



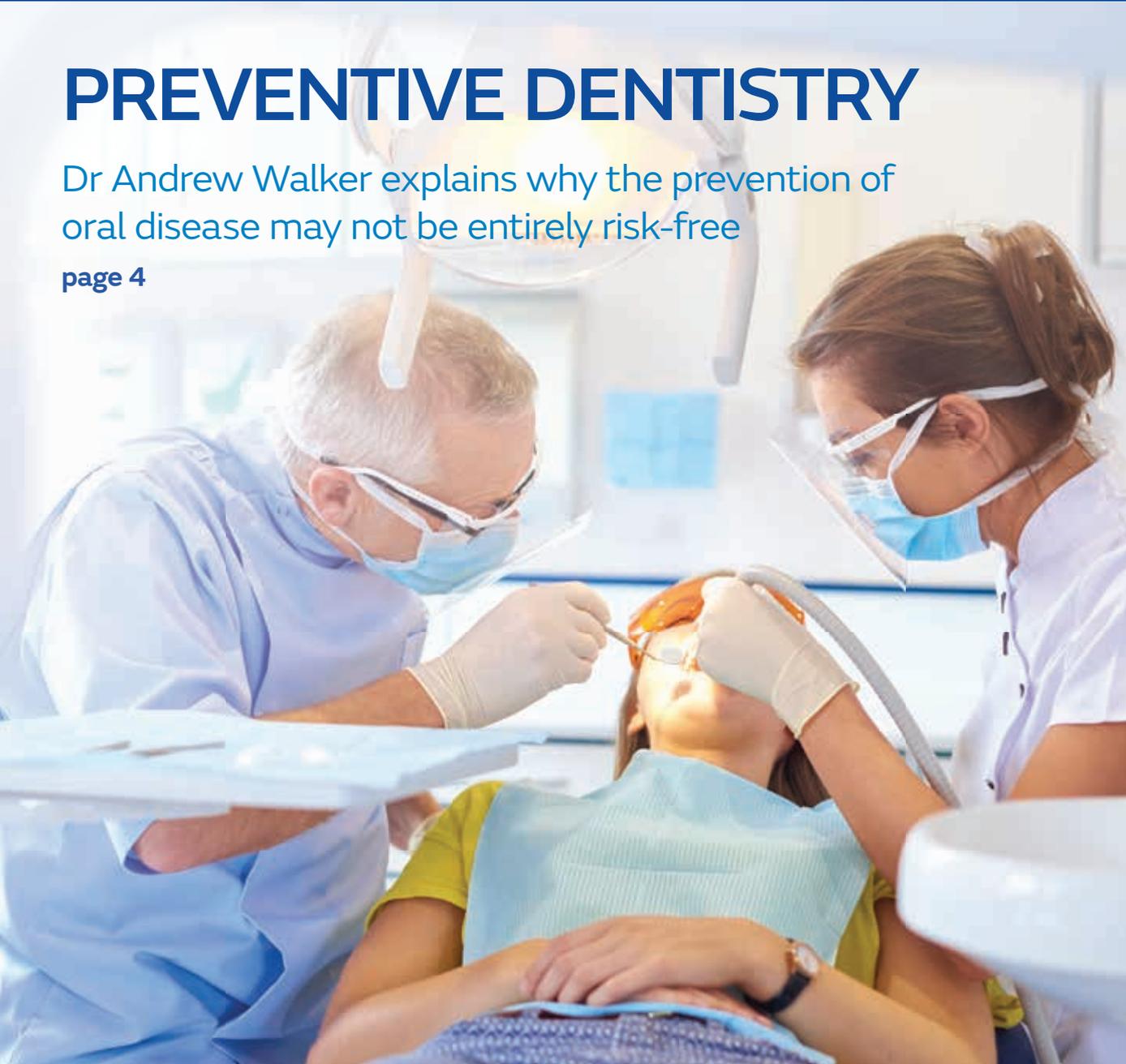
TEAMWISE

ISSUE 20 | MAY 2018

PREVENTIVE DENTISTRY

Dr Andrew Walker explains why the prevention of oral disease may not be entirely risk-free

page 4



INFECTION RISKS OF RECORD KEEPING

How to keep accurate notes and maintain effective infection prevention

TIMES ARE CHANGING

A look at recent and proposed changes to registration standards and guidelines

CASE STUDIES

Practical guidance and learning from real life issues members face

CONTENTS

4

PREVENTIVE DENTISTRY

Dr Andrew Walker assesses the risks associated with attempting to prevent oral disease.

10

TIMES ARE CHANGING

Shireen Smith, Dental Protection's Oral Health Therapist, Hygienist and Therapist Adviser, discusses recent and proposed changes to registration standards and guidelines by the Dental Board of Australia.

12

CAN AN APPLE A DAY KEEP THE LAWYERS AWAY?

Dental Protection's Dr Raj D K Dhaliwal draws on Apple techniques to avoid litigation.

14

INFECTION RISKS OF RECORD KEEPING

How does the dental team balance the need for contemporaneous records and, at the same time, maintain an effective standard of infection prevention and control?

16

PROTECT YOURSELF AND YOUR PATIENTS BY RECORDING IT

Dental Protection solicitor Julia Bryden talks about her experience of complaints and how practitioners can protect themselves with better record keeping.

17

CASE STUDIES

Experiences drawn from real life cases to give you practical tips and guidance to improve your practice.

Editor

Kirsty Sharp

Production and design

Emma Senior

Print

Panther Print, Brisbane



Dr James Foster
Head of Dental Services, Australia

Welcome to the latest edition of *Teamwise*, which offers the latest information on dentolegal topics and advice from our dentolegal advisers and professional experts.

In this edition, we assess the risks associated with attempting to prevent oral disease, such as periodontal disease. Dr Andrew Walker's article, which starts on page 4, will help you to offer preventive advice effectively and understand alternative preventive strategies.

I'd also like to draw your attention to the article on page 10. Shireen Smith, Dental Protection's Oral Health Therapist, Hygienist and Therapist Adviser, discusses recent and proposed changes to registration standards and guidelines by the Dental Board of Australia.

On page 12, you will see an article by Dental Protection's Dr Raj D K Dhaliwal. She draws on Apple techniques to help you to avoid litigation.

In addition, we provide a comprehensive overview of how to maintain an effective standard of infection prevention and control in your approach to record keeping. The article on page 14 highlights that in addition to ensuring that dental records are accurate and contemporaneous, the infection control protocol within the clinical setting is also worthy of further consideration. An article on page 16 also looks at record keeping – it considers how better record keeping can help protect dental practitioners when facing complaints.

CASE STUDIES

We're always looking for new ways to support members so, starting in this edition, *Teamwise* will now always feature a selection of case studies. These are practical examples of claims and complaints that have been faced by members, and we offer learning points and guidance for you based on these situations. From page 17, you will find case studies which focus on infection control, confidentiality, and communication and consent.

MORE SUPPORT

If you are concerned about any of the topics that have been discussed in this edition, or you have another query for which you are seeking advice, then please contact one of our dentolegal advisers on **1800 444 542** or **notification@dpla.com.au**.

