



DON'T FALL INTO THE TRAP

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KEY LESSONS

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PICK IT, LICK IT, STICK IT

AN MDDUS
PUBLICATION





Welcome to your SoundBite

THE issue of chairside assistance is a common theme in MDDUS dental advice calls. Who can provide appropriate chairside assistance and is it always necessary? Make sure you don't fall foul of General Dental Council rules by reading my advice on [page 4](#).

It is unusual for higher courts to hear claims arising out of professional negligence, particularly those of relevance to dental practice. On [page 10](#), MDDUS dental adviser Stephen Henderson highlights key learning points from two recent high-profile cases.

Treatment coordinators are becoming an increasingly valuable part of the dental team, but they must work within limits. Alun Rees explains on [page 6](#). Maintaining good relationships with dental colleagues is key to a successful work life. Dentist Laura McCormick offers advice on [page 5](#).

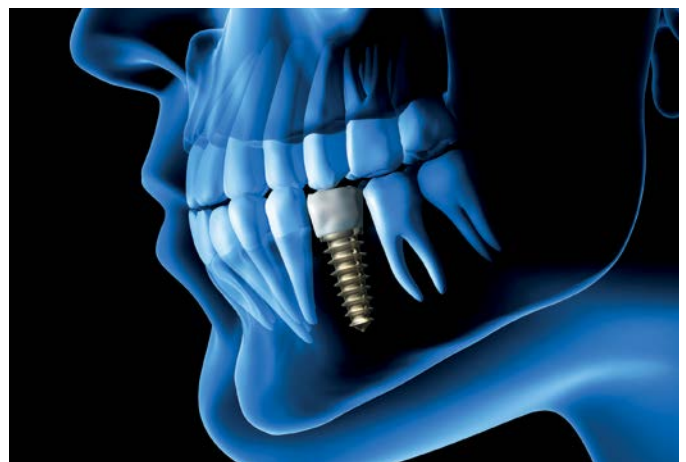
Do you know how long to hold onto dental records and

study models? Risk adviser Alan Frame has practical advice on [page 7](#).

Practitioners often struggle with periodontics in general practice, but on [page 8](#) restorative dentistry specialist Dr Madeleine Murray explores common risk areas when managing patients with periodontitis. We stick with this theme in our case study on [page 14](#) which explores an allegation of clinical negligence and failure to diagnose and treat periodontal disease.

With her catchy slogan "Pick it, lick it, stick it", restorative dentist Dr Serpil Djemal is helping to change the way UK clinicians deal with dental trauma. Read all about her innovative campaign to save teeth and rebuild smiles in our feature on [page 12](#).

• **Doug Hamilton**
Editor



ESSENTIAL GUIDE FOR IMPLANT DENTISTS

DENTISTS who carry out implant work can benefit from a new guide which offers practical advice on the latest developments in the field.

Key points for clinical practice answers a broad range of questions across four main topic areas in implant dentistry. These are: drugs and diseases; biological parameters; reconstructions; and biomechanical aspects.

The report was written by a group of dentists who attended the European Association for Osseointegration (EAO) 2018 Consensus Conference and observed expert discussions on emerging techniques and hot topics in the field.

It provides a clear summary of the experts' findings and gives readers key facts to include in their clinical practice.

The guide is written in a helpful question-and-answer format and is available in nine languages. Access at: www.eao.org/mpage/kpfcp

REPORT HIGHLIGHTS SIGNIFICANT UNAWARENESS OF ORAL CANCER

MORE than 8,300 new cases of oral cancer are now diagnosed in UK adults each year, representing a 49 per cent increase over the last decade, according to a new report by the Oral Health Foundation.

The UK's first *State of Mouth Cancer* report highlights that less than half of UK adults can identify common potential warning signs including long-lasting mouth ulcers (42 per cent), red or white patches (31 per cent) and unusual lumps (47 per cent).

There is also uncertainty about where mouth cancer appears, while more than four in five adults (82 per cent) are unsure how to check for mouth cancer.

Sixty per cent of smokers and almost 90 per cent of those who drink more than 20 units of alcohol a week cannot identify the symptoms of mouth cancer. Men are around 25 per cent less likely to know symptoms associated with mouth cancer compared to women, while a large proportion of over-65s (85 per cent) also do not know what to look for.

Chief Executive of the Oral Health Foundation, Dr Nigel Carter OBE, said: "For so long, mouth

cancer seems to have gone under the

radar. It is now time for us to take notice and learn what we need to, so that we can help protect ourselves and others around us."



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REDUCTION IN ANTIBIOTIC PRESCRIBING BY DENTISTS

DENTAL practices in England dispensed nearly a quarter fewer prescriptions for antibiotics in 2017 compared to 2013, according to figures published by the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR).

Antibiotic prescribing in primary care settings overall fell by 13 per cent over the period, with a 24 per cent drop in dental prescribing. Dental practice contributed to eight per cent of antibiotic prescription items in primary care in 2017.

The need to preserve the potency of existing antibiotics was underlined recently in a report by MPs which estimated that antimicrobial resistance (AMR) could kill up to 10 million people per year by 2050.

The reduction in antibiotic prescribing has been applauded by the BDA, but President Susie Sanderson added: "There is a whole range of fronts where we still need to secure progress to avoid inappropriate use of antibiotics in dentistry. Properly funded emergency treatment slots, and removing the pressures that push dental patients to GPs, are key to bringing down antibiotic prescribing."

DENTISTS 'SHOULD BE PROUD' OF INSPECTION IMPROVEMENTS

IMPROVEMENTS in dental practices inspected by the Care Quality Commission "should make the profession proud", the Faculty of General Dental Practitioners (FGDP UK) has said.

The CQC's latest annual *State of Care* review shows that of over 1,300 practices inspected last year, the proportion requiring enforcement action dropped from two per cent to one per cent. The number needing improvement in specific areas ('requirement action') fell from 10 per cent to nine per cent, and the percentage meeting the required standards in all five key areas assessed rose from 88 to 90 per cent.

Ninety-two per cent of practices re-inspected after being given

requirement actions were found to have addressed the identified concerns, as had 80 per cent of those re-inspected following enforcement action.

All practices were again judged to be responsive and caring and 99 per cent considered effective, while the number deemed to require action on safe care dropped from four to two per cent. Practice leadership was highlighted as one area requiring improvement.

FGDP UK dean Ian Mills said dentists should be "extremely proud of the consistency with which they provide high quality care to their patients."

