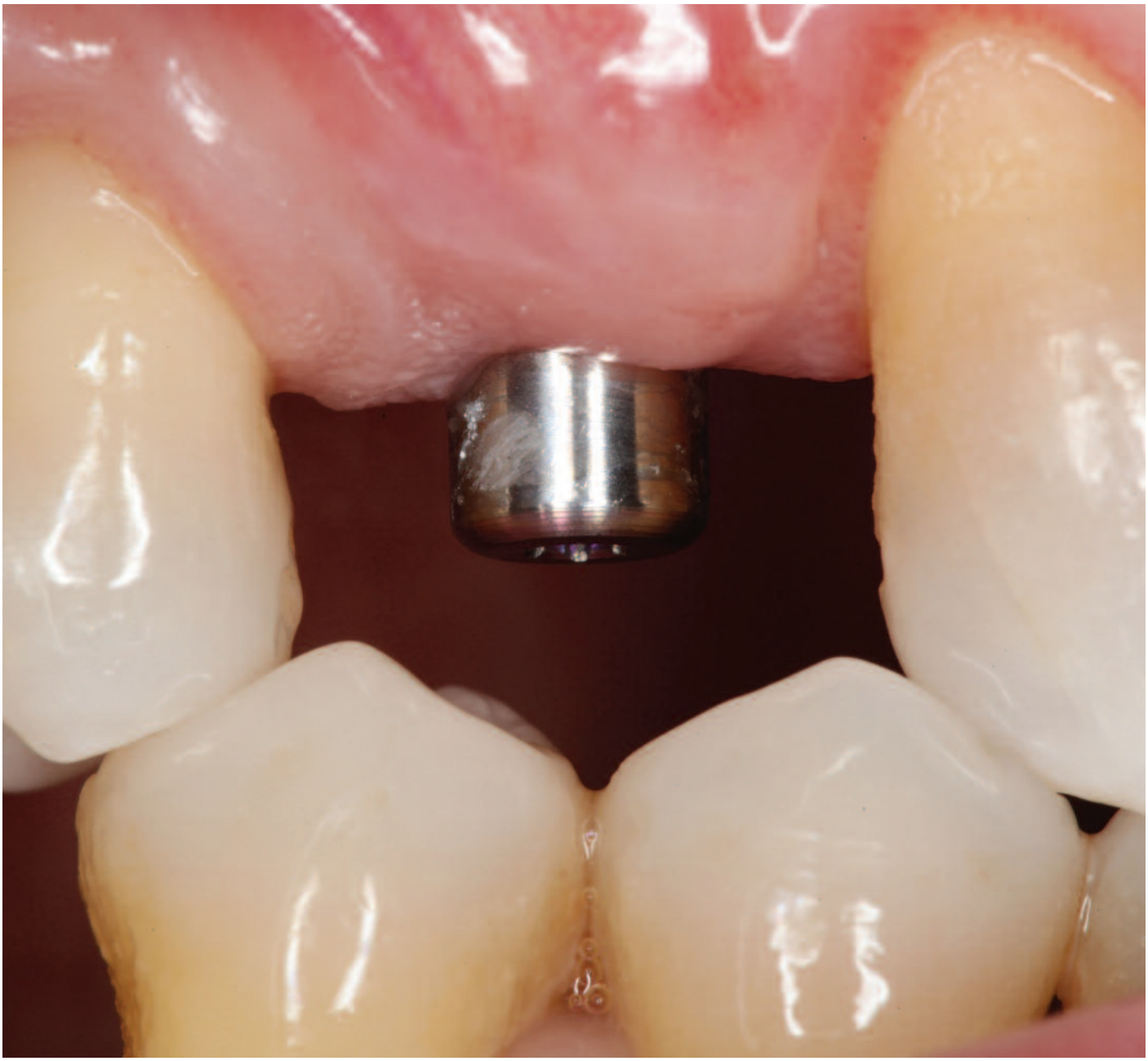
New Zealand

Dental Protection

Teamwise

Risk management from Dental Protection for therapists and hygienists



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www.dentalprotection.org

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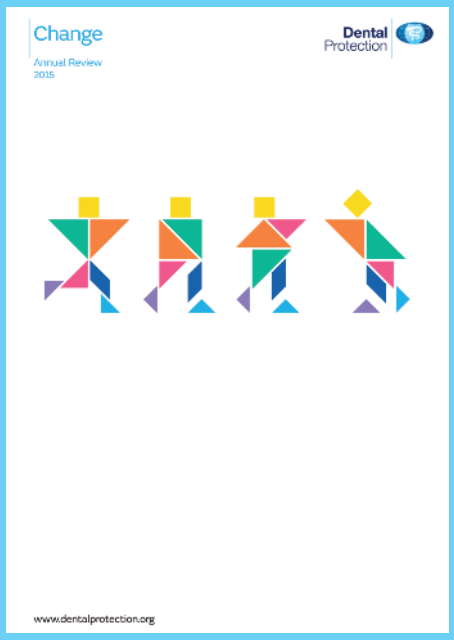

Did you know that you can obtain two hours online CPD associated with this years' Annual Review? To find out more, visit
www.dentalprotection.org/prism

Editorial

Dr James Foster
DPL's Head of Dental Services, New Zealand

Welcome to the latest edition of *Teamwise* which I hope you will find informative and beneficial

We have focused upon topics of particular relevance for today and, in addition, highlight below our range of services supporting professional development to help you be a safer, more successful member of your dental team. We believe that well-informed members are the safest members, and I would urge you to make full use of the wide range of services available.