I would also encourage you to access and use the education materials which are available on the website through Prism (**dentalprotection.org/prism**). Here you will find CPD and risk management at your fingertips.

I hope you find this edition interesting and enjoyable. If you have any feedback, please feel free to get in touch.

Best wishes,



Dr James Foster BDS, MFGDP(UK) LLM
Head of Dental Services, Australia
james.foster@dentalprotection.org

PREVENTIVE DENTISTRY



Dr Andrew Walker assesses the risks associated with attempting to prevent oral disease

LEARN TO:

- ✓ Provide preventive advice effectively and how to record this activity
- ✓ Assess the patient's risk of developing future dental disease
- ✓ Obtain consent even for the application of fluoride
- ✓ Understand alternative preventive strategies
- ✓ Consider a holistic approach



© Sturti/Gettyimages.co.uk

Over the last two decades there has been a shift in the management of patients towards prevention rather than cure. The associated refocusing of effort can be found in all fields of healthcare, including dentistry. The dental profession continues to invest time and resources in helping patients to achieve and maintain good oral health, rather than concentrating that investment in the treatment of oral disease.

The key elements of this approach include not only patient education, but also helping patients implement any advice given. In this sense, preventive medicine and preventive dentistry not only concentrate on the individual, but also look at communities and populations. Synergy can play a role here, if public health measures are aligned with the commissioning of primary care service providers.

As well as education, there are clinical interventions, such as fluoride application and fissure sealants, which can be implemented as part of an overall preventive approach. The provision of preventive dentistry is not restricted to dentists alone, and the whole dental team can be involved including dental therapists, hygienists, dental nurses and dental health educators – as long as it is in their scope of practice.

From a dentolegal perspective, many cases involve criticism of a clinician's failure to give primary preventive advice that would avoid the need for subsequent treatment. The resulting allegation is that the patient has suffered harm that could, and should, have been avoided. Even when there is genuine doubt as to whether or not the patient would have acted upon any advice offered, the alleged breach of a clinician's duty of care often arises from the assertion

that the patient was denied opportunity to benefit from an intervention that could have prevented the disease or damage in question.

The criticisms that a clinician might face broadly fall into one of three categories:

- The provision of inappropriate advice and/or treatment.
- The provision of treatment (or the decision not to provide treatment) without adequate consent having been obtained.
- The occurrence of problems which may have been prevented if appropriate action had been taken at an earlier stage.

SCREENING AND RISK ASSESSMENT

There is now greater emphasis on the benefits of performing a risk assessment on patients, which will allow more targeted and focused healthcare. RAG (Red, Amber, Green) scoring is one example of a risk assessment that has already been adopted by many healthcare systems.¹

All dental patients stand to benefit from a preventive intervention; however, the greatest benefits can be achieved by focusing such measures on those patients who present with a higher risk profile. There are many screening tools which can be employed to identify early problems, potential problems and high-risk patients. The two most commonly used examples of these are the Basic Periodontal Examination (BPE)² and bitewing radiographs. Specific guidance on the use of such tools may vary and you should be aware of the standards where you practise and ensure you are acting in the best interests of your patient and within your scope of practice.

In Australia, the accepted teaching is that appropriate recall intervals be based not on a set interval, but on the original diagnosis, the extent of the disease, the nature of any treatment carried out, patient response to treatment, and the need for long term review and maintenance. As dental caries and periodontal disease are essentially chronic diseases, this means that any treatment plan must account for and manage aetiological risk factors and treatment risks. Any individual treatment plan must include ongoing and long term reassessment and management. Failure to do so may mean inadequate patient care.

The importance of adequate dental patient records is an important part of patient management.³

ARPANSA outlines the Code of Practice and Safety Guide for radiation protection in Dentistry. The Australian Dental Association has additional guidelines for dental radiography.

The American Academy of Periodontology and the American Dental Association have extensive articles relating to guidelines and suggested requirements in managing periodontal disease from diagnosis to long-term maintenance.

FLUORIDE

There is overwhelming evidence that fluoride has a significant impact on the prevalence of caries. The use of fluoride can take one of two forms: topical application and systemic supplements. The introduction of fluoridated toothpaste is one example of how mass access to fluoride has improved oral health by reducing the incidence of dental caries.

Other forms of readily available fluoride can be found in varnishes, mouth-rinses and fluoridated additives, such as fluoridated salt. As already mentioned, specific guidance may vary from country to country and each practitioner should check their own local recommendations. This is important, as the information may vary depending on factors such as whether the water supply is fluoridated.

Regardless of location, the consent process for the patient is a key issue when using fluoride, especially in topical agents. As with many areas of healthcare, there is some controversy surrounding the issue. A small number of research articles, and a commensurately small number of clinicians, have linked fluoride to serious side effects, including cancer, in some instances. Such negative connotations have been reported in the media and, understandably, caused some concern for the general public.

Whilst the overwhelming body of evidence suggests fluoride is beneficial and safe, when used in the recommended dose, some patients or parents may not wish to have such treatment. Of course, it is their right not to do so and it is critical, if you are undertaking such treatment, that the patient or their parent fully understands what you are proposing, what materials you are using, the intended benefits and any associated risks.

Dental Protection is not the arbiter of clinical opinion; so when deciding on treatment approaches, each clinician must carefully weigh up the evidence and guidance for themselves and act accordingly. They must also be willing to justify all of these decisions in the event they are challenged at a later date.

DIET AND ORAL HYGIENE INSTRUCTION

These are two pivotal, patient-centred issues that are basic to promoting better oral health. Any assessment and advice needs constant re-enforcement, as they can both involve lifestyle changes that are often difficult for patients to implement.

It is simply not enough to provide patients with information. Clinicians also need to consider how they can help their patients use that information. This might involve looking specifically at the diet and helping the patient identify practical ways in which they can make positive changes. This aspect of care does not need to be performed by the dentist and is an opportunity for the whole dental team to be involved. Hygienists, therapists and oral health educators can all have a role in delivering the educational component of patient care.

ADDITIONAL RESOURCES

It is well-known that patients can only absorb a small amount of the total information presented to them at any one time in the clinical setting. This is one reason why it is so important to provide continual, positive re-enforcement of the information. One way to enhance the message you want to give is by providing written factsheets. There are many downloadable information sheets, which are published by recognised authorities, and those published by the ADA provide an excellent source of patient education.



SIMPLE CONSERVATION

Clinicians will be familiar with the dilemma of having to decide whether or not an early carious lesion can be re-mineralised and reversed, whether it can be kept under observation and reviewed, or whether immediate active intervention is required. With the benefit of hindsight, one can be criticised for any wrong decision. However, it is equally possible to defend a decision which turns out to have been misguided, if it was based on justifiable reasons at the time. This is dependent on an appropriate history, examination and investigations to support the decision are properly recorded in the patient's clinical notes.

A particular dilemma exists when treating early pit and fissure lesions, because in addition to the 'to treat or not to treat' decision that exists with interproximal or smooth surface lesions, there is the added problem that it is not always easy to detect developing lesions radiographically.

