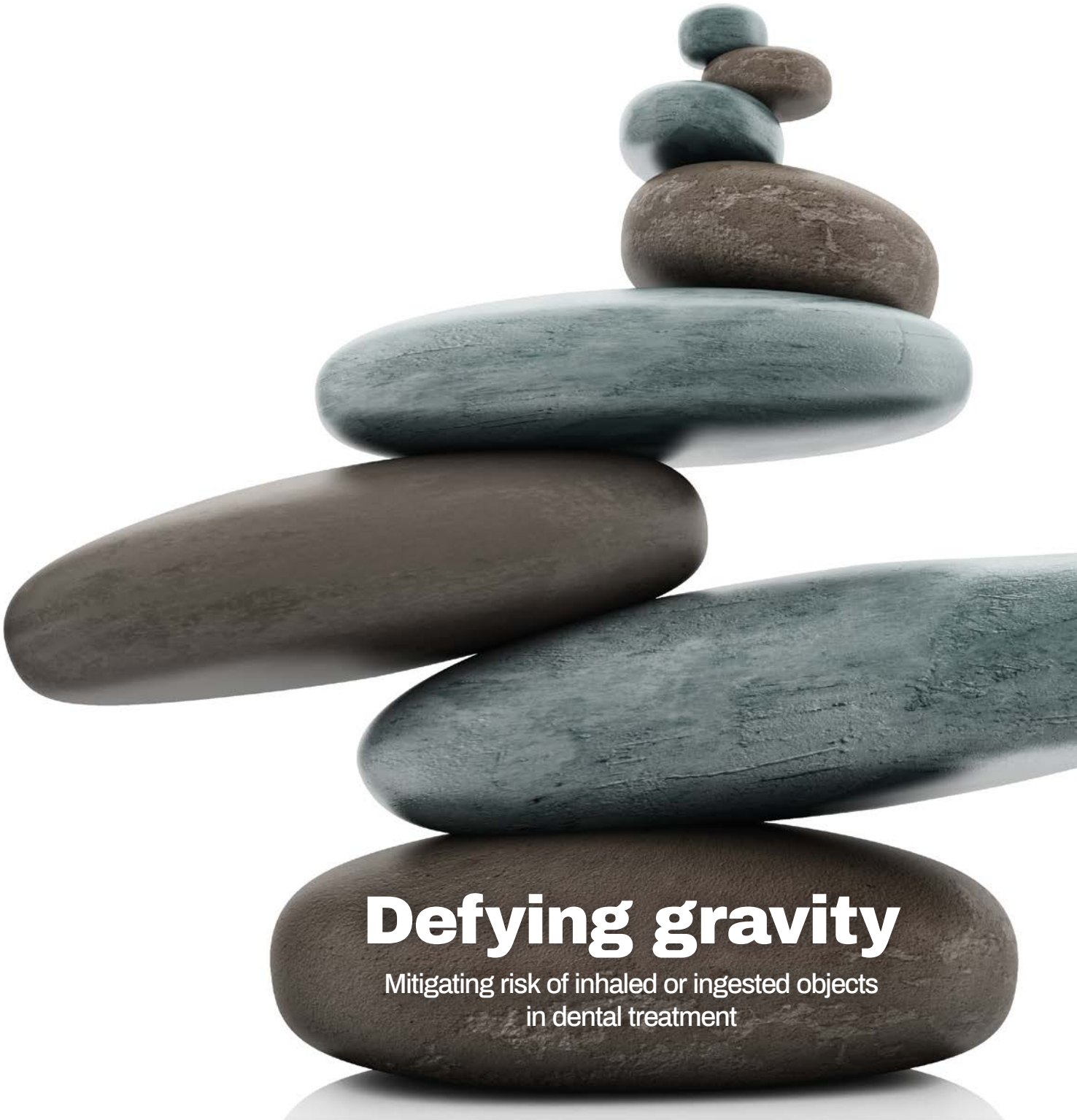
PROMOTING BEST PRACTICE

INSIGHT

MDDUS
UK INDEMNITY, ADVICE & SUPPORT

DENTAL

Featuring: **This too shall pass / Making SEA work for you / Dealing with racist abuse / Ethics: It's the small things**



Defying gravity

Mitigating risk of inhaled or ingested objects in dental treatment

MAY 2020

Welcome

Doug Hamilton
Editor

WELCOME to the first issue of *Insight Dental Care* — one of three new quarterly magazines we are launching at MDDUS to broaden the scope of content we produce for all our members. I'm excited to take on the role of editor of the magazine, which is basically the new *SoundBite* but with some added extras. We hope you find our inaugural issue both interesting and useful. Comments and suggestions are most welcome.

With coronavirus an inescapable theme in all our lives, Alun Rees dares to look forward at the post-COVID-19 dental landscape (**page 7**). Significant event analysis is not easy to get right and many of the SEAs we see at MDDUS are more description than analysis. On **page 8** of this issue, Liz Price offers tips on making your SEAs more than just simple box-ticking exercises.

On **page 10** dental adviser Sarah Harford highlights the perils of ingested or inhaled objects during dental treatment — anything from an endodontic file to a tooth fragment.

Is it reasonable to tolerate even "low level" racism from patients? Kay Louise Grant considers some safe strategies on **page 12**. Our risk column on **page 6** concerns the data protection implications in texting patients, and on **page 14** Professor Deborah Bowman offers a personal perspective on how even "small things" can reflect ethical choices when it comes to dealing sensitively with patients.

Our Call log on **page 4** features common (and not so common) advice requests from dentists and practice managers, and our case study on **page 13** concerns allegations of "poor treatment", with a tooth perforated during RCT.

Addenda on **page 14** includes a "modern" advance on the dental chair, and reviews of Bill Bryson's brilliant new book *The Body* and the corporate crime film thriller *Dark Waters*.

Doug Hamilton
Editor

EDITOR
Doug Hamilton

MANAGING EDITOR
Jim Killgore

ASSOCIATE EDITOR
Joanne Curran

DESIGN
Connect Publications (Scotland) Ltd
0131 561 0020
www.connectmedia.cc

EDITORIAL DEPARTMENTS
Dental: Aubrey Craig
Legal: Joanna Jervis

MDDUS
Mackintosh House
120 Blythswood Street
Glasgow G2 4EA

t: 0333 043 4444
e: jkillgore@mddus.com
w: www.mddus.com

Insight Dental Care is published quarterly by The Medical and Dental Defence Union of Scotland, registered in Scotland No 5093 at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA. Tel: 0333 043 4444 Fax: 0141 228 1208 Email: General: info@mddus.com Membership services: membership@mddus.com Marketing: marketing@mddus.com Website: www.mddus.com

INSIGHT. Briefing

MDDUS MEMBERSHIP

Lockdown rates

MDDUS subscription rates for dentists have been cut by as much as 75 per cent as clinicians are forced to down tools in the wake of the coronavirus outbreak.

All but emergency dental treatment has been halted by the government in a bid to stop the spread of COVID-19, and MDDUS has used its discretionary powers as a mutual organisation to remove a financial burden from its members.

MDDUS CEO Chris Kenny said: "This is a difficult and uncertain time for dentists. The impact of the coronavirus on the dental profession is unprecedented and will be causing worries and concerns — both practical and financial — across the board.