Regulation

Throughout the world, colleagues face an increasing tide of regulation and the associated challenges that accompany that expansion in regulatory activity.

The stress and anxiety of an investigation should never be under-estimated, no matter how insignificant the original complaint may appear.

The Dental Council of New Zealand's (DCNZ) *Conditions of Practice Handbook* sets out what is expected of practitioners and naturally it is imperative that the dental profession is fully aware of the rules against which their actions will be assessed, should an investigation take place. Two areas of particular significance are those of consent and competency. In this edition of *Teamwise*, we have explored some of the current issues with regard to implants, and reference both these important concepts. I hope that you find this and the other articles in this publication useful.

Matters that do come to the attention of the regulator are varied in nature. However, the standard against which the individual practitioner's actions are measured remains unchanged. Clearly, colleagues, who can demonstrate that the required standards have been met, are in the best position to achieve an early resolution with minimal impact.

Of course, prevention is better than the cure, and I would urge all members to review the range of professional development services which can help practitioners to optimise the quality of patient care in the increasingly difficult environment in which we practise.

Professional development with Dental Protection

- Free CPD
- Lectures and seminars
- Prism - Online learning at your fingertips
- Publications – Updating you with the latest news and case studies
- Downloadable information and advice booklets on key dento-legal topics
- Tools for clinical audit to support your record keeping
- Small group workshops on communication skills
- Learning online eg. Communication in Dentistry, Record Keeping (www.healthcare-learning.com)

New website

Take a moment to review our recently updated website where you can also find links to all our resources as well as putting online learning at your fingertips.

Prism

www.dentalprotection.org/prism

Log in to the e-learning hub and learn at a time and place that suits you. Log your completed courses in your personal profile and print off certificates for your CPD. If your module gets interrupted, just pick up where you left off next time.

Our courses cover a number of key risk areas:

- Dento-legal Issues and Ethics
- Professionalism
- Communication and Interpersonal skills
- Systems and Processes
- Clinical Risk Management
- Reflective Learning.

If you have not yet registered with Prism, please do so and have a look through the available material which includes dento-legal issues, professionalism and ethics, communication and interpersonal skills, systems and process and clinical risk management. Colleagues working in remote and rural areas may find this a particularly valuable and convenient method of achieving CPD.

Keeping up to date with clinical matters as well what is expected in terms of professional responsibilities is essential, and as long as we know the standards against which we are measured, then we are in a position to practice safely. I hope you enjoy this edition of *Teamwise*, and once again, please make use of all that is available to you from Dental Protection.

Best wishes,

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Consent

Dr Jocelyn Logan
Jocelyn has worked as an adviser for Dental Protection both in the UK and New Zealand where she now lives

We cannot assume that the patient who has been referred for treatment fully understands the treatment that you will be providing. There needs to be a conversation confirming this, and the process of consent documented

And finally

The final stage of any treatment plan is the process of consent, without which the treatment should not proceed. However, there are sometimes misunderstandings about this process that require clarification.

Meaning

When considering topics about which there is confusion and debate I like to seek a definition from the Oxford English Dictionary (OED).

As a noun, consent means "*permission* for something to happen or *agreement* to do something". As a verb it has no object, thus the term "I consented the patient" is nonsensical. The OED provides an example for the verb: "Give *permission* for something to happen".

There is a further definition of informed consent: "Permission granted in full knowledge of the possible consequences, typically that which is given by a patient to a doctor for treatment with knowledge of the possible risks and benefits."[1]

But is it valid?

Dental Protection along with the UK's National Health Service (NHS) prefers to use the term valid consent. (OED definition of valid is legally or officially acceptable.[2]) For consent to be valid in the NHS, it must be **voluntary** and **informed**, and the person consenting must have the **capacity** to make the decision.[3] These terms are explained below:

- **Voluntary** – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family.
- **Informed** – the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and what will happen if treatment does not go ahead.
- **Capacity** – the person must be capable of giving consent, which means they understand the information given to them, and they can use it to make an informed decision.

Our own code

Closer to home, the NZDA Code of Practice on Informed Consent dated March 2014[4] states that:
"The dental practitioner has an ethical and statutory responsibility to communicate effectively and take reasonable steps to ensure that the patient is given all the information necessary to make an informed choice about the management of their oral and dental health."

The Code of Practice (CoP) defines Informed Consent as a process, not a single event, relying on "open interactive dialogue between the dental practitioner and the patient". It is helpful for the patient to explain some treatments by using leaflets, diagrams, study models, education software, and internet references.

Consumer rights

The Health and Disability Commissioners Act 1994 and the *Code of Health and Disability Services Consumers Rights 1996* outline consumer's rights. Specific to the consent process are:
Right 5. The right to effective communication;
Right 6. The right to be fully informed;
Right 7. The right to make an informed choice and give informed consent.

The NZDA CoP details in a clear and logical manner how each of the above rights (5, 6 and 7) apply to the consent process. There is also an explanation that "consent must be given freely without pressure, coercion, undue influence or bias." The concept of competence is also addressed and described in easily understood terms, along with cautions in making assessment of competence.