He added: "Focusing on leadership and management

remains the key to our profession making further improvements, and the value of practice managers is once again highlighted in this regard."



SERIOUS DENTAL DECAY IN CHILDREN MAY INDICATE NEGLECT

DENTAL decay requiring hospital care could be a sign that a child is suffering neglect, according to a study published in the *BDJ*.

Researchers from King's College, London conducted an audit of under-16s who were admitted for oral and maxillofacial surgery for incision and drainage of a dental/facial abscess under general anaesthesia between January 2015 and January 2017.

Among 27 children included in the study, 11 were known to social services (SS). Five patients out of the 27 were discussed with a trust safeguarding team member during their hospital stay and of these five, one new SS referral was made and three cases were re-referred due to new safeguarding concerns.

On average 3.2 teeth were extracted with an average hospital stay of 2.5 days.

The researchers said: "Where parents or carers repeatedly fail to access dental treatment for a child's tooth decay or leave dental tooth pain untreated, 'alarm bells' should ring for clinicians to consider neglect."

They recommended that all children admitted with dental/maxillofacial space infections, where dental neglect may be present, should be discussed with the local safeguarding team.

Source: *BDJ*

ANNUAL GDC RENEWAL REMINDER

DENTISTS are reminded they must have renewed their GDC registration by 31 December or they will be removed from the register and not allowed to practise.

To renew GDC registration, dentists will need to:

- pay the annual renewal fee (ARF)

- make an annual, or end-of-cycle, CPD statement
- declare that they have or will have indemnity.

The quickest way to renew is via eGDC (www.egdc-uk.org). It can also be done by post (forms and payment must have been posted by 18 December) or by calling 0800 197 4610.

This year, all dentists (except those who joined the register in 2018) will need to make either an annual CPD statement or an end-of-cycle CPD statement. This is a new requirement of the Enhanced CPD scheme, rolled out at the start of 2018. Dentists who have not done any CPD this year will need to make a 'zero-hours' CPD statement. For queries, contact the GDC by phoning 020 7167 6000 or by email at renewal@gdc-uk.org.

CHAIRSIDE QUALIFIED

Who can provide appropriate chairside assistance in practice?
Dental adviser **Doug Hamilton** has the answers

WE ARE reviewing our practice policy on the provision of chairside assistance and are unsure whether it complies with the General Dental Council's (GDC) requirements. I am a dental therapist and ordinarily a nurse is not assigned to assist me. However, there is generally a dentist and dental nurse working in the neighbouring surgery, except on Saturdays when the only other staff member is a receptionist. Is this an acceptable arrangement?

This type of query is a common feature of advice calls to MDDUS relating to chairside assistance, particularly from members who are hygienists and therapists. There is undoubtedly a tension between the benefits of working with a nurse and the additional practice costs that this level of cover entails. Unfortunately, the arrangement described above would be unlikely to satisfy the relevant GDC standards.

In the first instance, the GDC standard 6.2.1 states:

You must not provide treatment if you feel that the circumstances make it unsafe for patients.

Attempting procedures without the assistance of a dental nurse may impact upon the safety (not to say efficiency) of treatment delivery. It also increases the risk to the clinician, both in terms of physical safety and complaints of improper conduct. Nevertheless, some practitioners feel content (or compelled) to work alone, perhaps believing that care can still be provided in a manner that is suitably safe and that, as a result, 6.2.1 has not been breached.

However, GDC standard 6.2.2 sets a higher bar:
You should work with

another appropriately trained member of the dental team at all times when treating patients in a dental setting (my emphasis).

Clearly, our dental therapist member is in breach of this standard during the Saturday sessions. However, it may be argued that, by having a dentist and nurse next door, she is "working with" another appropriately trained member of the dental team on weekdays. Unfortunately, the GDC tend to take the most restrictive interpretation of their standards when investigating complaints. So, there can be no guarantees whatsoever that an arrangement involving a therapist routinely working single-handed, but with other members of the team in the building, would be considered satisfactory. This view is supported by the fact that the GDC set down an exhaustive list of exemptions to the main stipulation of 6.2.2, including "exceptional circumstances". These are described as "unavoidable circumstances which are not routine and could not have been foreseen. Absences due to leave or training are not exceptional circumstances".

Therefore, if our member was a victim of circumstances (perhaps her nurse had called in sick) it may be possible to proceed with certain treatments, subject to a suitable risk assessment of each case. Even so, it would still be necessary to observe standard 6.2.6 which states that:

You must make sure that there is at least one other person available within the working environment to deal with medical emergencies when you are treating patients.

Ordinarily, the role of the second, life-support-trained person would be fulfilled by other GDC-registered members of the dental team (often the chairside nurse). However, logic and common sense dictate that this may not apply in unforeseen circumstances (as defined in 6.2.2). Therefore, the GDC accept that:

In exceptional circumstances the second person could be a receptionist or a person accompanying the patient.

Considering all these factors, in this scenario I would advise our member to have chairside assistance at all times. If her dental nurse is, for example, a recently recruited trainee, there must be someone else in the building who can properly assist with medical emergencies.

If it is known in advance that chairside assistance will not be available then the patient should have their appointment rescheduled for a more suitable time. However, if our member is caught out on a one-off basis by, for

example, last-minute staff illness, each patient should be risk assessed. Those with, for example, complex or non-urgent treatment needs should have appointments rescheduled. In other cases, treatment might proceed if this does not put patients at risk. However, in these circumstances, it would need to be established that the receptionist (or some other person) was present at all times and was trained in basic life support.

In short, the GDC's concessions to the vagaries of in-hours staffing are limited and heavily caveated. Strict adherence to the relevant standards is the safest approach, both from the perspective of care delivery and the avoidance of regulatory criticism.

Doug Hamilton is a dental adviser at MDDUS and editor of SoundBite





Maintaining good relationships with colleagues is key to a successful work life. Dentist **Laura McCormick** offers some advice

THE SECRET TO TEAM SUCCESS

EVERY dentist knows that maintaining good professional relationships within their team is key to a positive and productive working environment. Sadly this is not always easy and tensions can occur, especially considering you probably spend more time with your dental nurse than with your significant other.

Communication is crucial: not only with patients but also with colleagues. If you can sense an atmosphere in your surgery then so will your patients and this can negatively impact the care you provide.