"From a financial perspective, MDDUS is acting decisively in the interests of our members. We are able to use our discretion as a mutual to make swift decisions in our members' benefit at this testing time in a way that insurance providers cannot."

Aubrey Craig, Head of MDDUS Dental Division added: "We are reducing subscriptions for all GDP members currently working more than one session per week to our lowest sessional rate.

"If dental members are redeployed to work in support of NHS staff in hospitals/urgent treatment centres specifically on the response to COVID-19, we will apply a further reduction, if this is the only dental treatment provided and all practice-related work has ceased. Work in redeployed settings will be covered by the other crown indemnity schemes but maintaining MDDUS membership keeps GDC cover for this work too."

MDDUS will adjust its dental members' direct debits automatically from 1 April for three months in the first instance. It will maintain protection for claims from remote or emergency working and from regulatory actions in relation to both personal and professional conduct.

Dental hygienists and dental and orthodontic therapists will retain their full membership at no cost for the same period.

PRACTICE MANAGEMENT

COVID-19 advice from Acas

ACAS has produced a helpful guidance page for employers and employees, dealing with the COVID-19 emergency.

The page covers topics such as staying at home and social distancing, self-isolation and sick pay, workplace closure, using holiday entitlement, taking time off to look after someone, and what to do if someone develops symptoms at work.

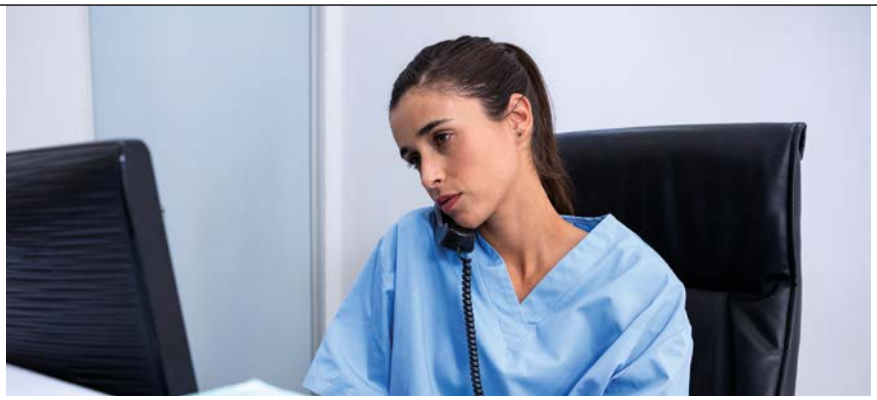
Access at **www.acas.org.uk/coronavirus**.

MDDUS Coronavirus Hub

MDDUS has gathered together news, advice, essential resources and training materials to help support you in the COVID-19 emergency. Access at **www.mddus.com/coronavirus**.

Go digital

Read, see and hear more content including coronavirus updates by accessing the premium digital version of *Insight Dental*. Go to **Resources** > **Publications** at **mddus.com** and ***View this issue via digital reader***



SCOPE OF PRACTICE

Offering assistance in triage

MDDUS has been contacted by a number of associate dental members (dental hygienists/therapists and orthodontic therapists) being asked to assist practices with online and phone triage of patients.

The GDC's *Scope of practice* states that dental hygienists and therapists can "diagnose and treatment plan within their competence". Triaging patients would fall into this category but staff should always work within their scope of practice, following established algorithms when providing advice. Such work should be overseen by a dentist for immediate support in out-of-scope advice/enquiries. Associate dental members can provide advice on analgesia where appropriate, ensuring that the patient's medical history is reviewed and any current medications are assessed, in particular any relevant asthma and gastro-intestinal problems. Decisions regarding potential administering of antibiotics should be reviewed by a dentist who can provide an appropriate prescription.

Orthodontic therapists should not be triaging patients, as this is not within their scope of practice as defined by the GDC, but they can speak to the patient/parent and gather information for the orthodontist to make a diagnosis and prescribe a treatment plan.

Inform MDDUS immediately if you are returning to work in any capacity, either in private practice or in support of NHS staff in hospitals/local urgent treatment centres. Employers should note that furloughed staff cannot be asked to provide such services for the practice under the terms of the Coronavirus Job Retention Scheme.

GDC

Pandemic guidance

THE GDC is providing updated guidance on its website on various regulatory and professional issues for dentists in the coronavirus pandemic.

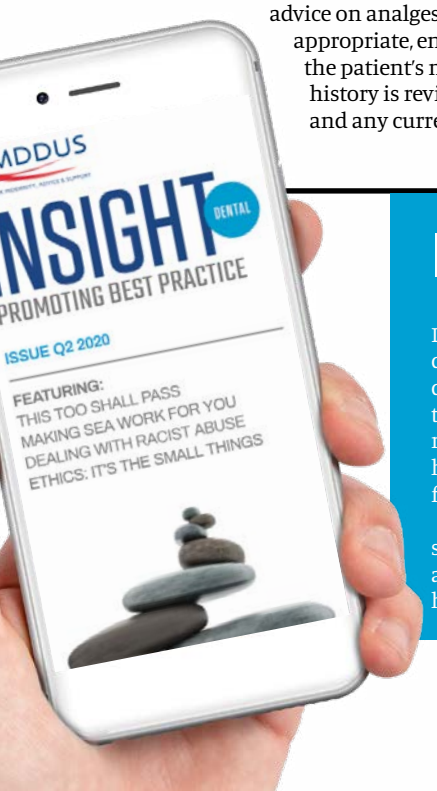
Its approach is being guided by two main principles:

- minimise the regulatory burden on dental professionals wherever possible
- maximise flexibility for dental professionals to manage their professional activities in response to the challenges of COVID-19.

The GDC states: "These are difficult and worrying times for us all as we navigate the many challenges we face and try to develop good solutions to problems as they emerge.

"The absence of immediate certainty understandably will lead to frustration and concern and, for our part, we are working to minimise this wherever we can."

Access at **tinyurl.com/yav7rn3o**



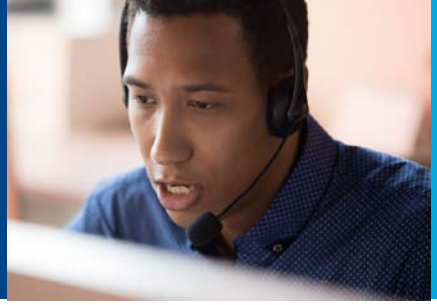
Insight on dental care

LAST year we launched the first edition of a new digital *Insight*, generated using the premium digital magazine platform, Foleon. The switch to digital was part of a larger initiative to reconsider our publication programme and how best to communicate with members going forward in 2020.

We have now decided to broaden the scope of the content we produce for medical and dental members. Starting in March we have been replacing our current range of magazines (including *SoundBite*) with three branded quarterly digital and print magazine titles. *Insight Dental Care* is the third of these magazines to be published, with a primary care publication launched in March and a secondary care publication in April.

All the *Insight* titles are being generated using Foleon and sent out via an email link, but those existing members who opted for print will still receive a hard copy in the post.