Unless the patient grants their permission in full knowledge of the consequences of treatment, their consent is invalid

[1] http://www.oxforddictionaries.com/definition/english/consent

[2] http://www.oxforddictionaries.com/definition/english/valid

[3] http://www.nhs.uk/Conditions/Consent-to-treatment/Pages/Introduction.aspx

[4] http://www.nzda.org.nz/pub/index.php?eID=tx_nawsecuredl&u=4794&g=1000&t=1422781664&hash=6ec5bf51ae24e2ffbcac081e9eb9f618b3f6b2ea&file=fileadmin/user_upload/resources/pdf/Codes-of-Practice/cop_informedConsent.pdf

Practitioners should review their understanding about Informed Consent before recertification

Documentation

The all-important process of documentation is referred to in the CoP. The advice is that contemporaneous written notes in the patient records provide evidence of the consent process. These records should include the presenting problem, treatment options, risks, costs and the option to which the patient has consented. This confirms that discussion has occurred and the nature of that discussion. It is emphasised that *"consent is not obtained simply by a signature on a consent form"*.

The four circumstances where written consent is required are outlined in the CoP, along with the suggestion that dental practitioners may wish to obtain consent in writing if treatment is protracted, complex or costly or if there are expectations and obligations for both parties to agree. Whenever a standardised form be used this should only is considered a *supplement* to the individual discussion, which should be personalised for that patient for a particular instance.

Good to know

The Dental Council of New Zealand (DCNZ) provides a Code of Practice for consent[5] on the website. This is a joint document with the NZDA that was written in March 2004 and is due to be updated in the near future.

The Handbook for the New Zealand Conditions of Practice (August 2011)[6] provides a list (page 44) of information which must be explained to each patient. The DCNZ annual recertification process calls for practitioners to confirm they meet the requirements for Informed Consent, so it may be prudent to review your understanding of this procedure before making your declaration.

A useful resource

Dental Protection Limited (DPL) has produced a dental advice booklet entitled "Consent".[7] Although the booklet was written for the UK the principles still apply here in New Zealand. A revised version of the text is planned to reflect the updated text from the DCNZ and the NZDA.

The advice booklet is available to download from the risk management section of the New Zealand section of Dental Protection's new website. It discusses autonomy in terms of choice and free will, and highlights the way we as clinicians may influence patients with our choice of words and tone of voice. The requirement for respect for patients is summarised in the phrase: *"dealing with patients as we would wish to be dealt with ourselves."*

There is further discussion on competence and capacity with helpful examples and scenarios, and references to international case law that has directed the current obligations on healthcare professionals in the consent process. Finally there is a consent checklist and summary, which provide a concise reference for the consent process.

Summary

This article[8] serves to bring to notice the important fact that consent is a process, and there are certain responsibilities and requirements within the process along with correct documentation to ensure the dental practitioner complies with the appropriate legislation. You are urged to refer to the NZDA and DCNZ Codes of Practice, and review The Code of Health and Disability Services Consumers Rights 1996, which should be on display in your practice. Dental Protection's booklet provides further explanation and background information.

[5] http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/Dentistry/Code-of-practice-on-informed-consent-dentist.pdf

[6] http://www.dcnz.org.nz/assets/Uploads/Codes-of-practice/New-Zealand-Conditions-of-Practice-handbook.pdf

[7] http://www.dentalprotection.org/docs/librariesprovider4/dental-advice-booklets/consent---excluding-scotland.pdf?sfvrsn=10

[8] One of a series prepared by Dr Jocelyn Logan and published in NZDA News 2015

Peri-implantitis and the hygienist

An examination of an increasingly frequent periodontal condition

We are seeing more “late failure” cases, especially involving so-called “peri-implantitis”. These cases can be attributed to the clinician who placed the implants, or the clinician who provided any subsequent treatment, but can additionally include clinicians (whether dentists or hygienists) who have examined or treated the patient subsequent to the provision of the implant(s) and restorations placed upon them and failed to identify and act upon the situation. This can happen even when they had no part in the original treatment. There is a growing consensus amongst those involved in the field of implant dentistry that we will be seeing more of these cases in the years ahead and this represents a growing risk for hygienists

Dr Susan Willatt
Susan is Dental Protection, Head of Dental Services

We are likely to see more late failure ("peri-implantitis") in the years ahead

Implant dentistry is an elective choice at the higher end of the fee scale, and the costs involved can contribute to patients being less willing to tolerate and accept unfavourable outcomes.

Periodontal cases

These cases present problems for a variety of reasons.

- Unlike cases with a single, specific incident date, they cover extended periods often stretching back many years and sometimes involving more than one practitioner (and also, hygienists).
- Where patients are able to demonstrate that they had not been advised of the presence and significance of their periodontal disease, and have only learned this relatively recently (for example, when seeing a different practitioner), they can be disappointed in the clinicians who have had responsibility for their dental care up to that point.
- Even where dentists and hygienists are adamant that they had told the patient over many years about their periodontal disease, given detailed and regular advice and instruction regarding oral hygiene, smoking cessation and other risk factors and regularly monitored periodontal health and bone loss, we are often disadvantaged by clinical records which do not confirm these facts in sufficient detail (or at all). Few clinicians could be entirely confident that there are no such cases lurking in their filing cabinets from 10 or 20 years ago (or the filing cabinets of practices that they left long ago). The advent of computerised records has not solved this problem and in some respects has made it worse.

A heightened awareness of the potential for implant failure allows you to optimse the management of the situation

Common themes

We have discussed the fact that these cases tend to arise and be reported to us much later than cases from most other kinds of dentistry. These intervals can be of many years and this brings its own problems in terms of being able to remember details that are not immediately apparent from the records, or even, remembering the patient at all. Many practices find it difficult or impossible locate records dating from 20 or 30 years earlier.

In both types of case, there are well known risk factors that affect the prognosis. It is important that the clinical records make it very clear that these risk factors were understood, investigated, kept under review and – most importantly – discussed with the patients concerned. A detailed medical history which is regularly updated (including any medication taken by the patient) is a prerequisite, and a failure to identify and act upon a systemic condition or complicating medical factor, seriously increases your vulnerability to criticism and challenge.