Transillumination is a useful diagnostic adjunct both for occlusal and interproximal lesions, but here again it is important to record the use of this investigation, and any conclusions reached, in the clinical notes.

When fissure sealants are recommended as primary preventive procedures (or when sealant restorations are advised in circumstances where any part of an enamel pit or a fissure system is thought to be actively carious), it is important not to give the impression to the patient (or possibly, their parents) that this provides any kind of guarantee of long-term protection against subsequent caries.

Allegations have been known to be made that fissure sealants were recommended and provided on the assurance by the clinician that the teeth would thereby be protected forever from becoming carious. Any such assurances or guarantees are misplaced, and should be avoided.

Checking the marginal integrity of fissure sealants, once placed, noting and acting upon any reported sensitivity from the teeth involved and their periodic monitoring by means of radiographs where appropriate, is an important aspect of preventive dentistry. Fissure sealants can, and do, 'leak' and they can then obscure the development and progression of caries in the depths of the fissures that they are designed to protect, sometimes leading to extensive caries occurring before the problem is detected.

COMPLEX CONSERVATION

The provision of restorative treatment for patients where caries are not controlled creates the ever-present risk of further caries at the margins of the restorations, or elsewhere in the same tooth. The provision of complex or expensive treatment, when the primary disease has not been controlled, could leave the clinician open to challenge regarding the appropriateness of the treatment plan. This may be a particular issue if there is premature failure of any treatment provided. To mitigate any criticism of the clinician, a careful discussion of all the treatment options is required and should be recorded before treatment starts, together with the reason for the patient's preferred option if this does not coincide with the recommendations of the clinician. Treatment should not be undertaken unless it is considered to be in the patient's best interests.

Some patients are at a higher than average risk of caries or tooth erosion because of impaired salivary function due to systemic disease or medication. In a similar fashion, a patient's susceptibility to both caries and periodontal disease can be affected by the introduction of fixed or removable prostheses, or orthodontic appliances. Acknowledging these factors, and acting appropriately, is another example of risk assessment and good patient management.

The provision of treatment without any necessary preventive advice, designed to maximise prospects for success and longevity, can lead to early failure. If this results in the patient being worse off than if the situation had no treatment been provided at all, which is often the case, complaints or claims may ensue.

SMOKING CESSATION AND ALCOHOL USE

Scientific research has clearly established smoking as a major risk factor for both periodontal disease and oral cancer; this has changed the standards expected of dental professionals. It is no longer acceptable for clinicians to ignore tobacco use and a failure to inform the patient of the risks it has on their oral health, or failing to advise smoking cessation, could be viewed as a breach of duty.

All patients should be asked specifically about the nature and extent of any tobacco use habit, including chewing tobacco or other carcinogenic chewing materials such as paan, and they should be made unambiguously aware of the adverse

effect that this can have upon their oral and general health. These enquiries, and any necessary follow-up advice, should be repeated at appropriate intervals. It would also be prudent to offer referral to a local professional smoking cessation service.

Most medical history forms used by dental practitioners also enquire about alcohol use. If it transpires that a clinician had information about the patient's habits that could impact on their health at a later date, but had not acted upon this information, they may be open to criticism. Although it may be a subject that dental practitioners feel uncomfortable discussing with patients, high alcohol consumption is known to increase the risk of oral cancer. The patient should be made aware of this fact along with the synergistic effect of smoking and alcohol. There is plenty of educational material online that can be used to raise patient awareness. In addition, there are public health campaigns which provide an opportunity to start a conversation with a patient that might otherwise be difficult to initiate.

HOLISTIC CARE

The following concepts encapsulate the idea of considering all aspects for patient care and there may be other areas of concern where the dental team may be able to implement a preventive strategy. Such areas include, but are not limited to:

- Dry mouth – there may be many reasons why patients have a lack of saliva and this can predispose them to a high caries rate. If this is recognised early, appropriate management can help reduce the impact of the condition.
- Acid erosion – this is a growing problem, especially in younger adults and teenagers. The restoration of severely affected teeth can also present a difficult challenge for the dentist. Again, early detection and prevention can prevent a lifetime of difficult problems for both the patient and dentist.
- Oral sex and the risk of HPV – although a sensitive subject, it still falls within the remit of dental care. It may not always be appropriate to directly ask or discuss this with patients and so it can be useful to use other forms of communication. Factsheets and posters subtly displayed in the practice can inform patients without causing embarrassment and offer them the opportunity to ask further questions if they so desire.

RECORD KEEPING

As with all complaints and claims, your clinical records are your best line of defence. Therefore, it is critical that they accurately reflect advice, warnings and treatment given.

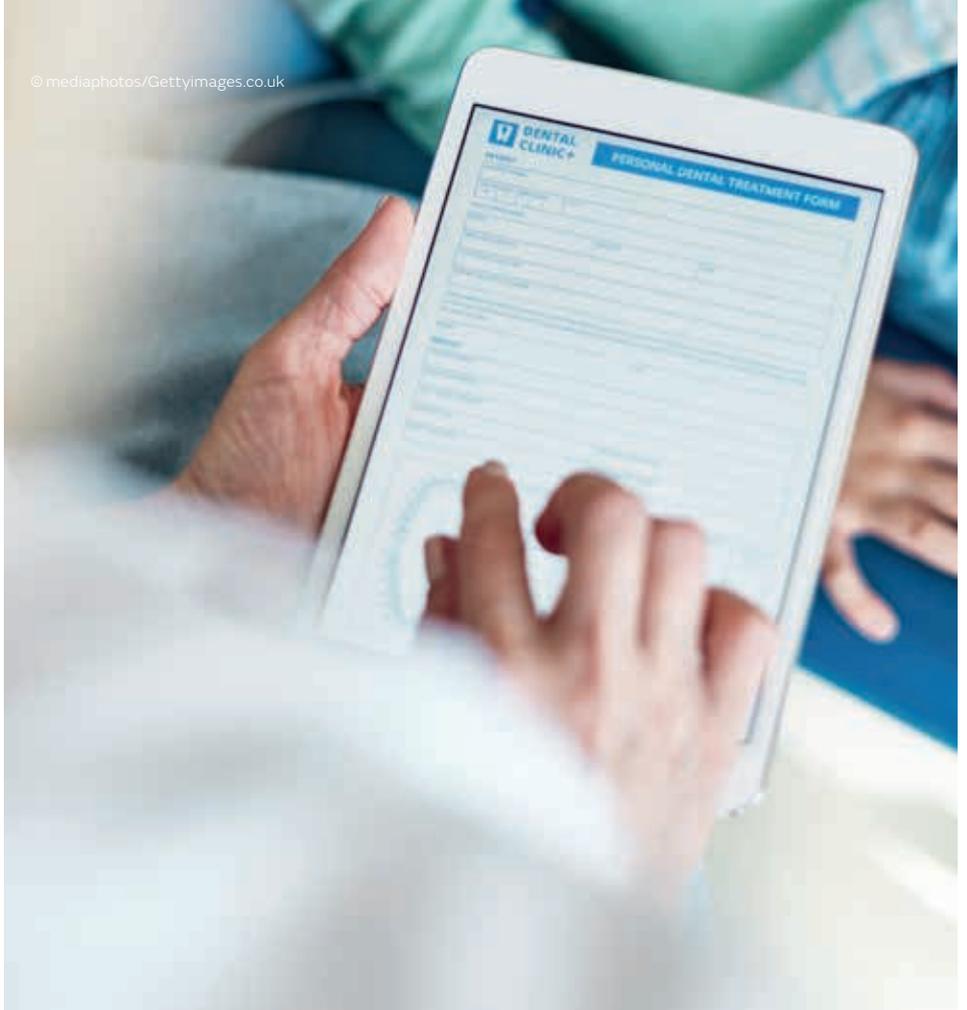
Detailed records should be kept of all occasions when preventive advice is given to patients, or parents. It should be clear from any such entries:

- who gave the advice
- what form the advice took (for example, whether verbal or supplemented by advice sheets or visual aids of any kind)
- how the patient responded to the advice.

It is particularly important to note instances where a patient appears apathetic or disinterested in the preventive advice being offered to them, or when the patient indicates that they are unlikely to follow such advice. Here, any entries should be sufficient to demonstrate that the patient was appropriately warned of the likely consequences of not acting upon the advice given.

It is sometimes conceded on a patient's behalf, especially when confronted with good contemporaneous records, that certain advice was indeed given, but then argued that it had been given in such a way as to attach no great importance to the advice.

When the advice given to a patient is likely to have a direct bearing upon their future oral health (or general health), it is advisable to ensure that the record entry properly reflects any emphasis given to the advice and also that the subject was re-explored with the patient at subsequent visits. If a preventive message is important enough to give to a patient, it follows that it is



important enough to reinforce at regular intervals.

A patient who may not be receptive to the advice on one occasion may well be more receptive to the same advice when it is subsequently repeated, often for reasons of which the clinician may never be aware.

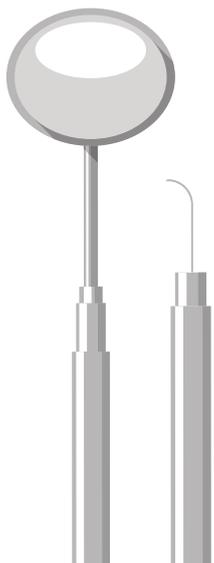
In the case of oral hygiene instruction, it is helpful if records provide sufficient detail of any specific preventive techniques that the patient is advised to use. If these techniques are demonstrated to the patient (for example, on a model, or in the patient's own mouth) and/or if the patient is encouraged to practise the technique(s) under the supervision and guidance of a

dentist, hygienist or therapist, then this similarly needs to be described clearly in the clinical notes. Vague entries such as 'OHI' are better than nothing at all, but are still of relatively limited value in confirming precisely what advice was given.

Similarly, a note should be made of any educational material, videos, leaflets or advice sheets that are given to patients (or parents) to supplement any preventive advice given verbally. Additional resources, such as clinical photographs and study models can help demonstrate not only the clinical situation, for example at first presentation, but can demonstrate appropriate monitoring and education.



It is particularly important to note instances where a patient appears apathetic or disinterested in the preventive advice being offered to them, or when the patient indicates that they are unlikely to follow such advice





© Sturrt/Gettyimages.co.uk

SUMMARY

Any member of the dental team who is involved in the provision of dental care, advice and treatment to patients, whether to specific patients or more generally, needs to be aware of current thinking in the field of preventive dentistry and to take steps to keep their knowledge and skills up-to-date. Preventive dentistry needs to be seen as an integral part of the care provided for all patients, rather than being reserved for specific patients in specific situations. This is reflected in The Dental Board's Code of Conduct, which states that healthcare professionals should encourage "patients or clients to take interest in, and responsibility for, the management of their health and supporting them in this".

Communication and documentation are key aspects to successful practice. For the right messages to be given and received, communication is essential, not only between the clinician and the patients, but also between all the members of the dental team. Advice is more likely to be acted upon if communicated effectively; consideration should be given to how,

when, where and by whom this advice is given, and also to the need for training and personal development of the dental team in the areas of behavioural psychology and communication skills.

When the team has worked hard on promoting oral health and providing high quality preventive dentistry, this should be reflected in the clinical records with excellent documentation. The critical aspect of record keeping is that a third party needs to be able to read and understand the records and subsequently know exactly what has happened, and when.

When there is nothing abnormal to be seen with the oral tissues and a fee is charged for achieving this highly desirable condition, a clear record of how this was achieved is the only way of proving that the outcome was due to professional nurture (a chargeable activity) and not a gift from nature (no charge).

REFERENCES

1. Asimakopoulou K, Rhodes G et al. Risk communication in the dental practice. *British Dental Journal* Vol 220 No. 2 Jan 2016. Department of Health. Dental Contract Reform: prototypes. Overview document 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/395384/Reform_Document.pdf
2. Council of the British Society of Periodontology. Basic Periodontal Examination (BPE). *British Society of Periodontology* 2016. http://www.bsperio.org.uk/publications/downloads/94_154250_bpe-2016-po-v5-final-002.pdf
3. Guidelines are available at Dental Board of Australia (dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx)



2018 RISK MANAGEMENT WORKSHOPS

Learn how to
manage your
risk and improve
patient safety

- ✓ **Dental Records for Dental Practitioners** **NEW**
- ✓ **Mastering Your Risk**
- ✓ **Mastering Adverse Outcomes**
- ✓ **Mastering Difficult Interactions**
- ✓ **Mastering Consent and Shared Decision Making**



REGISTER TODAY
at dentalprotection.org.au

REGISTRATION ENQUIRIES
email apeducation@dentalprotection.org

DURATION
Three hours

DESIGNED FOR
General dental practitioners and specialists

**ACCREDITED
WORKSHOPS**

**FREE TO
MEMBERS**

DPL Australia Pty Ltd ("DPLA") is registered in Australia with ABN 24 092 695 933. Dental Protection Limited ("DPL") is registered in England (No. 2374160) and along with DPLA is part of the Medical Protection Society Limited ("MPS") group of companies. MPS is registered in England (No. 36142). Both DPL and MPS have their registered office at Level 19, The Shard, 32 London Bridge Street, London, SE1 9SG. DPL serves and supports the dental members of MPS. All the benefits of MPS membership are discretionary, as set out in MPS's Memorandum and Articles of Association. "Dental Protection member" in Australia means a non-indemnity dental member of MPS. Dental Protection members may hold membership independently or in conjunction with membership of the Australian Dental Association (W.A. Branch) Inc. ("ADA WA").