CALL LOG



These cases are based on actual calls made to MDDUS advisers and are published here to highlight common challenges within dental practice. Details have been changed to maintain confidentiality.

Annual leave in lockdown

Q What are the rules on annual leave during the coronavirus outbreak?

A Rules relating to carry forward of annual leave have been extended in response to the coronavirus outbreak. The statutory four weeks provided for under the EU Working Time Directive can be carried forward and taken in the two leave years immediately following the year it was due, where it was "not reasonably practicable" to have taken it because of the coronavirus. The guidance now confirms that employees are able to take annual leave during a period of furlough. If an employee is on a period of annual leave, they should be paid their normal full-time pay for this time, with the practice able to claim back 80 per cent. You may wish employees to take any pre-booked annual leave to prevent large amounts being taken in the latter part of the holiday year. Employers are also able to require employees to take a period of holiday by giving them double the difference in notice: so 10 days' notice is required for a five-day holiday period. See ACAS guidance on annual leave at **www.acas.org**.

Access to teen's records

Q A 13-year-old patient at our practice has fallen out with his mother and is now living with his father. The mother has been in touch with the practice in regard to an ongoing health issue with the boy – but he no longer wants her to have access to his records. What is our legal position?

A Given the age of the boy it is possible he would be judged Gillick competent, with capacity to refuse disclosure of his personal information. We advise that the practice writes to the mother stating that, in order to consider whether information can be disclosed to her, the boy would need to be assessed regarding whether he is competent to make this decision for himself. It may be the mother would not want her child to be informed of her request. If she is content for this assessment and he has capacity but refuses, this would ordinarily be definitive. If he does not have capacity and the mother maintains parental responsibility, the key issue is what is in the child's best interests to disclose.

Late attendance

Q We have a practice policy in place for patients who attend late for hygienist appointments. We offer the choice of either undergoing treatment within the time remaining or, if they pay a late cancellation charge, they can reschedule for a full 20-minute appointment at a later date. As most patients choose to continue with treatment in the shorter timescale, I'm worried the hygienist may feel rushed and that the quality of care will be compromised. Should we amend the policy?

A It should be up to the hygienist to decide whether she has sufficient time to provide appropriate treatment to the late-comer. If not, the patient should be asked to make another appointment. Should there appear to be sufficient time, the patient could be advised that the planned treatment can be carried out within the remaining period but if time runs out they will again need to reschedule. However, if the hygienist feels that the late arrival could compromise her ability to carry out satisfactory treatment, she should not feel pressured into offering a shortened appointment. Remember, if a patient complains about a clinical outcome, the fact that treatment was rushed in order to accommodate their late attendance is unlikely to offer much of a defence. Any amended policy should be clearly publicised to patients, including late cancellation charges, or the practice could be open to complaints.

Work-shadowing

Q I'm a partner at a practice and have been asked by a friend if his daughter can shadow me for a few sessions. She is in her final year at school and is applying for dentistry at university. Is this problematic?

A Work-shadowing arrangements are not uncommon but there are a number of issues to consider. First a risk assessment should be performed and recorded prior to such an attachment to ensure that the work environment is safe for a visiting pupil. The Health and Safety Executive has published guidance related to work-experience pupils (**tinyurl.com/uo65xfu**). It is also crucial to consider issues of confidentiality and consent. The pupil should be required to sign an agreement and given firm guidance that personal patient details (even the fact that someone has attended the surgery) are entirely confidential. Patients must be asked for consent in advance (preferably in writing) for a school pupil to be present during a consultation and should also be advised that they may change their mind at any time. Notices in the waiting room to indicate that school pupil placements may occur are also helpful. Pupils should be informed that they cannot expect hands-on experience and will only be observing on a limited basis. Finally, it is important that the whole practice team are comfortable with the arrangements to ensure the pupil is appropriately supported and supervised.

Probationary employment

Q We hired a receptionist on a six-month probationary basis but there have been a number of issues arising in that period. These include not complying with practice protocols and procedures, despite being given repeated training. She has also stated that she will not be available to cover annual/sickness absence, which was clearly outlined in her interview. I have discussed these concerns and informed her that at present we will not be offering her a permanent employment contract. Are we within our rights?

A An employee with under two years' service does not have unfair dismissal rights. As long as the decision to dismiss is not based on a protected characteristic issue (age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity), it should be straightforward to advise the employee that her probationary period has not been successful. She should be given her notice – which can be worked or paid in lieu – along with any accrued outstanding holiday pay up until the termination date. MDDUS members can request a template letter by emailing **advice@mddus.com**.

Police enquiry

Q Our practice received a police request regarding a patient, Mr A, who was recently assaulted. The officer has asked for a statement outlining the dental injuries Mr A sustained and the subsequent dental treatment he received from us. Am I allowed to disclose the information?

A The key issue here is consent. In order to disclose any information to police, you would need written consent from Mr A. Ask the officer if he has a signed medical consent form from Mr A. Alternatively, you could contact the patient and request a short written note explicitly authorising you to discuss his dental treatment with the police and, if necessary, to disclose relevant records. Once you have consent, be sure to only speak to your own clinical records and remember that you are being approached as a witness to fact, not as an expert. Avoid any speculation regarding, for example, the cause of the dental injuries, any non-dental injuries or Mr A's state of mind. It may also be advisable to avoid being drawn into discussions regarding the prognoses of teeth or restorations, unless you have already assessed Mr A and formed a clear treatment plan for any remedial work required.

Rural implant service

Q We are a medium-sized dental practice located in a rural area and have begun recruiting for an implantologist to provide an enhanced service to our patients. However, we are concerned that, should the implantologist leave the practice in future, we may have patients experiencing long-term complications who would have difficulty sourcing additional expert care or remedial work. Would it be reasonable to advise potential patients at the outset of treatment that a long-term implant service cannot be guaranteed?

A Should you proceed with plans for such a service it would be sensible to advise patients, in writing, that implants generally require periodic review and certain complications may not manifest for a period of years. Therefore, attendance at an implantologist over a significant period of time may be necessary. You could go on to advise that, at present, your implantologist will be retained on a sessional basis but it cannot be guaranteed that this arrangement will continue ad infinitum. Given your geographical location, this could mean that in future years the implant service may not be available and follow-up would involve travel to a more distant centre. Clearly, individualised and case-specific consenting discussions will take place between the implantologist and the patient, but it would be reasonable for the practice to inform potential patients of this general point before they decide to proceed with treatment.

Carpal tunnel

Q I have recently been diagnosed with carpal tunnel syndrome, which has caused mild tingling and slight numbness in my hand. I am still able to carry out most dental treatments, but I have difficulty when attempting extractions. I may need surgery but I'm worried about the impact on my ability to work as a dentist. Is it okay for me to continue to practise?

A Unfortunately, MDDUS can offer only limited advice on this matter. We would draw your attention to the General Dental Council's standards guidance which emphasises your duty to put patients' interests first and to protect them from risks posed by your health or performance. You should seek occupational health or other appropriate specialist advice without delay. You should also discuss the matter with your general medical practitioner or the surgeon to whom you have been referred for treatment. Only then can you make a decision on how to proceed. If you are assessed as fit to practise, then your MDDUS membership will not be affected. If you are unable to work for any significant period of time then you may wish to defer your membership until you are back at work – email **membership@mddus.com** for further information. Perhaps you also have independent sickness insurance cover and should contact your provider. There should be no need to contact the GDC about the matter.