Smoking cessation advice, where necessary, needs to have been provided and followed up (see page 10). Patients need to fully understand the possible (or likely) consequences of not acting upon this advice in their own particular case, to avoid the suggestion that they had not appreciated that continuing to smoke might affect their oral health and/or the prognosis of treatment provided.

Many patients have been known to argue that this crucial link had never been properly explained and stressed, so they had simply thought that they were being given general advice. Inevitably the argument continues along the lines that they would have acted very differently had they only known the dental and oral consequences of continuing to smoke.

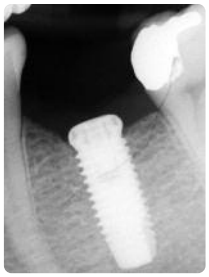
A heightened awareness of how important (and frequent) these cases are becoming, and a commitment to taking every available step in their appropriate management (including referral to specialist or more experienced colleagues where applicable), would help to hold back the approaching tide that these cases represent.

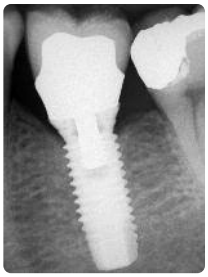
Read the next article, "Implants and the dental team" to learn more about peri-implantitis.

Implants and the dental team

How to avoid a disastrous outcome

Regular monitoring of the bone height and soft tissues adjacent to the restored portion of the implant will alert you to the first signs of peri-implantitis





In general, there are three approaches to trying to achieve a safe passage through any minefield. The first is to find out exactly where all the mines are located before you start, and then to carefully plan a safe route – and stick to it. The second is to take your time, proceed with extreme caution in small, measured stages and not take any step before knowing for sure that the ground upon which you will be placing your foot is safe. The third (which we do not recommend) is to ignore signs, keep moving and not ask for directions

Before you start
No hiding place

A few years ago it was relatively unusual for a patient to arrive in your surgery with implants in situ and restorations/appliances supported upon them. It is already a lot less unusual and it will very soon become commonplace. You may not work in a practice where implants are placed or restored, but that does not mean that you don't need to be just as familiar with the clinical issues relating to them, as you are with natural teeth and restorations provided for them.

Get proper training

Short courses, perhaps run by manufacturers and distributors of implant systems are an important part of the training "mix" in order that practitioners can properly understand the features of a particular system, but these bespoke courses can never be a replacement for a broader, extended course which goes into more depth and considers many different implant systems and their relative advantages and disadvantages.

The best courses are generally those which involve formal, structured training provided by acknowledged experts in the field, over an extended period of time.

The Dental Council will be particularly concerned about dentists who become involved in implant dentistry with relatively little formal, structured training and mentoring. Their existing guidance is clear in stating that dentists should not get involved in treatment for which they do not have the relevant training and in respect of which they are not yet competent.

It is not difficult to see how exposed a young dentist would be if they get involved in implant dentistry quite soon after qualifying, perhaps off the back of a relatively short course undertaken with no proper curriculum or structure, supervision arrangements, quality assurance or opportunity for hands-on mentoring after completing the course.

Similarly, a dental hygienist must either be confident to provide the necessary advice and treatment in relation to implants and the health of tissues around them, and the maintenance of restorations and appliances supported upon them, or should be prepared to refer the patient to someone better placed to provide the patient with the care and advice they need.

The tools for the job

Having the correct instrumentation to maintain implant fixtures without damaging their surface comes at a price. If your workplace doesn't have access to proper imaging to help you to assess the health of the bone into which the implant fixture is placed (in order to minimise any delay in identifying a failing implant and managing it appropriately), establish where and how you can take advantage of this technology if it exists elsewhere. Trying to keep the cost down for a patient by cutting corners, isn't really helping you or the patient in the long run.

Follow up and monitoring
Maintenance

It is essential that patients should be helped to realise that implants need to be looked after just as carefully as natural teeth. Meticulous oral hygiene, with techniques adapted to the specific needs of each patient, and (where applicable) continued encouragement to maintain smoking cessation, are crucial ingredients of implant maintenance.

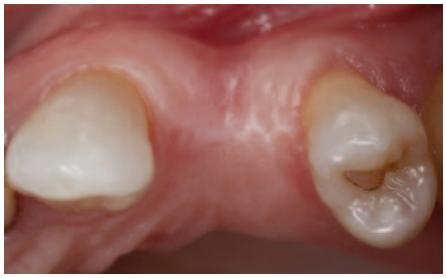
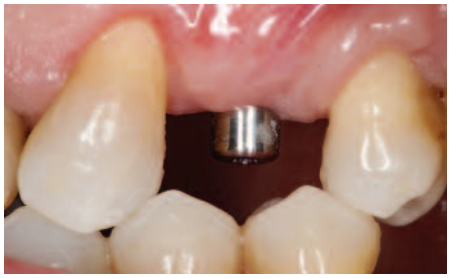
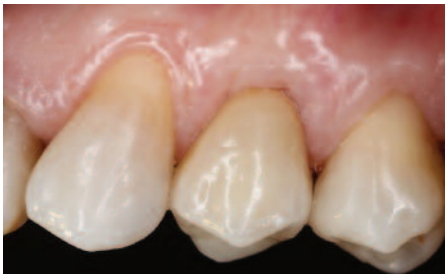
Patients must understand that attendance, as recommended for review purposes, will help to minimise problems in the months and years following implant placement. They must also accept responsibility for the potential consequences of not doing so.