Dental Protection members who hold membership independently need to apply for, and where applicable maintain, an individual Dental Indemnity Policy underwritten by MDA National Insurance Pty Ltd ("MDA"), ABN 56 058 271 417, AFS Licence No. 238073. DPLA is a Corporate Authorised Representative of MDA with CAR No. 326134. For such Dental Protection members, by agreement with MDA, DPLA provides point-of-contact member services, case management and colleague-to-colleague support. Dental Protection members who are also ADA WA members need to apply for, and where applicable maintain, an individual Dental Indemnity Policy underwritten by MDA, which is available in accordance with the provisions of ADA WA membership. None of ADA WA, DPL, DPLA and MPS are insurance companies. Dental Protection® is a registered trademark of MPS."

TIMES MAY BE CHANGING



Shireen Smith, Dental Protection's Oral Health Therapist, Hygienist and Therapist Adviser, discusses recent and proposed changes to registration standards and guidelines by the Dental Board of Australia

READ THIS ARTICLE TO:

- ✓ Understand how recent and proposed changes made by the Dental Board of Australia affect you

Times are changing for dental hygienists, oral health therapists and dental therapists in Australia and, for this reason, it is best to be mindful of what has changed and what further changes are being proposed.

It first started with the Dental Board's communique in February 2017 – an agreement was made to phase out the approval process of programs to extend scope of practice for dental hygienists, oral health therapists and dental therapists from 1 January 2017 until 31 December 2018.

Then more recently, on 22 March 2018, the Dental Board released a proposal for public consultation in relation to:

- a revised scope of practice registration standard
- revised guidelines for scope of practice and
- a new reflective practice tool for scope of practice.

At present you must only practise within a structured professional relationship with a dentist and must not practise as an independent practitioner.

RESOURCES

1. Dental Board Australia Consultation paper - Scope of practice registration and guidelines for scope of practice (March 2018)
2. Communique - meeting of the Dental Board of Australia (February 2017)

The proposed changes to the current registration standard and guidelines that may affect you in the near future are as follows:

1 REMOVE REFERENCE TO PROGRAMS TO EXTEND SCOPE

The programs to extend scope (formerly known as add-on programs) cover a range of skills which allow dental practitioners to extend their education, training and competence in certain areas and within the division in which they are registered.

The Board made the decision because the historical need for these programs has faded, resulting in a decrease in the demand for them, with most of the topics now being incorporated in the programs of study already approved by the Board.

The programs to extend scope can still be delivered as continuing professional development (CPD) programs. However, all dental practitioners are reminded that CPD programs alone cannot be used to increase scope and may not provide a dental practitioner with the sufficient clinical experience to incorporate techniques and procedures into their practice.

Registered dental practitioners are responsible for self-assessing and selecting CPD programs that:

- relate to the definition of their practice as defined in the Board's scope of practice guidelines
- "broaden knowledge, expertise and competence" in accordance with the Board's CPD registration standard and guidelines.

In addition, if you decide to expand your individual scope, you need to be mindful of:

- other regulatory requirements, including drugs and poisons legislation and radiation authorities
- whether your professional indemnity insurance covers any additional procedures or techniques
- always practising in accordance with the Board's Code of Conduct.

For this reason, it is important that you keep a clear record of any program to extend scope or any CPD activity/course that you complete.

2 CLARIFY EXPECTATIONS AROUND EDUCATION, TRAINING AND COMPETENCE

The guidelines may be restructured and re-worded to improve readability and clarify current requirements around education, training and competence. In particular, reference to dental and oral health therapist and adult scope.

The new descriptions imply that dental therapists and oral health therapists may provide dental therapy treatment (for example, simple restorative treatment) to patients of all ages (as opposed to only patients under 18 or 26 years), provided that they complete an education program approved by the Board.

Currently, at least three out of the eight Bachelor of Health (BOH) Board approved programs of study (La Trobe University, Newcastle University and Central Queensland University) teach

dental therapy treatment on patients of all ages. Additionally, two programs to extend scope related to adult scope include The University of Adelaide and The University of Melbourne's Graduate Certificate.

3 REMOVE THE REQUIREMENTS OF "INDEPENDENT PRACTITIONER"

Independent practitioner means a practitioner who may practise without a structured professional relationship.

The current registration requirements, which have been in place since 2010, state that oral health therapists, dental hygienists and dental therapists must only practise within a structured professional relationship and must not practise as independent practitioners.

Over the past years, the Board has seen the education programs for dental therapists, dental hygienists and oral health therapists continue to strengthen and mature and have indicated current training is sufficient to support these practitioners in working in team-based settings without supervision.

4 REMOVE THE REQUIREMENT OF A STRUCTURED PROFESSIONAL RELATIONSHIP

The requirement of a structured professional relationship was included in the registration standard to provide a framework to support the team approach for dental care.

Dental practitioners have a responsibility to recognise and work within the limits of their competence and scope of practice, which may vary over time.

Dental practice is fundamentally team based and requires practitioners to work with other practitioners to provide patient care, which includes the appropriate delegation, referral and handover of patient care.

All dental practitioners must only perform those dental procedures for which they have been educated and trained, and in which they are competent, as per the registration standard and the guidelines.

MORE SUPPORT

During these transitional periods, Dental Protection can be on hand to support and assist with colleague-to-colleague advice. However, your first point of call in relation to your individual scope of practice would be the university in which you obtained your qualifications for registration.

As part of your Dental Protection membership, you have access to free educational services such as such the Sliding Doors seminar series and workshops to help you and your team reduce dentolegal risks. Visit dentalprotection.org

At present you must only practise within a structured professional relationship with a dentist and must not practise as an independent practitioner. It is only a proposal at this stage and you must meet the current registration standards.

CAN AN APPLE A DAY KEEP THE LAWYERS AWAY?

Dental Protection's Dr Raj D K Dhaliwal draws on Apple techniques to avoid litigation

I think it's fair to say that complaints are upsetting to receive. At Dental Protection we are always assessing complaints and looking in more detail at how they arise. Most are borne out of clinical or non-clinical factors or, in many cases, a combination of both.

The non-clinical factors tend to relate to issues with communication: the manner of the dental team, being kept waiting and the lack of information. This was reflected in the Health Care Complaints Commission annual report for 2015-2016, which highlighted communication issues as the second most common reason (17.2%) for raising a complaint against a health service provider.¹

So if communication is an issue, can we look at other organisations in the service sector and learn lessons? The customer service provided by Apple is well known, and to such an extent that other organisations have tried to emulate this in improving their own customer relations.

It became public knowledge a few years ago that Apple employees are trained to follow a step-by-step approach to customer service. This approach follows the acronym A-P-P-L-E:²

- A** Approach customers with a personalised, warm welcome
- P** Probe politely to understand the customer's needs
- P** Present a solution for the customer to take home today
- L** Listen for and resolve issues or concerns
- E** End with a fond farewell and an invitation to return.

Could this step-by-step approach be transferred to our own practices to help reduce non-clinical complaints?



A – APPROACH

The first contact that a patient will have when they attend the practice is with the reception team. This is your chance to make a good first impression. We should be asking the following questions:

- How are the patients greeted?
- Do the reception team introduce themselves with their name? Names are powerful tools and are invaluable in building up a rapport.
- Is the patient's first name used or a more formal greeting? Is the greeting appropriate for all patients or will this depend on the patient relationship? Studies have shown that it may be best to ask the patient how they would like to be addressed.³

The continuation of this warmth in tone should continue as the patient moves through the treatment process. Does the treating practitioner come and greet the patient or is the patient invited into the clinic by the dental assistant?