Appreciation

You may have seen nothing wrong in the way you asked your nurse to get you the upper left molar forceps when you were presented with the upper right set. To your nurse, however, your manner was abrupt and unappreciative, especially as she was in the middle of developing that radiograph you requested. She feels you haven't appreciated the fact she had set up the surgery for a root treatment that has now become an extraction, and so giving you the wrong forceps was a genuine oversight as she was juggling so many other tasks.

Insufficient recognition and excessive workload can lead to negativity, resentment and ultimately hostility in the workplace. It's easy for this to happen in a busy dental practice when, under pressure, a dentist can take out their frustrations on a colleague. It is important to be mindful that if you are stressed then your workmate probably is too. An apology and an explanation for your behaviour will go some way to getting your relationship back on track. An acknowledgement or thanks in front of your patient shows the patient that their care is a team effort and shows your colleague that you appreciate them.

Confrontation

No one likes confrontation but sometimes difficult conversations with workmates are unavoidable. The key is to remain professional and avoid personal comments. Keep the conversation straightforward and simple and reinforce how your proposed changes in behaviour will improve patient care, after all that's what everyone is striving for. Also aim to address issues within your own surgery yourself before involving the practice owner. This involvement can sometimes be seen as an escalation of events and may make matters worse. Obviously, if steps you have taken have not been successful then it would be wise to involve the practice principal.

Negativity

Within every workplace lurks the life force vampire. This is the person who is just plain negative and loves to moan. We all sometimes need a moan at work but for this person it's a permanent state. This negativity can be contagious and impact on the whole team, so how can it be managed?

The first step is to consider whether they have a legitimate cause for complaint. If not, then do not engage with each and every comment as you do not want to reinforce their negativity or be influenced by it. This is easier said than done if you work closely with this person, e.g. your nurse. If this is the case then the best course of action is to set boundaries and to cut short any conversations which are negative. Stay professional and focus on creating the best environment for your patients.

Getting personal

But what if the relationship with your nurse/colleague is going a little too well? It is not unheard of for people who work closely

together to become romantically involved and MDDUS is certainly aware of cases in which personal relationships have caused problems within a practice.

The impact that this change could have in the surgery must be honestly considered. Can you continue to work together without the two of you flirting or sharing in-jokes which could make the patient feel awkward? Or worse, would you be able to keep any personal disagreements out of the surgery? To continue providing the best possible patient care, it may be appropriate for you to work with a different nurse. Proceed with caution here and also be aware of the potential for accusations of bullying, harassment or abuse of power.

Social survival

While most people enjoy themselves fairly sensibly on a night out, some may be tempted into excessive drinking, drug-taking or other bad behaviour. No one wants to be the subject of practice gossip or to lose the respect of colleagues, so bear this in mind when you are out socialising. Remember also that the General Dental Council takes a dim view of dentists who engage in unprofessional or inappropriate behaviour outside of work. MDDUS has handled many cases where a dentist's fitness to practise has been called into question due to their personal conduct.

Working relationships, like all relationships, can have their ups and downs. By maintaining good communication, behaving professionally and valuing your team there should be more ups than downs: something that will benefit you and most importantly your patients.

Laura McCormick is a dentist and early practitioner adviser at MDDUS

TIME TO TALK

Treatment coordinators can free up vital time for dentists but they must work within limits



THIRTY years ago I opened two “cold-squat” NHS practices and I was determined to differentiate myself from the competition.

I had taken the mantra: “Dentists should only do what only dentists can do” to heart and did my best to stick with the four Ds of time management: do it, delegate it, dump it or defer it.

I was determined to develop the roles of my team members as much as I could. I had visited some practices where the nurses took responsibility for explaining disease processes and methods of control to adults and I was inspired to follow suit.

The biggest problems in most practices seemed to be ones of communication. If patients fully understood their problems and the possible solutions then the relationships could flourish. The key to this was time. Clearly for the dentist, time spent on what only they could do was important but there was no reason why communication could not be delegated.

I decided that everyone should have a role. As part of our weekly 90-minute team meetings we worked on rewriting the words we used to patients from “dental-speak” to clear English. A newly recruited front-desk person with no dental knowledge helped with translation. The advantage was I could ask any of the team to explain to the patient what was involved. This also ensured everyone understood my philosophy of practice and transmitted our unique characteristics and authenticity.

When a full-time hygienist joined the team we could do even more.

Sharing concerns

By using both medical and dental questionnaires as the basis for every new

patient assessment, we encouraged patients to share their dental history, concerns, and thoughts about their dental health and their appearance. These questionnaires were the starting point for a sometimes lengthy conversation where we discovered more about our patients and could offer tailored solutions.

Where did the pre- and post-examination conversations take place? I had started the practice with space for two surgeries: a main operator and a hygienist’s room, plus a separate preventive dental unit. It was important that the room was private (reception was out). If I was to start again I would also have had a large screen to display photographs and radiographs.

Times and names have changed, but the principles have not. Patient or treatment coordinators routinely take on proactive roles with regard to elective treatments for aesthetic reasons and this can only be a good thing. Any communication which expands a patient’s knowledge of dentistry and the treatment choices available to them brings benefits all round.

They are also used for pre-examination conversations where a complimentary visit or telephone call can lay the path for the patient’s full examination. Fears, concerns and hopes are explored ahead of time in order to give the best possible formal examination and most suitable treatment plan.

I have seen the late adopters and laggards resisting the introduction of coordinators in the same way they did 30 or more years ago with hygienists. I have also encountered poorly trained coordinators who are used purely as “sales agents” with their income dependent on commission. In my opinion this is an abuse of the role.

Skills

Treatment coordinators should be great communicators with an enthusiasm for both dentistry and working with people. They need good organisational and system skills with a high follow-through. They must also have a high degree of emotional intelligence and empathy and be able to think on their feet.

Is this something that can work in NHS practice? Yes definitely, especially if you are looking to give patients choices between NHS and private treatments. In purely private practice the level of service should aspire to reach concierge level.

Risks

There are risks in using coordinators. Team members who are registered with the General Dental Council must operate clearly within their competence and training. The dentist can delegate, but must not abdicate, their responsibilities. Bearing in mind the advice following the Montgomery case, written consent must be obtained by the dentist following a full explanation of all risks involved.

