was the first baby, now we have a physical one, which is going to be more expensive and time consuming, but she gives better cuddles!"

## Links

- Find out more about the *Brush DJ* app at [www.brushdj.com](http://www.brushdj.com)
- NHS Digital Apps Library - [apps.beta.nhs.uk](http://apps.beta.nhs.uk)
- If you are inspired by Ben's story visit [www.ahsnnetwork.com](http://www.ahsnnetwork.com) or [www.shil.co.uk](http://www.shil.co.uk)

**Kristin Ballantyne is a freelance writer based in Glasgow**

### DAY ONE

Mr K is a 32-year-old sales manager and attends the dental surgery dissatisfied with the appearance of a crown on UR2. The crown had been fitted six years ago after he badly chipped the tooth while mountain biking. He is now unhappy with the colour. The dentist - Dr G - discusses options, including replacing the crown or whitening the natural teeth to better match the colour. Mr K agrees to whitening treatment and this is subsequently carried out.



### ONE MONTH LATER

Mr K states that he is still unhappy with the appearance of the crown and requests a replacement. Dr G provides a treatment plan and cost and the old crown is subsequently removed. The replacement crown is made on the first model as the fit was adequate, and Mr K attends the dental laboratory to ensure the best colour match. Ten days later the new crown is fitted and the notes state that the patient is happy with both shade and fit.



### THREE WEEKS LATER

Mr K re-attends complaining that the tooth feels too "tight" and Dr G notes that the crown is not properly seated. It is also evident that the patient's gingivae are irritated labially. The crown is re-prepared and a new impression is taken. Five days later a new crown is fitted and Mr K is again happy with the colour but some gum recession is noted.



### FOUR MONTHS LATER

Mr K returns to the surgery concerned over how much the gum has receded over UR2. The patient has a high lip line and the fault is very obvious when he smiles. Dr G advises the patient on correct brushing techniques and discusses further options, including an offer to refund treatment costs. Mr K refuses the refund.

## TREATMENT

# CROWN CLAIM

THE practice later receives a letter from solicitors acting on behalf of Mr K claiming clinical negligence in the treatment of UR2. It is alleged in the first instance that Dr G recommended inappropriate treatment in the form of tooth whitening, which was unnecessary and resulted in sensitivity. It is also claimed that the dentist failed to correctly mould the subsequent replacement crown and ensure an adequate fit.

The claim also cites a failure to appreciate that an ill-fitting crown may cause gum recession and that Dr G failed to resolve the complication. The letter states that Mr K is now self-conscious about smiling - a problem for someone who "works in sales" - and the only appropriate remedial treatment is replacement of UR2 with an implant-retained crown.

MDDUS instructs an expert dental surgeon to provide an opinion on the case, addressing each of the allegations. The expert considers that the choice of tooth whitening in the first instance was reasonable and, indeed, requested by the patient after discussion of the various options. Mr K was also advised of possible temporary sensitivity.

In regard to the ill-fitting crown the expert considers that it was reasonable to make the replacement crown on the first model as the fit was adequate. He advises that it is not possible to guarantee a crown will fit when it is returned from the laboratory and tried in, as there are numerous areas where the fabrication process can go wrong without any specific or obvious fault.

The expert states that it is unclear from the records what caused the gingival irritation and gum recession. It could be that the margin of the first new crown was not satisfactory and caused plaque accumulation. An excess



of luting cement left under the gum margin when the crown was fitted could also have caused inflammation - or the gingiva may have been traumatised when the first crown was drilled. Any of these would constitute a breach of duty and leave Dr G "vulnerable" in court.

In regard to the consequences of the failed treatment, the expert agrees that with the patient's high lip line the gum recession is noticeable. Various treatment options are possible - including a replacement crown edged with gingival coloured porcelain or referral to a periodontal specialist - but he considers extraction with a replacement implant inappropriate at this stage.

Given the "vulnerability" cited by the expert, MDDUS agrees with the member to settle the case with no admission of liability.

### Key points

- Keep adequate notes of patient discussions regarding treatment options and risks.
- Ensure patients have reasonable expectations of treatment outcomes.