Take time when the patient enters the clinic to greet them and maintain eye contact. We're all busy and it's easy to use this period to catch up with notes, but taking time to show the patient they have your attention can be a valuable and powerful technique. Studies have shown that computers can have a negative impact on a consultation.⁴

P – PROBE

This is an opportunity for us to gain a social, dental and medical history from the patient. Be polite and give the patient an opportunity to explain their needs without interruption. Do give non-verbal cues, such as nodding and open body language, to encourage the patient to talk.⁵

Use active listening to respectfully ask questions and listen for any relevant information. It's important that we don't approach each consultation with preconceived treatment plans, as all patients have different needs and wants.

Importantly, after listening to the patient, can you meet their expectations? Does this patient need a specialist referral?

P – PRESENT

After taking the history are you able to present all the treatment options?

It's important to remember that if you don't discuss all the treatment options, then it could be argued that you haven't obtained the patient's consent. Therefore, it is important to discuss all the risks, complications, and cost and time implications for all the options discussed. Will the patient require ongoing maintenance?

It's important to spend the time with the patient, ensuring that they understand all the options.

Studies show that those clinicians that spend extra time with their patients help to change their perception of care. Those patients that felt rushed are more likely to pursue a claim.⁶

L – LISTEN

Once all the options have been discussed, it's important to listen to any questions and queries that the patient or their families may have. Take time to document any specific concerns that the patient may raise and the responses you have given.

In addition to listening to them, pay attention to their body language, voice tone and facial expressions – these are key indicators and can often say more than their words.

Ensure that your non-verbal communication is indicating that you are listening to the patient and remember it is an ongoing process. This can show that you're actively listening and engaging, and give them confidence in you as a practitioner.⁷

REFERENCES

1. Health Care Complaints Commission Annual Report 2015–2016 hccc.nsw.gov.au/Publications/Annual-reports/Default accessed 29 August 2017
2. Gallo C. How the Apple store create irresistible experiences. <https://www.forbes.com/sites/carminogallo/2015/04/10/how-the-apple-store-creates-irresistible-customer-experiences/#16c6b48217a8> accessed 2 September 2017
3. Parsons P, Hughes A & Friedman N. Please don't call me Mister: patient preferences of how they are addressed and their knowledge of their treating medical team in an Australian hospital. *BMJ Open* 2016 Vol6 Issue 1 bmjopen.bmj.com/content/6/1/e008473
4. Frankel R, Altschuler A, George S et al. Effects of exam-room computing on clinician – patient communication: a longitudinal qualitative study. *Journal of General Internal Medicine* 2005;20:677-682
5. Warnecke E. The Art of Communication. The Royal Australian College of General Practitioners. RACGP vol 43 No 3 2014 p156-158 racgp.org.au/afp/2014/march/art-of-communication/
6. Mehta S. Patient satisfaction reporting and its implications for patient care. *AMA Journal of Ethics*. Vol 17 No.7 2015 p616-621
7. Kourkouta L & Papatthanasiou I. Communication in Nursing Practice. *Mater Sociomed*. Vol 26, No 1 2014 p65-67

READ THIS ARTICLE TO:

- ✓ Discover how communication issues can lead to complaints against health service providers
- ✓ Learn how Apple approach customer service
- ✓ Understand how this technique can help you avoid litigation

E – END

At the end of the consultation appointment, give the patient an opportunity to think over the treatment options. Address any questions and concerns and ensure they understand everything you have told them.

At the end of treatment, ensure that the patient is aware that if they have any concerns, they should come back to the practice. This openness helps to deal with the concerns locally, rather than a third party becoming involved.

All members of staff should know how to deal with a complaint or concern, even if it's, "let me take you to Mrs Smith our PM who can address this" rather than "I'm sorry I can't help you, you're speaking to the wrong person".

In conclusion, taking a bit of time to address the service we provide to patients can have dramatically positive effects on the way they interact with us as dental professionals and, ultimately, could reduce the likelihood of complaints.

INFECTION RISKS OF RECORD KEEPING

How does the dental team balance the need for contemporaneous records and, at the same time, maintain an effective standard of infection prevention and control?

READ THIS ARTICLE TO:

- ✓ Learn how to maintain an effective standard of infection control in your approach to record keeping
- ✓ Discover where major infection risks can occur in paper and computer records

Very few clinicians have the luxury of dedicated secretarial support at the chairside while they are working on patients. Whatever your approach to record keeping, maintaining an effective standard of infection control should be paramount.

MAINTAINING THE CHAIN OF STERILITY

Have you ever stopped to think what happens when contaminated fingers touch the paper record card or hit the keys of the computer keyboard? There will certainly be a greater risk of disease transmission if the writing instrument or the writer's fingers had been contaminated when the entry was made.

Operator-to-patient contact is one of the main methods of spreading bacteria but patient records handled by the dental team can also be the cause of cross contamination. Hand hygiene is essential if effective zoning is to be achieved. Periodic review by the dental team of adherence to this protocol is one method to ensure compliance.

PAPER RECORDS

In order to create effective zoning within a clinical area, paper records need to be kept beyond the area of clinical activity. Since barrier protection is applied to the hands whilst treating patients, it means that additions to the record can only be made before gloving up or after they have been removed and the hands washed. If the need arises to add information to the record during the course of the treatment, there are three ways to deal with this:

- Remove gloves, wash hands or use approved alcohol-based hand rub (AHBR), add notes, and change into new gloves after having washed hands or used AHBR after adding to the notes.
- Create a second barrier (such as a loose fitting bag or disposable 'mitt') placing it over your gloved hand before writing.
- Another member of the team who is not gloved up could make the entry.

SILVER PAPER

Superbugs, including MRSA and clostridium difficile, pose a growing challenge. Items such as patient records and case note folders can now be impregnated with an additive containing silver ions, which instantly kills microbes on contact. This provides a permanent hygienic solution that is active 24 hours a day throughout the

lifetime of the product. Clinical research conducted by one manufacturer showed that 99.9% of bacteria are killed within 24 hours. This approach will possibly become a required standard for the manufacture of record cards in the future, if we do not manage to go paperless.

COMPUTER RECORDS

In many dental surgeries there has been an attempt to eliminate paper records and to replace them with a computer-based equivalent. From an infection control perspective, the use of a computer in the surgery reduces the number of items touched by the clinical team and, with suitable safeguards, it can be utilised within the zone of clinical activity.

The risks arise primarily from direct contact (for example, a contaminated gloved hand/finger) or via aerosols and splatters. The former can be managed by ensuring that there are strict hand hygiene protocols in place, while the latter can be reduced by appropriate surgery design and computer positioning.