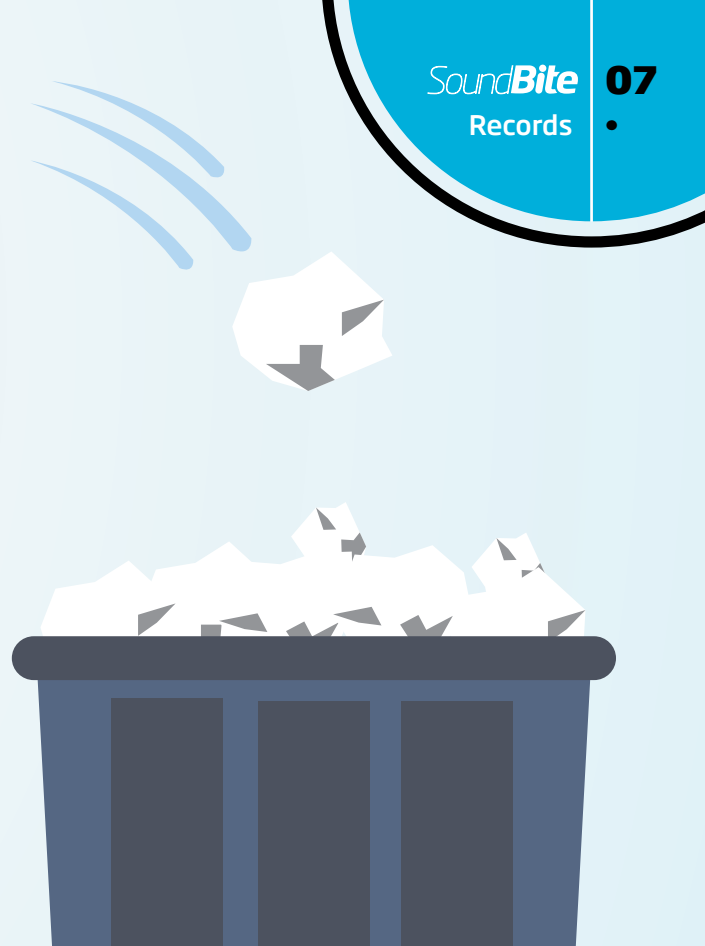
All conversations with the patient by either dentist or coordinator must be recorded and decisions must be clear. Any literature should be unambiguous and should not be purely for marketing or sales purposes.

To conclude, coordinators contribute to the smooth running of the practice by improving communication and providing clarity, by giving patients the time they deserve and by freeing the dentist to do what only they can do.

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who now works as a coach, consultant, troubleshooter, analyst, speaker, writer and broadcaster - www.dentalbusinesscoach.co.uk

KNOWING WHEN TO LET GO

Do you know how long to hold onto dental records and study models? Risk adviser **Alan Frame** explains



WITH hundreds or even thousands of patients on your list, dental practices can quickly become overwhelmed with records, reports, photos and study models. But before you decide to have a mass clear-out, be sure you are not getting rid of anything vital.

As a starting point, it is good practice to have a comprehensive written policy in place relating to record keeping. This should address both the specific legal requirements and also the relevant procedural dimensions set out in the NHS terms of service arrangements.

The applicable NHS regulations require general dental practitioners in England, Wales and Scotland to retain patient treatment records, associated radiographs, photographs and study models for a period of two years (six years in Northern Ireland) following on from the completion of the course of treatment and care under a continuing care/capitation agreement, or treatment on referral, including occasional treatments undertaken.

But from a dento-legal point of view, the Practitioner Services Division in Scotland and the Department of Health and Social Care both advise dentists to retain records for far longer periods, up to a maximum of 30 years.

Self defence

This is important when it comes to managing complaints, negligence claims and potential regulatory investigations by the General Dental Council (GDC). NHS complaints procedures in general allow a patient or their representatives to lodge a complaint up to one year from the incident they are complaining about, or from when they first became aware of it.

Clinical negligence claims allow an action to be notified for a period of three years following the relevant incident or from the date of knowledge of the potential claim; and in the

case of children until their 21st birthday (or up to three years from their date of knowledge). While there is no specific rule on time limits, in practice the GDC is more likely to look at fitness to practise issues arising from treatment provided within the last five years.

The availability of clear, comprehensive treatment records can be invaluable when responding to a claim/action as well as in the preparation of a robust defence to the allegations being made. Concise, comprehensive dental records can and do stop a claim in its tracks. Poor quality or non-existent records mean that a practitioner is left to rely solely on their memory of events and their usual practice, but the court tends to assume that a patient's recollection is more likely to be accurate when deciding any conflicts of factual evidence.

Other laws

In certain circumstances the Consumer Protection Act 1987 may also apply to dentists as suppliers and users of products. Such records have to be retained for at least 10 years following the patient's last attendance, irrespective of whether your practice uses manual or electronic records.

On this subject, where a practice has scanned all handwritten dental records, these should be backed up in line with system provider protocols. At this point they become the permanent record and all original handwritten records can be disposed of securely. This also satisfies the Data Protection Act 2018 (DPA) which prohibits "excessive" personal information being processed. One important step in digitising records is to ensure your system allows records to be printed if required for legal or regulatory purposes, or for subject access requests.

MDDUS therefore recommends:

1. Treatment records, X-rays, study models and all other correspondence, are retained for at least 10 years after the patient's last attendance at the practice.
2. For children, retention of records as above until the patient is at least 25.
3. Orthodontic models – retaining original pre- and post-operative models as above but discarding intermediate models after a period of five years.

Current data protection principles advise not to hold or process personal information for longer than necessary, but in the circumstances we have examined in this article the relevant regulatory or legal incentives for retention of records will trump data protection considerations.

Safe disposal

You must ensure your chosen method of destroying patient records is effective and fully protects confidentiality. The recommended methods are shredding, pulping or incineration. If you have contracted this service to a third party, you must firstly seek written assurances that they comply with the DPA.

Likewise, computer data storage devices should either be overwritten or destroyed. Your software provider can assist.

When considering culling older paper-based records, for example for patients who have had no contact with you for at least 10 years, it is good practice to use a manual log book or electronic spreadsheet to note the date, patient name, date of birth, last date of attendance, reason for destruction, destruction authorised by and method of destruction. This will allow you to provide a full response to anyone submitting an access request after the 10-year retention period.

Alan Frame is a risk adviser at MDDUS

AVOIDING PERIO PITFALLS

Dr Madeleine Murray highlights common risk areas when managing patients with periodontitis

PRACTITIONERS often struggle with periodontics in general practice. Good disease control depends largely on patient buy-in, as well as having sufficient time to treat. Achieving these can be challenging but risks can be minimised through careful diagnosis, treatment and crucially good communication and record keeping.