Keep your eye on the ball

Implants, once placed, are a long-term commitment for both the patient and the clinicians who are responsible for their on-going care. The conditions known as "peri-implantitis" and "peri-implant mucositis" are a growing problem not just for the clinicians who originally placed the implants or placed restorations or appliances upon them, but sometimes for others who had no part in the original treatment, but end up caring for the patients in the years following the provision of that implant dentistry. This includes both dentists and dental hygienists.

Peri-implantitis is an inflammatory condition which can often be reversed at an early stage. There will be redness, swelling, inflammation and the tissues around the fixture will not look healthy. At this point there is no bone loss and it is a precursor to peri-implant mucositis. Improved oral hygiene and better care of the implants will usually reverse or improve the condition. There is an abundance of evidence to suggest that the presence of keratinised gingival tissue at the "neck" of the implant at the point of emergence into the oral cavity is a desirable, protective situation which makes the initiation and further progression less likely.

We are grateful to Nobel Biocare for the use of the images on pages 12–13

Left uncontrolled, the inflammatory condition can progress to involve loss of crestal bone, often creating a characteristic dish-shaped bony defect which is clearly visible on radiographs. Careful comparison of such radiographs over time allows the situation to be assessed. Once peri-implantitis has become established, it is very difficult to treat.

A failing implant will continue to fail if no proactive attempt is made to rectify the situation. Clinicians who played no part in the placement or restoration of the implant can wrongly assume that they cannot be held responsible for the failure – but they can be held responsible both for failing to identify the signs that the implant is failing, and the failure to seek advice from colleagues who have more experience in implant dentistry.

Summary

Meticulous records

In implant dentistry, every stage of the process needs to be very carefully recorded. Especially important here are records of what the patient was led to expect, what information was provided to the patient, what warnings they were given etc.

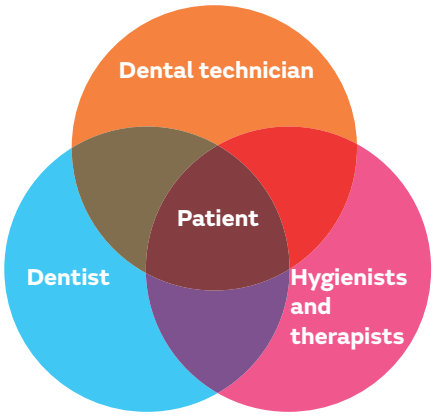
Your records must document every detail of the histories taken, the exploration of any possible risk factors that might affect the prognosis, any tests and investigations carried out, any liaison with professional colleagues, and all discussions with the patient.

Detailed records also need to be kept to demonstrate the meticulous monitoring of the status of the implants (both hard and soft tissues) in the months and years following their placement.

Stay up to date

Implant dentistry continues to be a dynamic and evolving field. Ensure that you keep your knowledge and skills up to date and be prepared to adjust your approach when necessary.

Well-rehearsed teamwork optimises clinical outcome for the patient



DCNZ Conditions of Practice Handbook

Practitioners offering services in an advanced area of dentistry or procedures using new techniques or equipment:

- must be able to demonstrate that they have the requisite knowledge and training to undertake such services/procedures including knowledge of the relevant scientific literature – this means having documented evidence of training including formal qualifications, courses, CPD and supervised or self directed training and evidence of logged experience in the advanced or new area of practice.
- must ensure the patient's informed consent to the service or procedure – the patient should be aware of the methods you have been trained in and the other options available to them such as treatment by a specialist or other practitioner; must understand the nature of the service/procedure and the possible risks and side effects; and should have a realistic expectation of the results that can be achieved. There must be a clear and comprehensive record of the consent process. The patient's written consent must be obtained in the case of research or an experimental procedure.
- must ensure that any new technique or procedure falls within the practice of their particular profession as defined by the Council in the "Detailed Scopes".
- should be aware of the indemnity position in relation to new techniques and procedures.

Practitioners should also ensure that they are competent to provide the appropriate level of expertise in the area of dentistry they are undertaking in each specific case. This should be done by appropriate case selection, full diagnostic information and treatment planning, and prior clinical and theoretical preparation.

Where diagnosis and treatment-planning indicate that the patient requires a level of skill greater than you are able to demonstrate, then you should refer the patient to more highly qualified colleagues for advice or treatment.

When deciding whether to treat or refer, your patient's informed consent is of paramount importance. The decision to refer may be influenced by access or economic considerations as well as clinical factors, and should be made in consultation with the patient. Patients should be given full information on the complexity of the case, the likely outcomes of treatment by either provider, along with the relative costs.

Smoke and mirrors

Some simple steps for the dental team to follow, to drive home an important message

Dr Joseph Ingham
Joe is a dento-legal adviser with special responsibility for dental hygienist and therapist members. He is also a tutor at the Eastman Dental Hospital

The link between tobacco smoking and the health of the soft tissues in and around the mouth (and beyond) is well known within the dental profession and also well documented. Unfortunately, it is not well understood by many at-risk patients despite all the public health messages designed to improve that awareness. Your involvement in discussing the risks of tobacco use will be in the best interests of the patients concerned, it will also help to protect you from dento-legal threats and challenges

Know your target audience

The better you know and understand what makes a patient tick, the easier it becomes to align your message to the things that matter to them, and are likely to influence their thinking, attitudes and behaviour. Different patients are motivated by different things, and the same patient may respond differently according to what else is happening in their life when you broach the subject.