Aerosols are inevitably created in the dental surgery when working in the patient's mouth. Aerosols and droplets generated by high-speed dental drills, ultrasonic scalers and air/water syringes are contaminated with blood and bacteria and represent a potential route for transmitting disease. Pathogens can settle onto surfaces anywhere in the clinical environment. Keeping a computer in the surgery means the keyboard, the mouse and the monitor are vulnerable.

KEY PLAYERS

The average unprotected keyboard is a hotspot for bacteria, each 2.5cm squared harbouring a staggering 3,295 organisms. One study found potential pathogens cultured from computers included coagulase-negative staphylococci (100% of keyboards), diphtheroids (80%), *Micrococcus* species (72%), and *Bacillus* species (64%). Other pathogens cultured included ORSA (4% of keyboards), Ossa (4%), vancomycin-susceptible *Enterococcus* species (12%), and non-fermentative gram negative rods (36%). Particular bacteria hotspots are the space bar and vowel keys because they are most often used.

Therefore, computer equipment should be covered with a plastic barrier when contamination is likely. This would apply primarily to the mouse and keyboard.

Like any barrier used during patient care, it should be changed between patients.

If a reusable form-fitted barrier is used, it should be cleaned and disinfected between patients. The use of disinfectant wipes has also been advocated, but the potential to damage the plastic keyboard needs to be considered. Infection control keyboards that are capable of being washed are also available.

Strict hand hygiene is also important. Before touching any office equipment wear powder-free gloves or ensure your hands are clean. Computer equipment is an example of a clinical contact surface and the basic principles of cleaning and disinfection used routinely in the dental environment should also apply. Further comprehensive hand hygiene measures can be found at Hand Hygiene Australia (HHA): hha.org.au

SCREEN ATTRACTION

The risk posed by the computer screen is slightly different. Bacterial cells possess a negative electrical charge, while the technology used in flat screens generate positively charged static electric fields.

Consequently, bacteria dispersed within the aerosols will be attracted to the computer screen. Avoiding contamination of the unit housing the screen is important because it cannot be properly cleaned and disinfected or sterilised. Avoid touching the screen whilst treating patients, be aware of the potential bio-load on the screen and perform hand hygiene if you need to adjust the monitor with ungloved hands.

In addition to ensuring that your dental records are accurate, complete and contemporaneous, the infection control protocol within the clinical setting is also worthy of further consideration. The resources listed below are just a few of those used in this article.

RESOURCES

1. Dr Philip Johnstone BChD MFGDP(UK)
2. Rutala WA, White MS, Gergen MF, Weber DJ; Bacterial contamination of keyboards: efficacy and functional impact of disinfectants. *Infect Control Hosp Epidemiol* 2006;27:372-377.
3. Bacterial contamination of computer touch screens. *American Journal of Infection Control* 44(3):358-360, March 2016, DOI: 10.1016/j.ajic.2015.10.013
4. Bacterial Contamination of Computer Keyboards in a Teaching Hospital, <https://doi.org/10.1086/502200> Published online: 01 January 2015
5. Maureen Schultz, Janet Gill, Sabiha Zubairi, Ruth Huber, Microbial contamination of laptop/ keyboards in dental settings, Anjum et al *International Journal of Public Health Dentistry*

PROTECT YOURSELF AND YOUR PATIENTS BY RECORDING IT

Dental Protection solicitor Julia Bryden talks about her experience of complaints and how practitioners can protect themselves with better record keeping

Regulatory challenges, complaints and clinical negligence claims are an occupational hazard in today's climate. Sadly, complaints can still occur even when quality care has been provided.

While our highly experienced team of dentolegal advisers can assist you through these challenging times, I would like to discuss some of the steps you can take in advance to protect yourself against challenge.

The importance of accurate dental records cannot be overstated. This is because the content and quality of dental records will determine whether a complaint can be successfully defended. Unfortunately, a number of claims have to be settled due to a lack of detail in the clinical records, and many dental practitioners have fallen foul of their regulator for the same reason.

Contemporaneous records will, however, support and supplement your recollection of the treatment and advice provided. They will also corroborate your version of events. This is invaluable in defending yourself, as we find there is often a conflict of evidence: in other words, it is your word against the patient's.

We recognise that members are busy and face huge time pressures, but here are some practical tips to help keep the lawyers at bay.

WHAT SHOULD BE INCLUDED IN DENTAL RECORDS?

- Details of the patient history, the nature of symptoms, and exacerbating factors.
- Objective examination findings, including the absence of significant signs.
- Differential diagnosis.

- Any other opinions regarding diagnosis.
- Details of any investigations required, for example, vitality tests, x-rays, and models.
- Details of any treatment carried out, for example, anaesthetic usage and materials used.
- Follow up arrangements. Is a review or a referral required?
- The specific issues discussed with the patient, such as recognised risks and complications associated with the procedure in question.
- Warnings about the importance of good oral hygiene.

Paper records should include your initials, signature and the date on which the record was made.

If you need to alter or remove an incorrect entry in paper records, simply cross through the wording and mark this with your initials, the date and the reason for the alteration. The original entry should still be legible. This is particularly important to ensure your credibility is not questioned if the case ends up in court.

If you need to make a non-contemporaneous entry, for example, if you recollect a conversation with a patient, you should ensure that the date of that entry is clearly recorded.

GOLDEN RULES

Abbreviations

Abbreviations should only be used when their meaning is universally agreed and easily understood by your colleagues.

Every patient contact is recorded

This includes each interaction with a patient (for example, telephone calls) even if no clinical advice is given.

The absence of significant symptoms/signs

It is best practice to record a negative, to provide objective evidence of your underlying thought process.

READ THIS ARTICLE TO:

- ✓ Understand how accurate dental records can help protect you when faced with a complaint
- ✓ Learn what needs to be included in dental records
- ✓ Discover top tips to improve record keeping

Diagnosis

Always record a diagnosis, even if provisional. This provides further evidence of your clinical reasoning. Making an incorrect diagnosis is not necessarily negligent if a reasonable logical explanation can be given.

Follow-up advice

The patient and dentist can have very different recollections of the follow-up advice provided, so it is always best to document this in clear terms.

Consent discussions

The vast majority of claims notified to Dental Protection contain allegations in relation to consent. In our experience, this is often used to get the weakest claims over the line, so it is vital to ensure those discussions are well documented. Limitations of treatment can be important in many areas of dentistry, such as advanced restorative treatment and orthodontics, and these issues should be explained and documented.

Discussions around any alternative treatment options should also be documented, along with advice provided in relation to any future treatment requirements. It is also crucial to fully explain any costs involved and ensure the patient is in agreement. Patient expectations can often be unrealistic, so you should be satisfied that the potential limitations are fully understood.

SUMMARY

Whilst it may not be possible to avoid a complaint being made, even if gold standard treatment was provided, following the above advice should increase your prospects of a successful defence. In the event of receiving notification of a complaint, then please contact our team on **1800 444 542** or **notification@dpla.com.au**

Further information about record keeping can be found on our e-learning programme Prism, including a recording of our recent webinar 'Recording your way out of trouble'. Visit **dentalprotection.org**



INFECTION CONTROL – THE INDIVIDUAL’S RESPONSIBILITY



©shironosov/gettyimages.co.uk

A young therapist was about to start work in a new practice and, on the day of her interview, was invited to walk around the practice. Whilst walking around, she visited the reprocessing and sterilising room and noted that the area was not well signposted, and the testing and maintenance documentation was not regularly completed.