Clear advice about basic standards of diagnosis, referral, treatment and follow-up can be found in both the Scottish Dental Clinical Effectiveness Programme (SDCEP) guidelines and documents produced by the British Society of Periodontology.

Diagnosis

Failure to make one. Follow-up by the clinician of either reported clinical symptoms or BPE scores of 4 is crucial. Major causes of under diagnosis of periodontitis include failure to:

- recognise symptoms of disease until the late stages
- carry out comprehensive assessment when BPE scores of 4 are recorded, or
- report incidental findings of periodontal bone loss on radiographs.

Failure to document the diagnosis. Accurately recording conversations relating to periodontal problems and findings of full chartings or radiographs is essential. Good clinical records can help support a practitioner who has discussed periodontal problems and offered treatment or referral, even if that was not taken up.

Failure to advise the patient of the situation. In many cases the practitioner recognises that there are periodontal problems, however the patient either hasn't been told or can't remember being told that is the case. If we accept that periodontitis is a chronic, debilitating, multifactorial condition with a strong basis in disordered immune and inflammatory mechanisms, like diabetes or rheumatoid arthritis, then it


becomes easier to explain to patients why they are at risk and why they have developed the disease. Periodontitis is not anyone's fault and diagnosing it does not imply blame or failure, rather it is a complex disease for which timely diagnosis and management present an opportunity to improve not only the patient's dental prognosis but their general health.

Failure to refer. Specialists now expect to save teeth which in the past would have been removed. Together with their teams they can help maintain teeth for many years, and this is especially true if referral is done at an early stage. Despite the challenges of long waiting times and limited access to NHS specialist periodontists, referral should at least be discussed as an option and followed up if the patient accepts it. Guidelines for when to consider referral can be used to make a case for access to specialist level treatment.

Treatment

Treatment schedules. Periodontal disease requires periodontal treatment, rather than periodontal maintenance. Initial treatment involves control of risk factors for disease progression, followed by in-surgery management of the tooth and periodontal tissues; oral hygiene instruction scaling, root debridement and subsequent follow-up. All of those aspects comprise treatment and depend on each other for successful ongoing management. Providing routine three-monthly scaling may control tissues where there is minimal disease but won't correct problems in those with established or more severe conditions.

Controlling risks. In patients who cannot be encouraged to reduce their general systemic risk (e.g. by stopping smoking) or who cannot be encouraged to clean their mouth at home, disease control will always be problematic. It is this stage of disease management that requires the dentist or hygienist to communicate convincingly. Documenting conversations about risk and risk reduction along with understanding objective measures



*"Periodontitis
is not anyone's
fault and
diagnosing
it does not
imply blame or
failure"*

of patient risk are important in helping both practitioner and patient understand what is likely to happen in the long term. Examples of this include: markers for diabetes control, patients' smoking habits and sequential plaque indices. They also provide feedback to patients about where they are on a continuum of disease control.

Providing good quality treatment. In an ideal world, practitioners have sufficient time and skill to remove calculus and plaque from teeth and root surfaces. Only a small cohort of patients have disease which does not respond to simple non-surgical treatment; a good maxim to follow is "if the patient isn't responding... look again." Break down the process of management into its constituent parts and think about what is happening. Does the patient understand they have disease? Do they understand how to control that disease and what their role is? Is oral hygiene good enough and, if not, which aspect of home cleaning is inadequate? Has the message you delivered about risk control and oral hygiene got through and if not, then is your delivery good enough? Have scaling and root debridement been carried out to leave teeth and roots clean, or is calculus still present, especially subgingivally?

Antiseptics and antibiotics. Often reliance is placed on either systemic or local antimicrobials in the form of mouthwashes, locally-delivered agents or courses of oral systemic antibiotics. These adjuncts do not have evidence supporting their effectiveness in disease management in the absence of good tooth cleaning. These agents may control symptoms in acute phases but do little in the long term.

Follow-up after initial treatment. In all cases where a course of treatment is needed and has been provided it is essential that the outcome of management is assessed after that treatment. This can only be done by again recording the indicators used to diagnose disease. For patients with complicated disease, BPE is not adequate for monitoring. The BPE index outlines treatment need and is not sensitive to probing pocket depth changes or recession, especially in deeper pockets. For monitoring of patients who have had more severe disease, full pocket

chartings, including probing depths, measurements of bleeding, recession and mobility carried out after treatment are needed. These charts should then be used to monitor on an ongoing basis and should be discussed with the patient.

Provision of complex treatment

Patients are increasingly presenting at the dental surgery requesting sophisticated and expensive dental treatments. The success of many of these treatments depends on a sound periodontal foundation. When complex treatment is planned, periodontal examination is paramount as part of the treatment planning phase.

Where periodontitis exists, patients should be informed. Ideally periodontal treatment should be provided and completed before final prosthodontic or orthodontic planning. The identification and management of periodontitis not only stabilises the dentition prior to complex treatment but also allows a degree of understanding of long-term tooth prognosis during planning and prepares the patient for maintenance challenges in the future.

Key points

In a busy general practice, managing patients with periodontitis is not easy. The key is to make sure that those identified as having signs of disease and those who are at risk are informed; and that the treating practitioner follows up the diagnosis with treatment and then closes the circle to check for a good response to treatment by review. If the patient fails to respond to simple treatment then referral to a specialist should be considered and offered. At all points, good record keeping and following of guidelines provide support for the dentist or hygienist if challenges to care arise later.

Dr Madeleine Murray is a specialist in restorative dentistry, limiting her practice to periodontics

MDDUS dental adviser **Stephen Henderson** highlights for dental teams some key learning points from two recent high-profile cases

It is unusual for the higher courts to hear claims arising out of professional regulation and clinical negligence, particularly those of relevance to medical or dental practice. There have been two such cases in recent months, one in the Court of Appeal and the other in the Supreme Court.

The sad story of Jack Adcock and Dr Hadiza Bawa-Garba has been widely reported and debated. In summary, a six-year-old boy with a complex medical history was admitted to hospital dehydrated and unresponsive. He died later the same day after a series of errors, some made by individuals and others resulting from the system the staff were working in.

Sadly Jack died. He had been suffering from pneumonia which evolved into sepsis and this was not identified correctly. Sepsis progresses very quickly in a child. Dr Bawa-Garba and nurse Isabel Amaro were subsequently convicted of manslaughter by gross negligence. Nurse Amaro was erased by the Nursing and Midwifery Council and Dr Bawa-Garba was suspended by the General Medical Council (GMC), a decision that was recently confirmed in the Court of Appeal.