ELECTRONIC MESSAGING AND GDPR

Alan Frame
Risk adviser at MDDUS

TEXT messaging has become almost routine in healthcare today — and dentistry is no different. Practices recognise that this type of communication can be effective both for business needs and as a benefit to patients. However, there must be robust processes in place which consider both the message content and intent, as well as the need to protect patient confidentiality.

The General Data Protection Regulation (GDPR) has raised questions among dentists about what exactly is permissible to send to patients via electronic messaging. Text messages are transmitted on public phone networks and are therefore potentially insecure and could be read by unintended others. A dentist may not be responsible for a message once received, but patients should still be encouraged to protect their phones and other devices if concerned over confidentiality.

Text messages should not contain any clinical information. All health information is classified as 'special category data' under GDPR, which demands even greater security measures to be in place. This may relate to the type of information being transmitted (e.g. a specific type of appointment, or mention of a condition) but it is also important to consider the potential implications if the information is misused.

The Information Commissioner's Office (ICO) has produced guidance that all health professionals should consider if already using or planning to introduce a text messaging service to patients. Specific advice can be obtained by phoning the ICO advice line on 0303 123 1113.

The starting point for data controllers is to identify a lawful basis under GDPR for the processing of all personal information, as well as a 'special category condition' for health information. Once this is established it should be set out in a privacy notice and publicised within the practice, on the website and on social media pages as appropriate. Any planned use of text messaging to contact patients should be clearly set out in the privacy notice in a "granular" and "meaningful" way. This means setting out the specific purposes for which you intend to contact patients by text messaging and not deviating outside those parameters.

"Text messages are transmitted on public phone networks and are therefore potentially insecure"

As a general rule, it is permissible to relay things like appointment reminders which are specific to individual patients, as well as important changes in service delivery arrangements, such as revised opening times. The ICO has also stated that during the current COVID-19 outbreak it is acceptable to send electronic messages to your patients regarding important public health information and specific practice arrangements being put in place. Such messages will come with no additional legal requirement under GDPR to obtain individual patient consent, but the ICO confirms that doing so would still be regarded as 'good practice' and more aligned to current regulator guidance from the GDC.

COMMON QUESTIONS

Is it acceptable for a dental practice to send 'appointment reminders' via text or email the day before a scheduled appointment? Yes — such a message is patient specific. This also extends to sending a reminder that a six-monthly check up is due, as it relates to an individual's dental health and treatment.

Can 'service update' messages be texted to all our patients? Messages such as "the practice will be closed for training next Tuesday afternoon" would be viewed as permissible. The intention is to inform patients about important service changes to prevent inconvenience and maintain the smooth operation of the service. Such texts can be especially useful and important in the current COVID-19 pandemic. Specific patient consent is not required but the ICO advises that a descriptor of such types of communication should also be included in your privacy notice.

What about marketing to patients? Direct marketing is defined as the "promotion of a service, whether for profit or not" and under GDPR and the Privacy and Electronic Communications Act would require explicit opt-in consent from each patient to receive such messages. An example of direct marketing would be a dental practice texting all registered patients about a "half-price teeth whitening offer during January". Another example would be a text/email message informing patients that a new dentist with a special interest in implant surgery is now available for appointments at the practice, as this would likely fall under the direct marketing criteria as promotion of a specific for-profit service to a large audience. Such a message could be relayed on the practice website.

ACTIONS

- Carefully consider the message content. Protecting confidentiality is foremost when communicating with patients.
- Provision of a patient's mobile number does not provide the practice with open-ended consent.
- Communicate intentions and purposes for sending texts and other forms of electronic messaging to patients via your privacy notice.
- Consider the purpose of your messaging on an individual basis. Could it be construed as direct marketing? Always seek explicit consent for this type of activity.

THIS TOO SHALL PASS

Alun K Rees BDS
Dental Business Coach

THE phrase "This too shall pass" has been attributed to many poets and seers, it occurs in Jewish folklore and was notably used by Abraham Lincoln in a speech before becoming US president.

At some point the lockdown will finish, and dentists and their teams will resume practice and put these months of 2020 behind them. There is a current debate about business protection and what format dentistry will be allowed to take but I want to put that to one side and explore how best to manage patients and their needs, wants and expectations.

Hopefully during the down time, practices will have kept in touch with patients via email and social media to update and reassure them. Telephone triaging has helped to comfort many who might have panicked and has also helped to show practices and the profession in a good light.

Never waste a crisis. This restart is an opportunity but not without challenges. Patients have endured and continue to endure insecurity and worry about their present and future.

My advice is to ensure that before you see a single patient, everyone on the team is clear on how they will behave, what they will say, and above all that they will focus on their listening skills. Take the opportunity to get every team member together to anticipate the problems and how you will deal with them. I predict that for the first three months after the lockdown it will feel as if your feet do not touch the floor and there will be a drift towards chaos unless plans are made. During this period, morning huddles, regular staff meetings and conversations are vital no matter how busy everyone becomes. Communication will be absolutely vital, both with our patients and with each other.

Prioritising patients — this is where our knowledge and understanding of patients comes to the fore. It is a fact of life that sometimes those who shout loudest get most attention. We have all seen the stoical patient with an irreversible pulpitis who didn't like to make a fuss, make way for someone more "persuasive" with a chipped anterior composite. This would be a good time to have one experienced team member dedicated to answering and filtering incoming calls. They can take personal details and a history to assess and appoint the patient, or if necessary promise to return the call at a set time. If required, dentists will need to speak to the patient on the phone or even via one of the face-to-face media with which we are all now familiar. It is vital that you keep your promises and do not drop the baton.

The ongoing frustrations and stress of the COVID-19 pandemic may now lead to patients being less tolerant and more prepared to complain about any element of care.

For some, priorities may have changed. Patients who were mid-treatment before the crisis will want to continue without further delay. Some will face financial problems and may want to put treatment on hold until their finances improve. Others may have had a change in perspective and what was important in January will appear less so in July. It is important that we exercise empathy and respect our patients' wishes.

All dental businesses and individuals will have been damaged financially during the months of shutdown and will be keen to improve cashflow. Now is the time to encourage patients to pay at the start of treatment or to stage payments so that income can improve in the short term. This will require sensitivity, the right language and good antennae to sense if your patient has similar money worries. If that is the case, ensure that there are opportunities for them to spread cost or even to defer treatment. It has to be a win/win or there is a risk of losing the patient forever.

Time management is both an art and a science that balances patient demand and expectations, income and pressure on the clinician. Post-lockdown the ability to be agile and flexible will be essential by incorporating "rocks, stones and sand" into your schedule. Rocks are longer appointments, for example root canal treatments or multiple tooth treatment. Stones are appointments for "medium" restorations or extractions, whilst sand describes recall examinations, reviews and brief assessments. Many practices allow their book to "just happen"; some still use the mantra "fill the book". This is a time to take control and not let the diary tail wag the dental dog.