The therapist sought advice from Dental Protection on the extent of her responsibility for infection control procedures in the practice if she decided to work there, which in her view did not meet current standards. She wanted to know who was responsible for the infection control policy in the practice – was it solely the practice owner’s responsibility?

She was advised that each practising clinician has a duty of care to their patients. Any clinician who believes that the environment compromises patient

safety and the quality of care should not treat patients until the situation has been rectified.

Any clinician who believes that the environment compromises patient safety and the quality of care has the option of declining to treat patients until the situation is rectified, or even that of leaving the practice.

In this case, however, the therapist’s enquiry and the advice she was given then led to a discussion with the owner. The owner subsequently undertook a fundamental review of the practice’s infection control in order to improve the ways in which the procedures were implemented to ensure a consistent standard of care.

LEARNING POINTS

- Clinicians are individually responsible for the standard of care they provide.
- Review the infection control procedures when attending a potential practice where you may work in the future.
- Regularly review the infection control procedures at the practice.
- Ensure all new members of staff undergo the necessary training.



A LATE FITNESS TEST



©g-stockstudio/gettyimages.co.uk

An oral health therapist accepted a young male adult patient for treatment and saw him on three separate occasions. He was a dental-phobic patient but regularly ate a diet based around chocolate and fizzy drinks. This had resulted in the premature loss of several teeth and the need for further extractions.

Due to the severity of the patient's phobia, the oral health therapist decided to refer the patient so that the surgical treatment could be provided under conscious sedation. The therapist had a professional relationship with a particular dentist, and following a discussion with him, an assessment was arranged at the referral practice.

Unfortunately, there appeared to be a lack of communication and the patient had assumed they were being referred for a general anaesthetic. After being assessed for treatment under conscious sedation, the treatment was declined due to an excessive BMI and the patient was subsequently referred for a general anaesthetic. The patient was upset about the delayed treatment, but all the same, he returned to the oral health therapist for some restorative care. Local anaesthetic was used and the patient experienced his first ever ID block, which proved to be a slightly uncomfortable experience, and an infiltration so both upper and lower quadrants were anaesthetised.

The oral health therapist had suffered some eye damage the day before this episode, and

when the operating lights were switched on it became obvious that it would be impossible for him to continue working – his vision had been badly affected.

Rather than risking any harm to the patient, the oral health therapist made his apologies and the patient returned home with a further appointment for the following week. The patient was clearly unhappy, and extremely numb. Sadly, the patient suffered several days discomfort following the ID block.

The patient's parents then called the practice to complain about the lack of treatment that had been provided for their anxious son, only to be informed that the practice could not enter into conversation about other adult patients. The following week a six page letter of complaint was received which accused the oral health therapist of being rude, thoughtless and patronising.

The son complained that he had not given consent for the sedation appointment, and confirmed that he had been to another dentist for an examination. He alleged that the fillings that were planned were unnecessary and that he was being subjected to excessive treatment.

Fortunately, the oral health therapist had taken good radiographs and the cavities were clearly visible, and with this in mind, a written apology was sent to the patient regarding the failed treatment, but it was made clear to the patient that the cavities

were visible on the radiographs and the member stood by his clinical opinion on the need for restoration.

The patient did not return and sought further treatment elsewhere.

LEARNING POINTS

- Anxious patients may have exaggerated expectations and can sometimes be unpredictable. Management of these patients can be very rewarding but can also create considerable challenges.
- It is important that when referring patients they are aware of the reason for the referral and the treatment that would be undertaken.
- If treatment needs to be delayed this must be discussed with the patient. The reason for undertaking treatment or not is important and needs discussion to ensure consent is achieved.
- It is important that there is clear communication at all stages of treatment from all members of the team.



CONFIDENTIALITY IS KING



©tomazl/gettyimages.co.uk

A dental receptionist received a telephone call from the headmaster of a local school enquiring whether a particular 14-year-old child had attended the surgery that day for an appointment with the hygienist. Apparently the child had a history of truancy at the school and it was suggested that this was another ploy to explain his non-attendance.

On this particular occasion, the child had in fact attended the clinic, but without his mother. The receptionist, having checked the appointment book, was about to provide the information requested when the hygienist – who was passing the reception desk at the time – overheard the conversation.

Fortunately, before the information was released, the hygienist realised that an issue of confidentiality was involved.

The headmaster was stalled for some hours while the mother was located and her parental consent for release of the information was obtained.

Acting in the patient's best interests prevented disciplinary action by the school against the boy, and also the possibility of a professional misconduct case being brought against the hygienist for the breach of professional confidentiality by the member of staff.

LEARNING POINTS

- Even when someone in a position of authority makes an enquiry about a patient, the rules on confidentiality remain the same.
- It is important to ensure all staff understand the implications of maintaining patient confidentiality.
- The level of information released should be proportionate to information sought. For example, once the mother's consent had been obtained, the headmaster only needed to know that the child had attended the practice and not the nature of the appointment.

CONTACTS

You can contact Dental Protection
for assistance dentalprotection.org.au

Membership Services

Telephone 1800 444 542

Dentolegal advice

Telephone 1800 444 542

DPL Australia Pty Ltd (DPLA) is registered in Australia with ABN 24 092 695 933, CAR No. 326134 is a Corporate Authorised Representative of MDA National Insurance Pty Ltd (MDA) ABN 56 058 271 417, AFS Licence No. 238073.

Dental Protection Limited (DPL) is registered in England (No. 2374160) and along with DPLA is part of the Medical Protection Society Limited (MPS) group of companies. MPS is registered in England (No. 36142). Both DPL and MPS have their registered office at Level 19, The Shard, 32 London Bridge Street, London, SE1 9SG. DPL serves and supports the dental members of MPS. All the benefits of MPS membership are discretionary, as set out in MPS's Memorandum and Articles of Association.

'Dental Protection member' in Australia means a non-indemnity dental member of MPS. Dental Protection members may hold membership independently or in conjunction with membership of the Australian Dental Association (W.A. Branch) Inc. (ADA WA).

Dental Protection members who hold membership independently need to apply for, and where applicable maintain, an individual Dental Indemnity Policy underwritten by MDA National Insurance Pty Ltd (MDA), ABN 56 058 271 417, AFS Licence No. 238073. DPLA is a Corporate Authorised Representative of MDA with CAR No. 326134. For such Dental Protection members, by agreement with MDA, DPLA provides point-of-contact member services, case management and colleague-to-colleague support.

Dental Protection members who are also ADA WA members need to apply for, and where applicable maintain, an individual Dental Indemnity Policy underwritten by MDA, which is available in accordance with the provisions of ADA WA membership.

None of ADA WA, DPL, DPLA and MPS are insurance companies. Dental Protection® is a registered trademark of MPS.