What emerged from the Court of Appeal judgment is that the criminal court and the Professional Conduct Committee are "different bodies with different functions making different decisions at different times". It does not automatically follow that a serious criminal conviction will result in erasure.

Darnley case

The claim of Matthew Mark Junior Darnley made against a hospital Trust arose following an assault in which Mr Darnley sustained a head injury. He was taken to A&E where he told the receptionist that he had sustained a head injury and he felt unwell. It was accepted that Mr Darnley had been told he would have to wait some four or five hours to be seen. Mr Darnley told the receptionist he felt close to collapse but was informed that if he did collapse he would be seen as an emergency.

Nineteen minutes after arriving in hospital, Mr Darnley went home without notifying staff. His condition deteriorated and an ambulance was called. During the journey to hospital he collapsed, suffering a large extra-dural haematoma with a midline shift. In spite of surgery Mr Darnley suffered a significant brain injury and has been left seriously disabled.

The claim was made that the non-clinical receptionist breached her duty of care by giving incorrect information and, but for that breach of duty, Mr Darnley would have had a scan much earlier and the surgery would have been carried out earlier, with a significant chance of success.

In overturning the decisions of the lower courts, the Supreme Court found that the Trust had a duty of care to the patient as soon as he was



booked in, and it did not distinguish between clinical and non-clinical staff. It found that the failure to tell Mr Darnley that he would be seen by a triage nurse within 30 minutes (rather than being told he would have to wait four or five hours to see a doctor) was a breach of the duty of care because the information was incomplete and misleading.

Dental implications

So how can these two sad stories be interpreted for dental practices? While the circumstances in dental practice are highly unlikely to mirror the problems faced by Dr Bawa-Garba, nurse Amaro and Jack Adcock, some lessons can be learned. The situation with Mr Darnley is more likely to happen.

Effective systems

Dental practice receptionists are often not clinically trained but part of their role is to assess the urgency of a patient's request for an appointment. We learn from these two cases that it is important that the practice has effective systems in place to properly assess and manage requests for emergency assistance.

Patients can present for urgent care with a dental abscess that is potentially life threatening because the airway is at risk and as a result of the infection the patient may go on to develop sepsis. The whole team needs to be aware of these risks and have a plan for managing the patient, from the first phone call or walk-in. Patients must be given the correct advice, and if the receptionist is in doubt, there must be a system in place that someone with clinical training can speak to the patient and carry out the necessary assessment and triage. This is even more important when the first contact is by telephone.



RESPONSE

Systems should be in place for a rapid assessment and referral to hospital where appropriate. The assessment should include baseline medical observations: pulse, temperature and possibly blood pressure. Similarly, when faced with acute dental trauma cases, a plan for rapid assessment and management should be in place. Each team member has a role in both types of case, even if that is simply documenting the notes and comforting the relatives.

Well rehearsed

The nearest to the Dr Bawa-Gaba situation is an acute medical emergency in the dental surgery. The dental team often has the advantage of an up-to-date medical history and list of medications, but that may not always be the case, especially if the unknown companion of the patient collapses in the waiting room.

A well-rehearsed drill should follow, with a scribe capturing the times and key steps taken, liaising with the ambulance service to ensure a safe transfer to secondary care. Imagine that a new team member was the only other person present when the patient collapsed and they didn't know where the oxygen and emergency drugs were kept, nor the exact address of the practice to tell the 999 operator. Whilst it might not amount to manslaughter by gross negligence, HM Coroner and the relatives would be asking some searching questions in the subsequent investigation.

Speaking up

What steps can an inexperienced member of any team do to protect themselves, and their patients from a disaster as outlined in the examples above? First and foremost, speak up. No one should be

treated badly for saying "I don't know" or "help, what should I do?" Team leaders and senior members of the team should ensure that in any given situation no one is expected to operate outside their level of competence.

In the examples given above, medical emergency care should be practised with the whole team, including non-clinical members, so that everyone has a basic competence in life support techniques. Lifelong learning is crucial, but it has to start somewhere and no one has special skills without starting at the beginning.

Key lessons

- Have a clear plan in place to rapidly assess and refer patients who require urgent care.
- Ensure the entire practice team – including non-clinical staff – are familiar with this plan and act only within their competence.
- Encourage staff to speak out.
- Induction and training logs are crucial to an investigation, as are the contemporaneous notes of any interaction with a patient in distress.
- A confident leader is a leader who is present and welcomes challenge and debate from their teams.

Stephen Henderson is a dental adviser at MDDUS

(This article is adapted from one originally published in the BDJ)

SAVING SMILES

With her innovative 'Pick it, Lick it, Stick it' campaign, Dr Serpil Djemal is trying to change the way we deal with dental trauma

ACCIDENTALLY knocking out your front teeth is both physically and emotionally traumatic, and one woman who knows this all too well is restorative dentist Dr Serpil Djemal.

Based for the last 10 years at the centre of excellence for restorative dentistry at London's King's College Hospital, the consultant dentist and her team have rebuilt the smiles of more than 2,000 patients by saving their teeth instead of extracting them.

Like these patients' smiles, restorative dentistry in the UK has undergone a transformation too, and a lot of that is down to Dr Djemal.

When she arrived at King's, she was frustrated to see that patients with severe mouth and teeth injuries did not know where to find the best treatment. They would often attend two or three different clinics before finally finding the adult dental trauma unit at King's, the first of its kind in the UK. In many cases, patients arrived too late to save teeth that could have been preserved with prompt treatment.

Skills gap

"Dental trauma isn't a regular occurrence," says Dr Djemal. "Although we see dental trauma every day at King's, general dentists don't see it very often, so a lot of them don't know how to manage it or don't feel confident managing it. They don't have the opportunity to become skilled and efficient in treating these patients because they are not doing it on a daily basis."

"It became very apparent that the knowledge and skills weren't out there."

Even at King's, she says, the emphasis 10 years ago wasn't on saving teeth but getting



PHOTOGRAPHS: DR SERPIL DJEMAL

patients out of pain, often removing pulps and even teeth before sending them to their own dentist to manage. Under Serpil's leadership, the focus there has changed significantly, meaning more teeth are being saved.

"These patients are not only traumatised by the physical effect of knocking out, displacing or breaking their teeth, they are also emotionally disturbed by what has happened," she says. "I could see a great need to improve how dental trauma was managed to help patients save their teeth."