## OUT THERE

**PREHISTORIC PAIN** Neanderthals may have treated toothache using plants, according to research in the journal *Nature*. Investigation of the ancient remains of a man found in Spain suggest he ate poplar, which contains the active ingredient of aspirin, to treat an abscess. His dental plaque also had a natural form of penicillin, 40,000 years before its discovery. Source: *CNN*



**BITTER PILL** Scientists have embedded chewing gum with a special biosensor to detect peri-implant disease. Specific enzymes occurring in disease-sufferers trigger the release of a bitter taste to alert the chewer to the problem. But *Nature Communications* reports it's so far only been tested using an "artificial tongue" rather than real patients.

**TEETH INFLATION** The amount left to UK children by the tooth fairy has increased by five per cent in the past year, rising to an average £1.49 per tooth. Research by SunLife found London children get the most at £1.88 per tooth while those in the South West get the least at £1.18.



## FROM THE MUSEUM

The use of ether for dental extraction came back into fashion once clinicians realised the dangers of the once-popular chloroform. John Clover designed the first regulating ether inhaler in 1877 as an alternative to less scientific methods of administering, via a soaked towel or inhaling through a cone. The gadget was widely used and modified thanks to its effectiveness and speedier patient recovery times.

PHOTOGRAPH: BDA MUSEUM

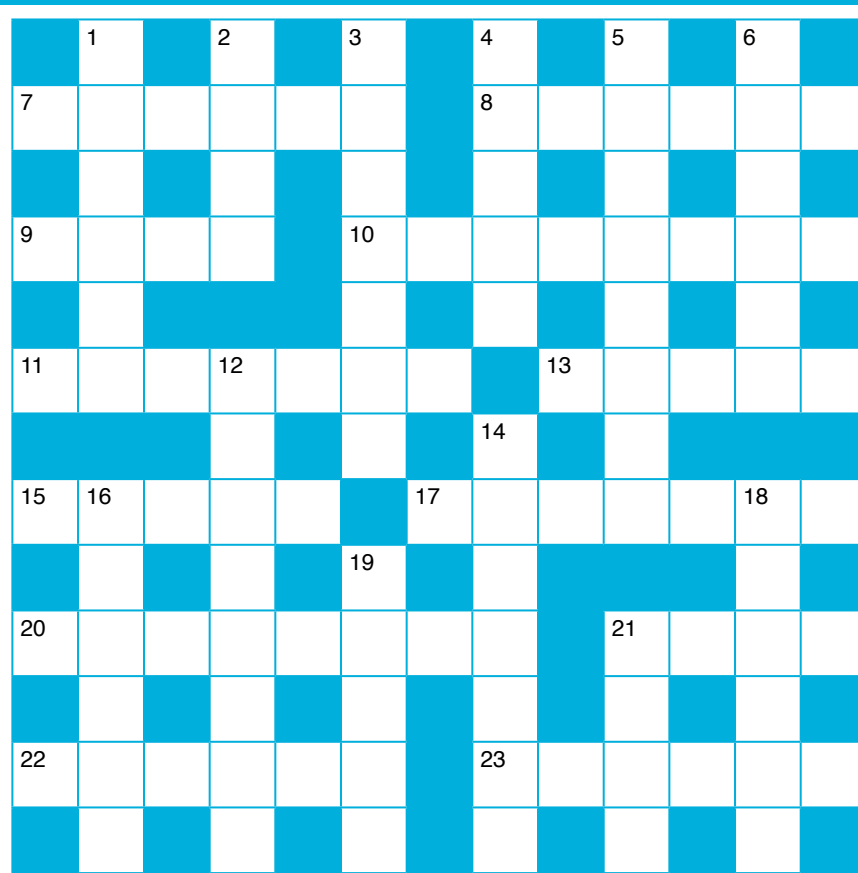
## CROSSWORD

### ACROSS

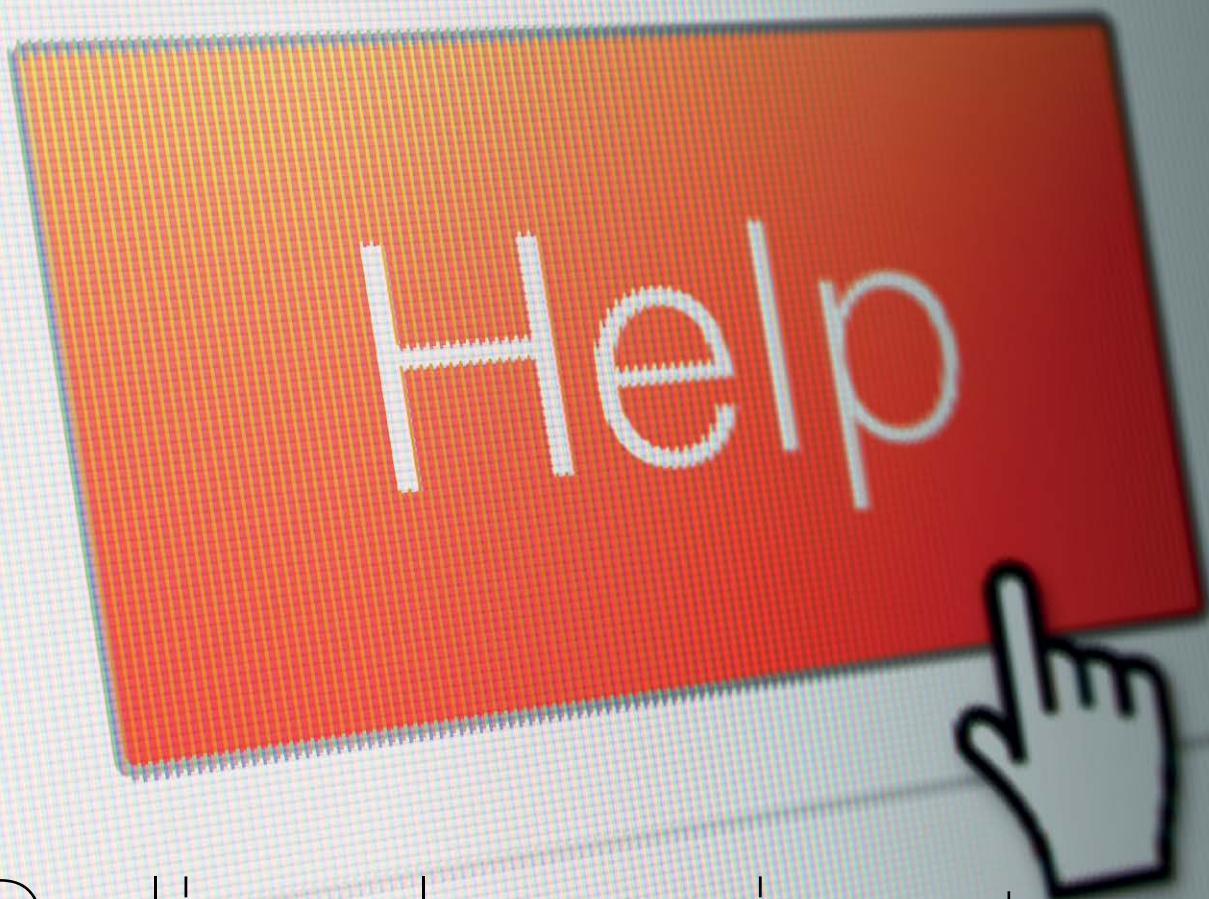
7. Relating to the lips (6)
8. Direction towards the anterior midline in a dental arch (6)
9. Civil disturbance (4)
10. Removable orthodontic device (8)
11. Sliced (7)
13. Sense detected by tongue (5)
15. Person acting on behalf of someone else (5)
17. Non-existence of (7)
20. Over-the-counter gingivitis treatment (8)
21. Fe: chemical element (4)
22. Globe (6)
23. What Simon Cowell and friends hope to find in Britain? (6)

### DOWN

1. Like Mads Mikkelsen or Sandy Toksvig (6)
2. Nutritional regime (4)
3. Primed to go off if tampered with (7)
4. Containing nothing (5)
5. Quotation for future work (9)
6. Most recent (6)
12. Made to pay for criminal activity (8)
14. Knack (7)
16. Sets (6)
18. Artificial restorations capping teeth (6)
19. Perimeters (5)
21. In a work-free state (4)



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