Establish the facts and check them regularly

Try to establish the patient's actual tobacco usage. Is it stable, increasing or decreasing? Has the patient ever tried to reduce or stop their smoking in the past and if so, how many times, using what approach and with what degree of success? Do they genuinely want to stop smoking and if so, why?

Plan your message

Pick your moment when you have the patient's full attention, free from other distractions, and work out in advance what you plan to say and how. It is more likely to be effective if you do.

Deliver the message in context

Look for ways to discuss the subject in a specific context that can provide relevance and emphasis, such as immediately following an intra-oral mouth cancer screening check or when discussing the cost of treatment, the longevity or success of which might be compromised by continuing to smoke. Let the patient know what the likely consequences of continuing to smoke are for their general health and in the specific context of their oral health and any treatment that they are receiving or about to undertake. Link their smoking to other risk factors to demonstrate the cumulative risk to which they are exposing themselves.

Repeat and reinforce your message

Don't assume that by delivering your message once, that it will be acted upon. There is a now a research-based cognitive model for predicting patient compliance. This has identified guidelines for improving patient's understanding and recall of information which, in turn, leads to better patient engagement/involvement and increased compliance, and well as increasing patient satisfaction. Philip Ley who pioneered this research in medicine suggested that the content of oral communication and patients' subsequent recall can be improved with the following strategies:

- Use the primacy effect – patients have a tendency to remember the first things they are told; it is processed in short-term memory with relatively little proactive interference.
- Stress the importance of compliance (leave no room for the patient to misunderstand or fail to appreciate the consequences of non-compliance). Make it personal and specific.
- Simplify the information; reduce the amount and don't use jargon.
- Use repetition. Ask the patient to confirm the main points.
- Be specific.
- Reinforce and supplement information provided verbally by providing it in written form too if possible.

Attention to these factors can significantly increase patient recall thereby increasing patient compliance.

Follow up at appropriate intervals

If you send the patient the signal that what you talked about at a previous visit is not important enough to follow up, you should not be too surprised if they attach very little importance to it. Following up these conversations in a planned and structured way gives you another opportunity to check on progress and reinforce the messages.

Keep detailed records of every smoking cessation discussion

Instead of a general entry which simply records that smoking cessation advice was given, try to place the advice in context ie. periodontal disease, implant provision or maintenance, oral cancer risk etc.

Record any undertakings or commitments made by the patient, and/or any indication by the patient that they were unable or unwilling to commit to smoking cessation or to try to reduce their tobacco usage. Don't leave your records of these conversations open-ended; if you warn the patient of the risks of not following your advice, be sure to include a note to that effect.

Resources

https://www.nice.org.uk/guidance/ph10
http://www.ash.org.uk/stopping-smoking/for-health-professionals/smoking-cessation-services
https://www.dentalhealth.org/our-work/mouth-cancer-action-month
http://www.health.govt.nz/publication/new-zealand-guidelines-helping-people-stop-smoking

Domiciliary dental care in care homes

How to minimise risks when treating patients away from the dental surgery

Dr Heather Lloyd
Heather is a UK specialist in special care dentistry and former director of community and salaried dental services. She is a past Hon Membership Secretary and current President Elect of the British Society of Gerodontology

As the population ages, more challenges are emerging in delivering oral healthcare for older adults

Domiciliary dental care is undoubtedly an essential part of maintaining the health and wellbeing for those homebound patients who cannot, for a variety of reasons, attend a dental practice for treatment. Frail older people, in particular, have shown a preference for home visits for dental care. This allows them to use their limited energy on receiving the dental care, rather than on travelling to the dental practice. For some patients, the most disabled and those who are bedbound, it can be both difficult and distressing to be transported out of their home to a dental surgery.

The most common issues that the dental team will be asked to deal with for the elderly resident in a care home setting will be check-ups, oral cleaning, adjusting dentures or provision of new ones and simple restorative treatments to maintain the worn dentition. Providing oral hygiene advice to the elderly resident and their carer, is both straightforward and rewarding, and could prevent many future problems. Training carers in oral healthcare provides a useful insight into what it is like working in a care home, and whether you wish to develop a domiciliary dental care service there.

Dentistry in care homes

This article focuses on providing dental care in care homes, both residential and those with nursing provision. For the practitioner new to providing dentistry outside of the surgery setting, this is a good place to start. Additional considerations not covered in this article would be required for providing dental care in a patient's own residence.

Risk assessment checklist

It is vitally important to carry out a risk assessment checklist before doing domiciliary work. We can consider the risks of domiciliary dentistry under the following:

- Location of domiciliary visit
- Information gathering before your visit to ensure good communication with the care home
- Medical, mental health and social histories
- Employer's liability
- Personal protection
- Equipment, including emergency equipment
- Moving and handling
- Infection protection and control
- Clinical waste
- Safeguarding issues.