National campaign

After taking charge of the adult dental trauma service at King's, she set out to change not only the way patients are treated there, but at dental practices across the UK.

In 2014 she launched Dental Trauma UK, a charity that aims to educate dental teams on all potential traumatic dental injuries, as well as raise awareness among the general public about what to do if they are unfortunate enough to knock out a tooth.

There are 15 dental traumas that dentists could be faced with in their practice. One of the most urgent is avulsion (when a tooth is completely displaced from its socket), which could be caused by an accidental trip or fall, sporting and biking injuries, or assault.



Many people may not realise that the best way to save a tooth in these circumstances is simply to "pick it, lick it, stick it". This catchy slogan is a key message of Dental Trauma UK, whose website includes an animated information video around the slogan.

Serpil explains: "Pick the tooth up, make sure it's clean and put it back in the socket where it has just come from - ideally within five minutes - then go see a dentist immediately. Otherwise, putting the tooth in milk can keep live cells on the surface of the root alive for up to six hours, a simple action which can improve the chances of saving the tooth long-term. The only caveat is that baby teeth should never be re-implanted. Generally this applies to children under six."

If more people were aware of this, Serpil says, more teeth would be saved.

Extreme cases

At King's, she has seen everything from all four upper teeth (including the bone) being knocked out, to a tooth pushed right up into the gum



"I feel satisfied when I treat patients ...we put patients' teeth back together"



until it was no longer visible (this needed dis-impacting and repositioning). In each case, the patients' smiles were restored.

Another memorable case was London paediatrician Dr Geraint Lee who broke his top five teeth in a horrific biking accident in the Pyrenees. The consultant neonatologist came off his road bike and his face took the force of the impact. He was subsequently quoted in news articles urging cyclists to wear mouthguards.

Serpil, who treated the doctor, says: "He clipped the back of his brother's bike on holiday and totally displaced his upper teeth. He came to King's and we picked up the pieces and got him rehabilitated. Emotionally, he was very upset about his trauma - even professional healthcare providers themselves are susceptible to the emotional aspect of dental trauma.

"Today he has his own teeth in his mouth and can smile again."

At King's, the techniques and solutions to save patients' teeth are wide and varied, but are all performed under local anaesthesia. They include: building teeth up; repositioning and

temporarily splinting teeth; carrying out root treatment; or, when teeth cannot be saved, fitting bridges or, in some cases, implants.

Rebuilding people's smiles is something Serpil finds hugely rewarding. "I feel very satisfied when I treat patients - I don't always know what to do immediately and it is not always straightforward, but in a systematic way, we put patients' teeth back together."

Spreading the word

So passionate is Serpil about her team's work that she took part in the 2015 BBC documentary, *The Truth about Teeth*, and was interviewed live on the *BBC Breakfast* couch.

She is encouraged by the increasing numbers of dentists who send her patient X-rays seeking advice on how to proceed, but there is still some way to go.

She says: "I will never be satisfied until every dentist is confident to manage traumatic dental injuries. The charity has 280 members but I'd like to spread the word much wider."

Now, thanks to the work at King's and

campaigning by Dental Trauma UK, there are adult dental trauma services in Manchester and Glasgow. Serpil is also pushing for better remuneration for dentists to deal with dental trauma cases. Prevention of sports trauma is also important and the charity has launched a 'no mouthguard, no play' campaign.

Away from the dental surgery, you won't find Serpil risking her smile in extreme sports, although she is currently nursing a netball-induced dislocated finger. Fortunately this won't hold her back and, in addition to delivering lectures nationally and internationally, she is already planning her charity's next annual conference at the British Library in London on 4 May, 2019.

- Dental Trauma UK provide members with free CPD material and free access to the online Dental Trauma Guide. Annual membership is £30. For details visit www.dentaltrauma.co.uk

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DIAGNOSIS

Slow perio

DAY ONE

A 42-year-old long-term smoker – Mr K – has been a patient at his dental surgery for two years and attends Dr J for a regular check-up and scale and polish. He complains of ongoing bleeding gums on brushing and Dr J undertakes an oral examination. This includes a BPE scored at 000/020. The dentist notes that Mr K is at moderate risk of periodontal disease and advises him on good oral hygiene and the need to quit smoking.

**ONE YEAR LATER**

Mr K attends the surgery for another check-up and complains again of intermittent bleeding gums. Dr J notes a cavity in a rear lower molar and also general periodontal infection and pocketing. His BPE is recorded as 342/221 and he is prescribed antibiotics and a medicated mouthwash. Mr K also sees the hygienist who notes that his gums are sore and inflamed, and there is bone loss in all quadrants. The patient is asked to return for a radiograph but fails to attend. No other details are recorded in the notes.

**ONE YEAR LATER**

Dr S reports that despite serious efforts by Mr K to improve oral hygiene and having quit smoking, there is still active disease, especially in the anterior teeth. The patient is referred for specialist periodontal care.

**18 MONTHS LATER**

Mr K moves house and registers at a new surgery. He attends Dr S complaining of bleeding gums and the dentist records BPE scores of 332/323. Dr S discusses the implications of periodontal disease and refers Mr K to a hygienist. She finds gingival health is very poor and undertakes root surface debridement of deep pockets. Mr K claims he was not told of the full implications of periodontal disease. Advice is provided on proper oral hygiene and he is offered a referral for smoking cessation.

**10 MONTHS LATER**

The patient returns to see Dr J for an examination along with a scale and polish from the hygienist. It is noted that his oral hygiene is much improved.

A LETTER of claim is sent to Dr J alleging clinical negligence in failing to diagnose and treat Mr K's periodontal disease. It states that appropriate BPE assessments were not undertaken at all appointments, despite the patient being at risk. There was also failure to act on BPE scores indicating the need for subgingival scaling, and no radiographs were taken to monitor the condition. It is also alleged that Mr K should have been offered smoking cessation advice and referred to a periodontist.

A periodontal specialist instructed by the patient notes a significant risk he could lose a number of teeth in the medium to long term.

MDDUS instructs an expert dental surgeon who takes the view that the patient has not received a reasonable standard of care from Dr J. This opinion is based partly on the poor quality of the notes, which offer few details of the presenting complaint and history, no special investigations and findings, and no stated diagnosis or prognosis with discussion of treatment options. There is also no mention of radiographs being taken apart from the recall which the patient failed to attend. There

is also no record of smoking cessation advice given beyond Mr K being told to quit.