In the coming months it will be essential to show flexibility. That will mean reserving more time every day for emergencies and assessments, plus being able to open up longer visits a couple of days ahead. Extended opening hours where appropriate will help catch up on longer treatments, deal with demand and provide much needed income.

Communication and clarity will lead to control.

Alun K Rees is an experienced dental practice owner who works as a coach, consultant, troubleshooter, analyst, speaker, writer and broadcaster. Find out more at www.dentalbusinesscoach.co.uk

SEA CHANGE

Is your practice truly learning from adverse incidents? MDDUS senior risk adviser Liz Price offers some reflections on SEA

SIGNIFICANT event analysis (SEA) is now (hopefully) embedded as an ongoing process which supports complaints handling and acts as a collective learning exercise within the dental practice environment. But when was the last time that you took stock of how much value your practice is getting out of the process?

Many of the SEAs we see at MDDUS in our role assisting members with potential dento-legal and medico-legal cases are more of a description than analysis. A lack of analytical rigour in SEAs, if routine, can lead to poor engagement in the process with much less learning and a reduced impact on patient safety. If your practice is sleepwalking through SEAs, consideration of the following can help.

HOW ARE EVENTS TARGETED FOR ANALYSIS?

Factors at play here include the use and effectiveness of your incident reporting processes. Does the team understand what to report? Are low level incidents, near misses and 'good catches' being collected as well as significant incidents for thematic review? There is some evidence that unless there is a significant proportion of these incidents, it may be that your processes are not sensitive enough.

Among additional benefits in capturing lower level but repetitive incidents is the identification of training needs, system reviews, and also a reduction in unnecessary follow-up activities. Practices should also consider who captures and reports incidents. Are the same people putting forward the same events for discussion or do SEAs cover the full range of activities undertaken by the practice? Does your organisational culture support reporting? Staff who feel unsupported are much less likely to report an incident in which they were involved.

It can be helpful to nominate a member of the team to review all reported incidents on a regular basis in order to identify any themes. Particular systems or protocols associated with lower level incidents can then be targeted for analysis, and solutions presented for a sense-check at team meetings. Highlighting efficiencies and safer protocols adopted as a result of such reporting can encourage future engagement. Reviewing the ease of reporting is also important: achieving a balance between simplicity and gathering sufficient data is crucial. Depending on the complexity of the event, further factual information may need to be gathered, particularly when more in depth analysis is required.

WHO DO YOU INCLUDE IN THE PROCESS?

Some clinical incidents may be too sensitive for discussion in a wider team setting, but should an SEA involve non-clinical systems it is essential that a suitable member of the non-clinical team is involved to ensure that any changes are sensible and do not create additional risks. Alternatively, clinical SEAs or non-clinical SEA outcomes can be shared with the wider team at regular practice meetings. Either way it is important to ensure changes are properly communicated, understood (and embraced) by the wider team.

Routine SEA meetings involving the full team should include a range of topics or potential risks (errors) over a set period of time (e.g. a year cycle). This will ensure that no one feels left out or unengaged in the process. In some dental surgeries this can be part of regular practice meetings.

HOW IS THE SEA MEETING STRUCTURED?

Many practices use similar styled templates for structuring conversation and analysis around significant events.

Questions could include:

- What happened?
- Why?
- How could things have been different?
- What can we learn from what happened?
- Is change required, if so, what?
- How will we implement this change?
- How will change be monitored?

An open and inclusive learning culture with a positive team dynamic is a major factor in the success of such meetings. It's also useful to collect as much relevant information as possible beforehand in order to maximise the quality of discussion. This could include more detailed written statements, copies of current policies or other records, as appropriate.

IS THE MOST COMPREHENSIVE LEARNING EXTRACTED?

Often only superficial learning and training opportunities are identified through the SEA process. What went wrong may be put down simply to: "the process or protocol wasn't followed" or "the person should have asked for advice from a colleague at the time of the incident". Subsequent learning is then noted as: "the protocol should be followed in these circumstances" or "in future a dentist should be asked to speak to the patient if they present in this way". Such conclusions may be true but unless "why" questions are asked many incidents are more likely to reoccur.

This is because in most scenarios there will be other underlying factors that contributed to the adverse incident. Such factors usually range across:

- People — the specifics of the patient or the team member involved.
- Activities — the task(s) or process being engaged in at the time.
- Environment — the setting or situation within which the incident occurred.

Asking "why" multiple times will help draw each strand of an investigation to its natural start point. Indeed there is evidence that asking "why" five times is the optimal strategy to achieve deeper learning and a root cause.

Exploring the contributory factors more fully could lead to findings such as: "the protocol was not followed because the individual was under too much pressure" or "the dentist was not consulted for advice because the receptionist was aware that they were over-booked and running late, and didn't like to approach them". In the latter example, asking why is likely to identify potential system issues relating to bookings, as well as whether the receptionist needs support to be

more assertive, whether there should be an agreed protocol for interruptions, or whether the dentist needs to adjust their response to interruptions.

Identifying such underlying issues can often be uncomfortable and challenging to resolve. They may relate to deficiencies within practice management/leadership, practice protocols, or issues created by stress/overload. Such factors will increase the risk of future incidents if not recognised and resolved.

ARE OUTCOMES BEING MAXIMISED?

To ensure that any lessons learned from incidents are cascaded properly, the practice should agree a mechanism by which staff not directly involved in an SEA still receive an update. Any amendments to protocols or practice systems should include clear information about the efficiency, effectiveness or patient safety gain from the proposed change, as this is likely to encourage compliance.

Sometimes, research or audit is required to assess the extent of any issues identified, or further training will be necessary to support improved practice. It is important to agree a timescale within which this should be completed, and an individual should be appointed to make sure it happens and is reported back. At the end of the review, an anonymised written record of the analysis, including insights gained, lessons learned and actions agreed should be completed and retained securely.

There are obvious benefits to gaining insights and learning from events. If there is a patient complaint, and there is learning from that complaint, it is very powerful to share that learning with the patient as part of the complaint response. Learning from events can also be used by dentists and other dental care professionals as evidence of reflective practice.

Should you need assistance in reviewing your incident reporting system, members can access our incident reporting checklist in the training and CPD pages at **mddus.com**. Getting this right will set your efforts off in the right direction.

Liz Price is senior risk adviser at MDDUS

DEFYING GRAVIT

MDDUS dental adviser Sarah Harford discusses the perils of ingested or inhaled objects during dental treatment

A CALL received with increasing frequency at MDDUS — albeit in more normal times — is the panicked dentist reporting that one of their patients has "swallowed" a dental instrument or restoration. Examples of such foreign objects can include a post crown, a Maryland bridge, an implant screwdriver, an implant healing cap, an endodontic file, a scaler tip, a diamond or steel bur, a denture, an extracted tooth or a Monoject syringe tip. The possibilities seem endless.

Dentists will often say: "They didn't cough so I assume it wasn't inhaled" — and in the majority of cases, the foreign object will have been ingested and can be expected to eventually pass through the gastro-intestinal (GI) tract. However, there are a significant number in which, upon medical assessment, the foreign object is found to have been aspirated (inhaled), even without signs of coughing or choking at the time of the incident.