Domiciliary dental care in care homes

The application of fluoride varnish together with oral health education for patients and their carers is a low-cost preventive strategy for house-bound patients

Risk	Risk reduction
Location of domiciliary visit	Check full address and telephone number of the particular part of the care home you are visiting. Several houses or units may be located on one site within a large complex. Check if visitor parking is available at the care home, or whether there are any parking restrictions on the road.
Information gathering before your visit to ensure good communication with the care home, residents, relatives and your team	Make the initial telephone call to the care manager (subsequently you may be liaising with a Team Leader or Key Worker) and give the names of the dentist or hygienist and dental nurses visiting. Send the appointment details, together with your contact details, in writing to the care home manager and resident. Where appropriate, communicate directly with the resident's relative, and invite them to be present for the visit. If you have been asked to specify a time for your visit, give a time period of one hour to allow for unexpected delays and/or traffic.A delay may cause annoyance or anxiety. Inform the care home manager/staff that the dental team will be wearing identification badges. A mobile phone should always be carried to communicate with your practice, the care home and for your personal safety.Prior to your visit, establish whether the resident has any pets. These may be a safety risk to the dental team in terms of contaminating your equipment, or being bitten! It is appropriate to ask for pets to be put elsewhere when you visit. Check whether the care home has a clinical room.
Medical, mental health and social histories	Ensure your team knows details of the resident/s you are visiting. Share appropriate information in a confidential manner both at the team briefing before you go on the visit, and written clearly in the patient's notes. Ensure you and are up-to-date with your understanding about consent.
Employer's liability	Check that you are insured to practise outside the environment of a dental surgery. Check that the car driver is insured to use their car for the business of domiciliary dentistry.
Personal protection	Personal safety is paramount. It is a legal requirement that a third party is present when the dentist or hygienist visits a care home resident. The dentist or hygienist would routinely be accompanied by a dental nurse, but occasionally the operator may visit a care home unaccompanied (eg. a dentist may make an urgent visit to relieve pain caused by a denture rubbing). In these circumstances, the operator MUST be accompanied by a member of staff from the care home when visiting the resident. Mobile phones and, if necessary, personal alarms, should be carried by the dental team. The dental team should decide whether to wear uniform or smart non-uniform clothing on care home visits. In some locations, it would be wise not to be recognisable as a health team. Always give your practice an approximate time of return from the visit, and notify them if you will be returning later than expected.

In the past, many care home residents were edentulous. That is no longer the case. Optimising access to care for an ageing dentate population is a growing challenge

Risk	Risk reduction
Equipment including emergency equipment	Domiciliary equipment needs to be modern, and kept tidy and compact, both in transport and at the location. Toolboxes are ideal. Access to water, adequate lighting and electricity is essential. If portable lighting is used, ensure the lamp bulb has a shatter proof protective cover. Dental teams should have their own resuscitation kit, emergency drugs kit and portable oxygen. A portable oxygen cylinder should be carried and clearly identified on the case. Dentistry must be practised to the same professional standards you would adhere to in your dental practice. You cannot assume that the care home will have what you need in the case of an emergency occurring during the course of dental treatment.
Moving and handling	Dental teams must know how to move and handle both equipment, and patients, to avoid incurring injuries either to patients, themselves or colleagues. Within the care home setting, dental teams should request the assistance of a carer or carers, if residents need to be transferred from their chair or bed for dental care.
Infection protection and control	Infection protection and control must be to the same standards that are applied in the dental surgery. Visors rather than facemasks are very useful for patents that need to lip-read, or who are anxious. Disposable plastic aprons should be worn over uniforms or clothing. Whether you are working in a dedicated clinical area of the care home, or the resident's own room, the area must be zoned into clean and dirty areas. Resident's clothing must be protected from spillage. If a spillage occurs, inform a member of the care home staff and follow the Health and the DSH guidance on care homes. Disposable, single-use items should be used wherever possible. Dirty instruments must be kept separate from the domiciliary kits and transported in rigid securely lidded containers. Any sharps used must be transported in a sealed sharps container. All laboratory work should be rinsed on site but disinfected back at the dental surgery. This should be labelled to avoid confusion with contaminated clinical waste for disposal.
Clinical waste	Environmental Law, along with any local guidelines should be adhered to, for the storage, transport and disposal of clinical waste. In a care home setting, waste bags and sharps containers will be available to use. Any waste that is transported back to the dental surgery should be double-bagged and transported in a rigid container.
Record keeping	The is a need to maintain detailed records of any interaction with (or in relation to) every patient. Protecting the security and integrity of patient information both in transit and in the home can be a challenge. It is crucial that all relevant information about a patient and their dental care is available, complete and up to date at all times and can be accessed when needed.

Generation-friendly family practices

For the whole dental team, providing regular care to a care home located near their practice is both a personally rewarding experience and a practice builder. With the application of correct professional standards, including meticulous record keeping, providing dental care outside the environment of the dental surgery can offer a refreshing change of scene for the busy dental practice team.

There is no better advertisement for the local general dental practice than to be known as the generation-friendly family practice that sees all members of the family wherever they are located.

References
BSDH Guidelines for the Delivery of a Domiciliary Oral Healthcare Service August 2009
Oral healthcare for Older People 2020 Vision check-up January 2012 British Dental Association

In the medicine cabinet

Professor John Gibson highlights recent pharmacological developments that are already having an impact on dental patients

Background

It seems that there has never quite been a time like this for medical advancements – both diagnostically and therapeutically. The result for the dental team is that there are more and more orofacial manifestations of systemic diseases to be aware of and recognise, also more and more drug therapies that you need to have a handle on regardless of who writes the prescription

To whet your appetite, let me introduce you to some of the challenges currently evident at the medical-dental interface.

Metformin and vitamin B12 deficiency

For example, did you know that metformin, the commonly prescribed oral anti-diabetic drug, has recently been shown to cause vitamin B12 deficiency (Ko *et al*, 2014)? Vitamin B12 deficiency can present with myriad oral manifestations, including macroglossia, glossitis, oral ulceration and angular cheilitis. Maybe, you will be the clinician who diagnoses these signs and suggests the underlying aetiology in your cohort of patients with the increasingly common condition of Type 2 diabetes mellitus?