The expert opines that BPE scores should have been recorded at every patient review and he doubts the accuracy of the first BPE, given the patient's bleeding gums and subsequent scores. Only one bitewing radiograph (undated) was in the records, with no record of relevant findings. The expert finds this insufficient.

In his response to the claim Dr J said he did not refer Mr K to a periodontal specialist because the BPE scores did not warrant it – but the expert believes that referral should have been discussed (and recorded) to ensure shared decision making. The expert opines that BPE scores of 3 and over should have prompted an analysis of plaque and bleeding distribution, along with 6-point pocket charting of the affected sextants after initial periodontal therapy. The patient should then have been provided with intense oral hygiene instruction and treatment arranged for debridement of the affected root/tooth surfaces.

A separate opinion is sought for causation (consequences of the breach of duty of care).

A periodontal specialist examines Mr K and says that with good treatment and compliance there is a reasonable chance he will retain all his teeth in the medium term – but that with earlier appropriate treatment the patient's periodontal condition would not have been as severe. Given the unsupportive opinions, MDDUS settles the case with Dr J's agreement.

KEY POINTS

- Ensure patients at risk of periodontitis are informed/aware.
- Do not neglect to make and record BPE assessments.
- Discuss referral with patients with definite or borderline periodontitis.
- Ensure records reflect all examination/assessment discussions with patient and advice given.
- Ensure appropriate justification for prescribing antibiotics.

OUT THERE

BURIED TEETH Construction workers in the US state of Georgia got more than they bargained for when they discovered 1,000 human teeth inside the wall of a building they were renovating. It's thought the teeth were discarded by dentists who occupied the property around 1900 and may not have been too strict on clinical waste disposal. *Source: Valdosta Daily Times*

SUGAR SNAP Sugary drinks are to become a rare sight in NHS England hospitals after they pledged to cut sales to 10 per cent or less. Dentists can breathe a sigh of relief as 23 trusts have decided to stop selling them altogether. Many have also agreed to cut confectionary sales as part of the Government's anti-obesity strategy which should also help fight tooth decay.



DENTAL DIAMONDS

Microscopic diamond particles could be used to protect against infection after root canal treatment. Researchers at UCLA, USA, embedded so-called nanodiamonds into gutta-percha making it less prone to breaking, thus allowing healing.



FROM THE MUSEUM

This partial ivory denture, held in place by a silk thread, was carved from a single piece of hippopotamus or walrus ivory. This was the preferred material for dentures although it was prone to discolouration and foul smell due to oral fluids and food and drink. These were only available to the wealthy of society and date from the 1750s.

PHOTOGRAPH: BDA MUSEUM

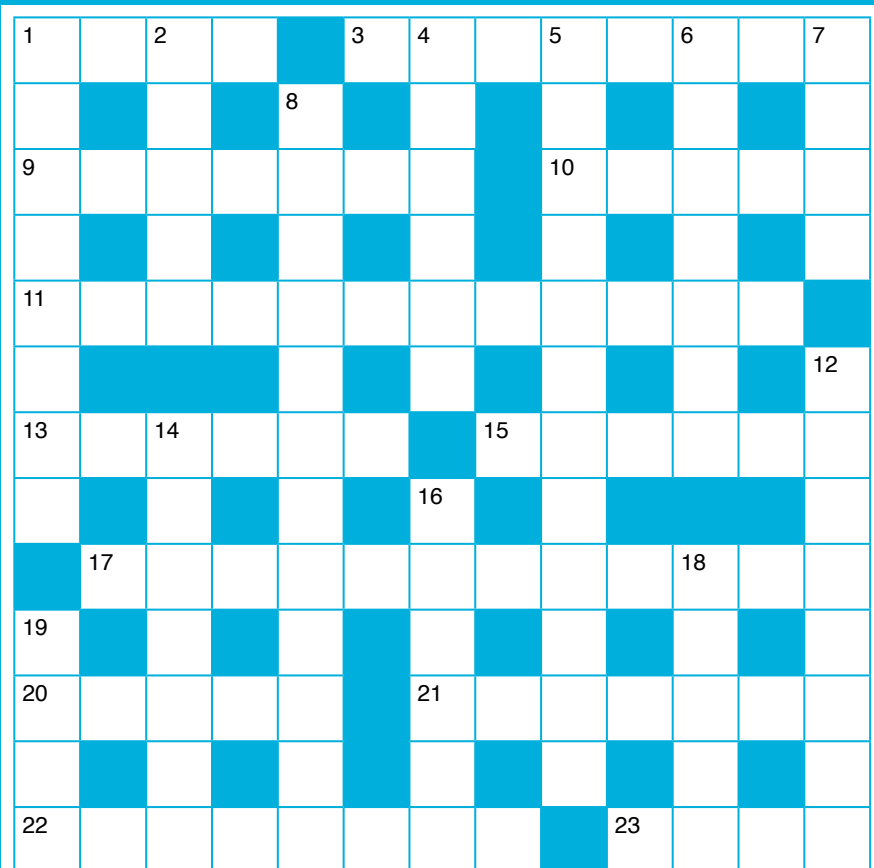
CROSSWORD

ACROSS

1. Team (4)
3. Expecting (8)
9. American rodent (7)
10. Regions (5)
11. Connection (12)
13. How long is a piece? (6)
15. Staple tuber (6)
17. Rooms for experimentation (12)
20. They turn blue litmus red (5)
21. Clothed (7)
22. All (8)
23. Touch (4)

DOWN

1. Astonish (8)
2. Rigid self-setting material used in dentistry (Trademark) (5)
4. Without pattern (6)
5. Type of dental cement (5,7)
6. Trumpland? (7)
7. Discard (4)
8. Happening without interruption (12)
12. Medicated mouthwash (Trademark) (8)
14. Cause to happen (7)
16. Green space (6)
18. Supply (5)
19. Change policy after pressure (4)



See answers online at www.mddus.com. Go to the Notice Board page under About us.

Questions



MDDUS members can now take advantage of a great new service designed especially for dentists who are just starting out in their career.

If you have questions about what to expect from practice life, need advice on choosing a job or help understanding associate agreements - we can help.

Our new **Early Practitioner Adviser Laura McCormick** is an experienced dentist who will be on hand to offer free educational support and expert insight into working life.



This great new service is provided at no additional charge for MDDUS dental members in Scotland who have graduated within the past five years.

To find out more email Laura on
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