The most important way to deal with ingested or inhaled instruments is to prevent such incidents happening in the first place by protecting the patient's airway during dental treatment — and this will be considered later in this article. Here we consider more immediate measures.

KEEP CALM

A dental instrument or restoration dropped in a patient's mouth should obviously be swiftly and effectively retrieved. Should the object be ingested or inhaled, it is imperative to stop treatment straight away. Calmly tell the patient what has happened (even though inside you might be panicking) and ask them to cough. If nothing appears and they are not choking (which would need immediate intervention), inform them that medical assessment will be necessary.

Send the patient immediately to the local accident and emergency department with a referral letter, clearly setting out was has happened. A sample or scaled photograph of the object can be attached to the letter so that the medics will know what they are looking for. A medic will decide whether a chest X-ray should be taken. Do not refer a patient directly for an X-ray as this is not something a dentist can determine is needed or report on.

Explain to the patient that in referring them to A&E you have their best interests at heart and want to rule out/avoid any possible complications. Inform them that an A&E visit may involve a significant wait but the patient should still be assessed as soon as possible. Any patient declining to attend A&E after being fully informed of the risks should be briefed on red flag symptoms, and a clinical note of their decision and your advice should be recorded. Follow-up is advised with such patients to further encourage them to attend A&E, and if they still decline, offer to liaise directly with their GP (with patient consent).

Once the patient has attended A&E, it can be helpful to request (with their consent) a copy of the hospital discharge sheet for your records in order to provide confirmation of the outcome. Being informed that an object was ingested, rather than inhaled, may offer some relief but the patient should still be monitored until it has passed through the GI tract. Concern that the foreign object has not been passed may necessitate further medical intervention.

Should the object be identified on a chest X-ray as having been inhaled, the patient will likely require bronchoscopy or, in the worst-case scenario, surgery. Again, in these circumstances, it is wise to keep in touch with the patient or family to check on progress.

SAYING SORRY

Incidents like this will be stressful for all concerned and saying sorry is important. An apology is not an admission of liability but expresses an understanding of how the patient might feel about having to spend several hours in A&E. Goodwill can go a long way.

Some patients may take the view that "accidents do happen", but others might be rather more disgruntled. It may seem counterintuitive, but if a patient is expressing concerns, it is better to tell them about the practice in-house complaints procedure rather than risk them complaining directly to an external organisation.

Seek immediate advice and assistance from MDDUS when an incident occurs or if a complaint or legal claim is received. In cases where there is no clear evidence of the airway having been protected during treatment and with resulting harm (i.e. requiring bronchoscopy or surgery), a claim for compensation is likely to be successful.

Consider completing a significant event analysis (SEA) in order to explore what happened, how it happened and how it might be prevented from happening again (see p. 8 of this issue). This will demonstrate insight and a proactive approach to future risk, both to the patient and in any possible escalation of the matter. It is important that the SEA is anonymous (i.e. not stating the patient's name and only describing the incident) and that it is recorded in the practice incident file and not in the patient's clinical records.

CASE EXAMPLES

- Root canal treatment at LR4 with no rubber dam in situ. An endodontic file disappeared down the throat. The patient was asked to cough, nothing appeared, and they seemed well. The patient was advised to visit A&E and a chest X-ray revealed the endodontic file in the right lung. Rigid bronchoscopy was unsuccessful and the patient required open surgery to remove the foreign body from the lung. A legal claim was received.

- Implant screwdriver without floss attached, used to tighten component. The instrument was dropped and went down throat. There was no coughing or reaction from patient. The dentist referred the patient to A&E with a letter and sample of instrument. The chest X-ray revealed a foreign object in tracheobronchial tree. Bronchoscopy was planned, but the patient miraculously coughed up the foreign object prior to the procedure. A complaint from the patient was received highlighting the stress and anxiety caused.

Aspiration or ingestion of a foreign body requiring medical intervention, such as a surgical procedure, will almost certainly be considered an "unexpected or unintended incident" involving harm to a patient and, as such, will trigger the statutory duty of candour procedure for the practice (details for each jurisdiction can be found at **tinyurl.com/ydyqsnke**). In England, if there is a "retained foreign object post procedure" it will be classed as a 'never event', requiring CQC notification.

PREVENTION BETTER THAN CURE

Rather than having to deal with the fall-out of an ingested or inhaled object, it is obviously far better to avoid such incidents happening in the first place. We all know not to lie down when eating to avoid the risk of choking, and yet as dentists we usually treat our patients in the supine position, producing water and debris from drilling with our handpieces and precariously dangling dental materials, restorations, instruments and components over the black hole of every patient's airway.

In these circumstances, high vacuum suction is obviously essential and a rubber dam, (pictured right) can thankfully provide the safety net we require, but on other occasions we should still consider how to protect patients and ourselves. For example, tying floss around fiddly implant instruments, using a throat gauze screen in addition to high-vacuum suction when cementing that slippery post crown, using a parachute chain or a throat sponge. It is important to record in the clinical notes what precautions have been taken, and it is essential to regularly service equipment such as handpieces and scalers to ensure that they are latching securely onto burs and tips.

"Some patients may take the view that 'accidents do happen', but others might be rather more disgruntled"

Can we defy gravity? No. So we must take steps to protect every patient's airway during dental treatment.

Sarah Harford is a dental adviser at MDDUS

DEALING WITH RACIST ABUSE

Kay Louise Grant
Risk adviser at MDDUS

RACIST abuse directed at dental staff by patients remains a serious problem. Dentists and dental teams take great care to ensure that patients are treated fairly. That makes it all the more painful when they are on the receiving end of such abuse.

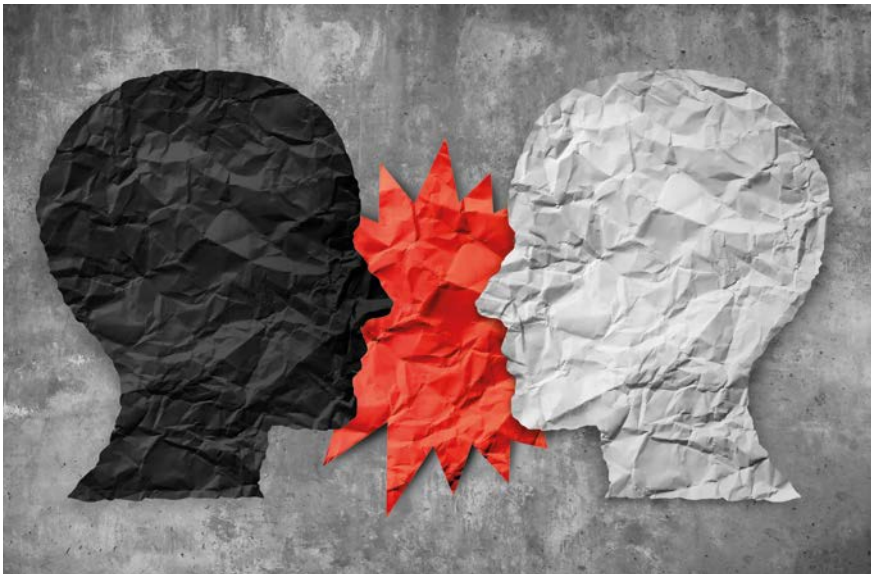
Mainstream media reports regarding racist abuse directed at healthcare professionals tend to focus on NHS staff in general without specifically recognising the similar issues faced by dentists and their teams. A recent ITV report featured a moving interview with senior surgeon Mr Radhakrishna Shanbhag, who has worked in the NHS for more than 20 years. He described how one of the patients on his waiting list requested a "white" doctor carry out his operation, and how this gave him cause to reconsider his position in the NHS.