Chlorhexidine

One of the current concerns in medicine is the increasing prevalence of hypersensitivity ("allergic-type") reactions. Until recently, chlorhexidine would not have figured in the list of substances of concern within dental practice. For chlorhexidine, Type IV hypersensitivity (i.e. delayed) reactions on the skin have been documented for years but are rare. Type I hypersensitivity (i.e. anaphylactic) reactions have been reported where application has been made to broken skin and the urethra, vagina and eyes.

Prior to 1970, no reactions had been reported within the oral cavity, but a number of Type I and Type IV reactions have been reported since, to both solution and gel preparations. In more recent times (2009 and 2011), there have been two UK deaths in dentistry apparently due to chlorhexidine by anaphylaxis – a 63 year old male and a 30 year old female. Both cases appear to have resulted from irrigating sockets with chlorhexidine after dental extractions. In each case, the Coroner reported: "accidental death due to an allergic reaction" and "death by medical misadventure due to anaphylaxis" (Pemberton and Gibson, 2012).

Shortly after the second such tragic death, the UK Government's Department of Health issued a warning via its Medicines and Healthcare products Regulatory Agency (MHRA) drug safety update: *Chlorhexidine: reminder of potential for hypersensitivity* (DOH, London, 2012).

It is worthwhile revisiting the recommendations offered there, whilst reminding ourselves that open wounds seem to increase the likelihood of an allergic reaction. Therefore, it would seem sensible not to irrigate sockets with chlorhexidine; and, further, to advise all patients when you issue a prescription or a product containing chlorhexidine of the possibility of an allergic reaction and to document this warning in the patient's record.

Although chlorhexidine should be viewed as a relatively safe substance which has been in use within dental practice for many years, it is timely to remind ourselves that patients should only be advised (or prescribed) any product when there is a clear clinical indication and the benefits outweigh any potential risks.

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Oral contraceptives and antibiotics

It is always thought-provoking when "tried and tested" advice which has been incorporated into conventional clinical practice over many years is challenged by up-to-date knowledge. It is particularly challenging when such original advice has been generated by oneself! This was the case with the advice on the use of oral contraceptives and the potential interaction with antibiotics suggested by myself in 1994 (Gibson and McGowan, 1994): *when prescribing a broad-spectrum antibiotic, recommend to patients to use a barrier method of contraception whilst taking the antibiotic and for seven days after stopping.*

Since then, Taylor and Pemberton (2012) have challenged this view, highlighting that 25% of women in the UK (aged 16-49 years) use the oral contraceptive and that there are two chief types of hormonal contraception:

- Combined (oestrogen and progestogen – "monophasic" and "phasic"); 21 day cycle with 7 day break
- Progestogen-only; taken continuously.

Current thinking is that oestrogen works by stopping ovulation and progestogen works by thickening cervical mucus (thus decreasing the passage of sperm) and thinning the endometrium (thus preventing embryo implantation).

Taylor and Pemberton state that antibiotics may be classified as:

- Enzyme inducers: which induce the cytochrome P450 enzyme in the liver and so oestrogens are destroyed more rapidly; or
- Non-enzyme inducers: with no effect on progestogen and minimal effect on oestrogen.

The majority of antibiotics (and, indeed, all those in use in conventional primary dental care) are non-enzyme inducers and so the Faculty of Sexual and Reproductive Healthcare (of the Royal College of Obstetricians and Gynaecoloists in the UK) issued new guidance (2011), such that, "*additional contraception precautions are not required even for short courses of antibiotics that are not enzyme inducers when taken with combined oral contraception*".

Similar advice has been given by BPAC (www.BPAC.org.nz). In addition, advice for women who are prescibed enzyme inducing drugs is available from the New Zealand Medicines Formulary. (www.nzf.org.nz).

Sleep apnoea

Patients seem to be complaining more commonly about symptoms of dry mouth – often due to the complexities of drug regimens – but we should always bear in mind the possibility of underlying systemic disorders such as Sjogren's syndrome.
One such complex disorder – is sleep apnoea which may have both local (muscular) and systemic origins. Its complexities demand that the diagnosis of sleep apnoea is established in all cases by a medically-qualified specialist in sleep medicine. The major symptom of sleep apnoea is daytime sleepiness, measured by the Epworth Sleepiness Scale.

There is some suggestion that sleep apnoea, when left untreated, may increase the risk of hypertension, cerebrovascular accident, type 2 diabetes mellitus, mental health morbidity, and possibly myocardial infarction (Loke et al, 2012). Accordingly, identifying patients with sleep apnoea is important and dentists may first find such individuals through the symptom of dry mouth.

Further questioning may reveal fatigue and daytime sleepiness, and the consideration of discussion with the patient's GP regarding referral to a Sleep Medicine unit. Appropriately trained and experienced dentists may subsequently be involved in managing patients with diagnosed sleep apnoea in providing oral appliances (e.g. mandibular repositioning appliances).

Regardless, where patients with sleep apnoea show evidence of dry mouth, additional preventive measures may be encouraged to reduce the risk of caries and tooth loss. Where patients are prescribed oral/nasal masks by sleep medicine physicians to provide CPAP (continuous positive airway pressure) to keep the upper airway open and thus prevent apnoeic episodes, oral dryness may, again, be experienced. Such patients should also be offered augmented preventive advice.

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Contacts

You can contact Dental Protection for assistance via the website www.dentalprotection.org or by using the contacts listed below

Dental Protection

Scheme of co-operation

If your membership with Dental Protection has been arranged through the NZDA scheme you should contact the NZDA as soon as you become aware of any claim, or possible claim, complaint or other need for assistance.

Contact

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September 2015