The report sparked much debate, with some taking the view that adhering to such requests is the easiest solution, despite believing it only rewards bad behaviour. Are you expected to carry on treating a patient despite feeling abused and threatened? Can you refuse to treat such patients? What if there is no alternative dentist available or if it relates to your receptionist and you only have one?

It's important to remember that there are a range of potential appropriate responses, dependent on the specific issue and the context. For example, you may have a patient who appears to be reasonable and non-threatening but still asks for an "English-speaking" or "non-foreign" dentist. Such a request may not require an immediate reaction from you and perhaps finding an opportunity to highlight how the patient's behaviour is inappropriate will be enough to make them think again.

Any formal steps taken to warn a patient in regard to such comments should be communicated by letter. Should such behaviour persist you can then escalate matters and potentially refuse treatment.

Situations where a patient is demonstrating clear abusive and threatening racist language or behaviour should not be tolerated. Such behaviour may understandably result in a breakdown of trust between you and the patient, therefore compromising your professional relationship with them. Our advice would always be to keep yourself safe — and if at any point you feel threatened take appropriate steps. In extreme circumstances, this may even include calling for police assistance.



"Your organisation or practice should have a policy in place which sets out its expectations of patient behaviour towards staff"

The GDC's *Standards for the dental team* offers guidance on ending your professional relationship with a patient (paragraph 1.7.8).

It states: "Before you end a professional relationship with a patient, you must be satisfied that your decision is fair and you must be able to justify your decision. You should write to the patient to tell them your decision and your reasons for it. You should take steps to ensure that arrangements are made promptly for the continuing care of the patient."

In delivering care, where any delay could result in undue harm to a patient, MDDUS advises that you prioritise urgent care needs first before taking any action.

Your organisation or practice should have a policy in place which sets out its expectations of patient behaviour towards staff. It should highlight that any kind of racial abuse towards staff is unacceptable, and within this policy there should be clear guidance on how these situations will be handled. Employers are required, under the Equality Act 2010, to protect their staff from discrimination relating to age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

ACTION POINTS

- Avoid reacting out of anger or upset and take time to assess the situation before taking action.
- Consider whether a warning to the patient would be deemed enough to deter them from further abusive behaviour.
- Should you or a colleague feel threatened, you may need to take immediate action, such as phoning the police and having the patient (or family member/carer) removed from the premises.
- For employers, ensure you are complying with the Equality Act 2010 and have clear policies and procedures in place that protect your staff from abuse of any kind.

PERFORATED TOOTH

DAY ONE
Mr G makes an emergency appointment at his dental surgery complaining of severe pain on chewing at LR4. His regular dentist is on holiday so the patient is examined by Dr B. The tooth is tender to percussion with no response to cold, and the adjacent buccal mucosa is painful on palpation. A periapical radiograph reveals clear radiolucency surrounding the root apex and this along with the clinical signs suggest a diagnosis of necrotic pulp with symptomatic periodontitis. Treatment options are discussed, including extraction or root canal treatment (RCT). Mr G opts for private RCT.

DAY TWO
The patient returns the next day for a pulp extirpation under local anaesthesia. Dr B removes the existing restoration and during the subsequent procedure notes excessive bleeding but attributes this to hyperaemic pulp tissue. A temporary dressing is applied and the patient is advised to attend his regular dentist for the remaining treatment.

DAY 17
Mr G attends Dr T, who has returned from holiday. He examines the tooth and notes a small perforation at the gingival margin. Subsequent attempts to complete the RCT reveals bleeding at the base of the access cavity with a communication to the periodontal ligament and surrounding bone. The patient is informed and a referral is made to a specialist endodontist. On the basis of MDDUS advice, the practice provides a written apology to Mr G with an offer to meet all reasonable costs associated with the repair and restoration of LR4.

ONE MONTH LATER
Mr G attends a specialist endodontist who undertakes a periapical radiograph revealing a significant perforation in the mesial aspect of LR4. Remedial treatment is undertaken but he notes the need for further complex care to ensure the long-term viability of the tooth.

Mr G is unhappy and raises a complaint with the GDC over the "poor" standard of treatment provided by Dr B. He also claims to have not been made aware of the relevant risks and potential complications prior to RCT; nor did the dentist inform him of the significant bleeding during the procedure.

The GDC sends a letter to Dr B informing her of the complaint and requesting employment details, proof of indemnity and copies of the patient records. She is further informed that an assessment will be undertaken by a clinical adviser to determine whether any action is required in regard to her fitness to practise.

Dr B contacts MDDUS and an adviser writes to her offering reassurance and a reminder to notify her local health board of the matter. The dentist is also encouraged in the meantime to consider undertaking CPD relevant to the case in the event that the GDC should decide to instigate an investigation.

Five weeks later Dr B is informed by the GDC that the information relating to the complaint does not amount to an allegation of impaired fitness to practise – but that some aspects the care provided did fall below a "level reasonably expected" in some aspects.

In a report on the case, the GDC clinical adviser states that, given Mr G's claim to have not been told of the treatment risks, it is possible that he did not have sufficient information to make an informed decision. The adviser is also critical of Dr B's failure to use dental dam isolation and of the standard of the access canal at LR4 – but there is no criticism in regard to the easily missed diagnosis of tooth perforation, even with excessive bleeding.

The GDC later writes to the practice principal and the health board informing them that no further action will be taken in the matter.

KEY POINTS
- Check that patients understand material risks in procedures to ensure informed consent.
- Record risks discussed and ensure these are noted in a signed treatment plan.
- Use dental dam when clinically indicated.

ETHICS

IT'S THE SMALL THINGS

Deborah Bowman
Professor of Bioethics, Clinical Ethics and Medical Law at St George's, University of London

WHEN I first became interested in medical ethics, it was an issues-led field that was predominantly concerned with 'big questions'. The relatively few books that existed had titles such as *Matters of Life and Death*. There were no syllabi nor any agreed curriculum content, but the lectures I attended were commonly concerned with a triad of abortion, euthanasia and reproductive ethics. These are, of course, important. Yet, early on, I became interested in the intersection of ethics and the small things. For example, those precious initial moments in an encounter that set the tone and allow for trust, dignity and humanity to flourish, how we adapt in pressured environments to queries or interruptions, how constructively we can disagree and the tone of our communication with others. I wrote a lot about the "ethics of the everyday", largely absent from curricula and textbooks, but integral to healthcare.

I have been thinking a lot about the small things and the big challenges that they can present for staff and patients. A few weeks ago, I received a letter from 'the NHS'. It advised that an appointment had been booked across the road from my office for breast screening. The letter explained why this appointment was valuable, talking about age, risk, early detection and improved prognosis.

As some readers will know, this letter was received by a woman who no longer has breasts and, so far, has received two and a half years of treatment for breast cancer. I was, in a response that is increasingly familiar when I think about illness, both rational and emotional. I appreciated that it was an automated letter and no one's fault or responsibility. I understood that for many, the letter would be welcome and the ease of a pre-booked appointment appreciated. In a complex and resource-constrained system, it isn't efficient or perhaps even possible, to identify those who might be considered exceptions.

Yet, I was also upset. The letter was a stark plunge into dark places. Its unexpected arrival was an unavoidable reminder that I was relatively young when diagnosed, that I had late stage disease with a poorer prognosis, that I was physically different from most women, that I was frightened about the future, that I felt ashamed about perhaps having 'missed something' before I was diagnosed and that maybe I should have been more alert to avoid being in this position in the first place.

"The letter was an unavoidable small thing; a consequence of the complexities and challenges of running a national screening system"

I knew enough not to do anything immediately but to sit and process my response; to attend both to the rational and to the emotional. After a few days, I began to wonder about the member of staff who would take my call when I rang to explain that I would not be attending the appointment. He or she would have no idea about my circumstances, or that I have deliberately avoided having any clinical care at my own hospital. Rather, I'd encounter someone likely to be working in a pressured environment and juggling myriad demands.

I wanted to explain why I wasn't coming, but I knew I needed to do it in a way that was calm, factual and kind. I understood that the person I contacted was not responsible for, or even aware of, my personal response. I rehearsed the conversation. I debated whether to go over to the Breast Centre and speak to them in person whilst at work, or whether it was better to make a telephone call from home. The task hung over me and I was apprehensive when I passed the unit as I walked through the hospital. I knew though that this 'small thing' was no one's fault and I had to acknowledge that truth in my response.

Eventually, I rang the unit. It was not the conversation for which I hoped. I was reminded by the staff member that screening slots are precious and, although it was a fortnight until the pre-booked appointment, asked why I had waited a few days to get in touch. I was asked twice if I was "sure" even as I explained that I have had a radical bilateral mastectomy. No one knew whom I should contact to avoid being invited to future screening in the hope that I could save the NHS time and resource by preventing further letters and pre-booked appointments.

When I put down the phone, I reflected on "the small things". The letter was probably an unavoidable small thing; a consequence of the complexities and challenges of running a national screening system. However, the response of another person to my call was a small thing that could have been different. The conversation, imbued with officiousness, irritation and misunderstanding, reflected ethical choices. It could have made all the difference. There was nothing "small" about it.

Addenda

PHOTOGRAPH: BDA MUSEUM

FROM THE MUSEUM

Morrison dental chair

James Beall Morrison, an American dentist working in Europe, filed a British patent for this innovative cast iron dental chair in 1867. It was the first chair to allow dentists to work from either a sitting or standing position and incorporated a compensating backrest and arms that could be dropped out of the way to allow greater access. Morrison went on to design the first commercially manufactured foot drill but it was the chair that made his fortune.

BOOK CHOICE

The Body: A Guide for Occupants. By Bill Bryson

Oneworld Publications, paperback, £9.99, 2019
Review by Dr Greg Dollman, medical adviser, MDDUS

I MUST admit I was a little sceptical at first. How could anyone, even Bill Bryson, keep me engrossed throughout nearly 400 pages of a lay description of the human body? There are only so many "we blink fourteen thousand times a day" and "the body makes millions of red cells every few seconds, and discards one billion every day" facts that I could appreciate. I was wrong. Within the first few pages, Bryson describes the human body as "a warm wobble of flesh" and I was hooked.

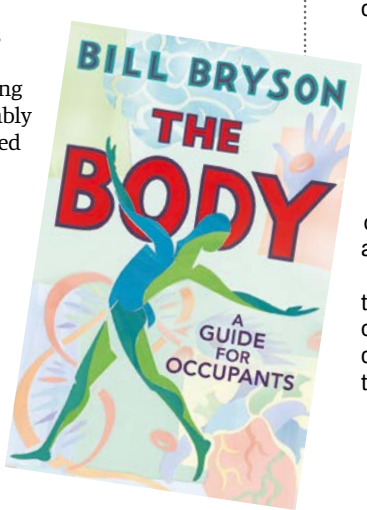
The chapters whistle-stop their way through the anatomy and physiology of the body, reminding us how we come to be, what makes us who we are and how we live — marvelling at what 'goes right' and considering what can go wrong.

Bryson's descriptions are witty and astute: he observes that, considering the nature of the skin's stratum corneum, "all that makes you lovely is deceased", and explains how we are infected with viruses and colds on being "exposed to others' leakages and exhalations".

The Body surely contains something for everyone. There are the bizarre facts (Bryson notes the difference in bowel transit times between men and women), the 'pub quiz' facts (the record for staying awake is 11 days, 24 minutes), the history lessons (pioneers of medicine along with the 'firsts'), refresher courses on immunology, microbiology, nutrition (you name it, it's mentioned) and of course the references (over 40 pages of them).

I anticipate that experts will note factual inaccuracies, unsurprisingly given the volume and detail within the book. Remarkably, however, Bryson provides considerable facts and figures, in a very entertaining format, for a non-medical audience.

The Body provides a comprehensive account of something that I know reasonably well and yet managed to keep me turning the pages — and smiling while I did (contracting the orbicularis oculi muscle in each eye to make them sparkle, as Bryson tells us).



FILM

Dark Waters

Directed by Todd Haynes, UK 2020. Starring Mark Ruffalo, Anne Hathaway

A SHOCKING true story of corporate greed wreaking untold environmental damage is at the heart of this legal thriller. Ruffalo stars as real-life corporate defence attorney Rob Bilott, who went from advising businesses on how to pollute legally to suing one of the world's largest chemical companies, DuPont, for dumping toxic sludge into a small town river.

Ruffalo puts in one of his best performances yet as the determined lawyer who responds to a plea for help from a West Virginia farmer whose cows have been dying in mysterious circumstances.

At great personal cost, Bilott doggedly investigates DuPont and uncovers a corporate cover-up that is breathtaking in its disregard for the environment and the health of the town's people and animals.

This is a story that deserves to be widely told and, while it is often intense and infuriating, director Todd Haynes never lets the story drag.

COVID-19 WEBINARS – ONLINE NOW!

Learn how to manage key risks for dental practices weathering the coronavirus outbreak by accessing webinars from the MDDUS Training & CPD team.

Exclusively for members, all our webinars are available to access both as live events and pre-recorded resources that can be watched at a time and place to suit you.

Hot topics for 2020 include:

• COVID-19 – Dentolegal essentials: 40 min, accessible on demand. MDDUS head of dental division, Aubrey Craig provides (and signposts) advice to dentists at this challenging time and highlights the most common requests for advice

• COVID-19 – Stress and wellbeing: 45 min, accessible on demand. Risk adviser Alan Frame explores the increased stress and resulting feelings of anxiety compounded by the enduring effects of lockdown measures.

Check out the webinars page under the Training & CPD section of our website to find other pre-recorded and future webinars. Or email **risk@mddus.com** for more announcements on topics such as complaints handling, confidentiality and managing social media risks.

Follow us on Twitter **@MDDUSNews**

MDDUS

UK INDEMNITY, ADVICE & SUPPORT