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Risk management from Dental Protection

Dental Protection

RISKWISE

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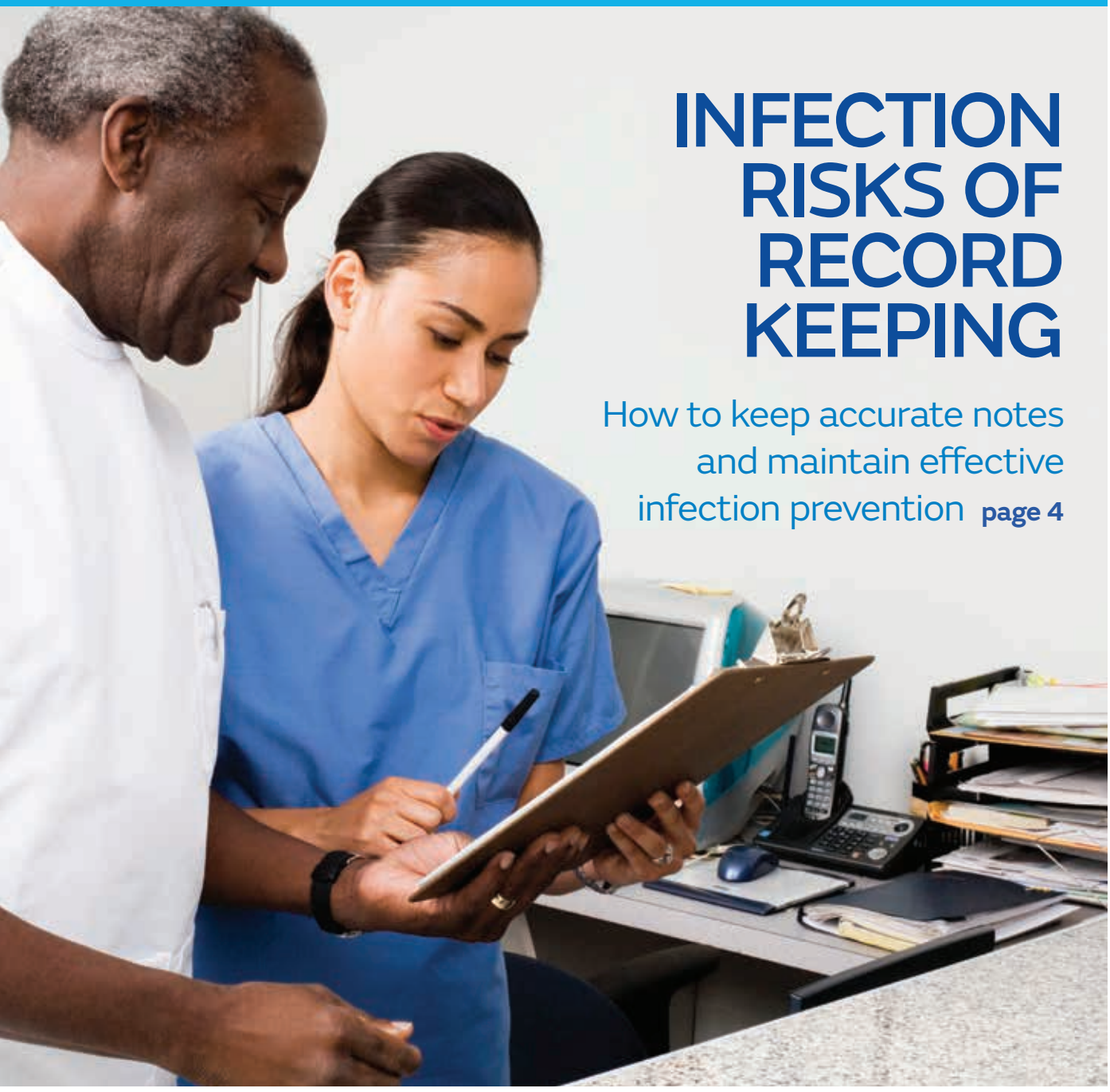

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Editor
Kirsty Sharp

Production
Philip Walker

Design
MOSS

Print
Panther Print, Brisbane

EDITORIAL

Dr James Foster
BDS, LLM Head of Dental Services, Australia

Hello and welcome to this edition of *Riskwise*. As Dental Protection's flagship publication, *Riskwise* offers the latest information on dentolegal topics and advice from our dentolegal advisers and professional experts.

IN THIS ISSUE

In this edition, we provide a comprehensive overview of how to maintain an effective standard of infection prevention and control in your approach to record keeping. This article on page 4 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.

I'd also like to draw your attention to the article on page 7 which was written by Dental Protection's Dental Director Dr Raj Rattan. He has created a detailed and interesting feature on patient interaction and the management of patient expectations. This is a timely feature as patients are now invariably more demanding when it comes to making decisions about their treatment. Raj will be presenting at the Young Dentist Conference on 12 May – for more information visit **dentalprotection.org/australia/events**

We also continue to share with you some case studies based on real-life experiences of members. Some of the topics covered in these include endodontics, incorrect tooth extractions and claiming and auditing – an increasing area of focus for investigations.

NEW WORKSHOP LAUNCH

Members can now participate in a new workshop entitled 'Dental Records for General Dental Practitioners'.

This workshop provides GDPs with knowledge, insights and updates based on current legislation and guidance to improve the quality of record keeping within the dental team.

The workshop will help you to:

- reduce the risk of harm to patients
- contribute to clinical care and correct sequencing of treatment through effective record keeping
- consider the role of other team members in record keeping
- reduce risk of receiving a complaint due to poor record keeping
- successfully respond to a complaint or claim.

For more information or to book a workshop, visit **dentalprotection.org** or contact us on **07 3511 5005** or **apeducation@dentalprotection.org**

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 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.

Best wishes,

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

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 blackspot 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, Anjumn 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*

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

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.

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**

SAFER PRACTICE

Dental Director ***Dr Raj Rattan*** *discusses the value of checklists*

READ THIS ARTICLE TO :

- Understand why all professionals can make mistakes
- Discover the advantages of using checklists

All professionals are vulnerable to making mistakes – even the very best. Our brain is full of knowledge and experience and it is challenging to analyse and apply that information during our work without the risk of sometimes getting it wrong. There has been a proliferation of research in recent years to identify root causes, human factors and the impact of systems design within healthcare.

WORKLOAD

There are many ways we can prevent errors arising, ranging from the design of clinical procedures and effective communication to the broader aspects of working conditions and culture. Many dentists work under the time pressures created by their workload and the need to achieve targets.

Research has shown that working under these conditions can increase the likelihood of errors significantly. Many members cite time pressure as the root cause of omissions and/or mistakes as a significant factor in adverse outcomes.

In a recent case, a member observed "I just wasn't thinking properly. I was running late and we were short-staffed...this was waiting to happen". He faced a surgical complication at a time when the nurse was out of the room to locate some instruments he required for the procedure.

When mistakes arise, we must determine why the human error occurred. In other words, we must review and reflect upon the so-called causal chain. It could be a system-induced error (for example, an omission like failing to take a peri-apical radiograph for a planned difficult extraction because of time pressure) or at-risk behaviours (using an inappropriate instrument to elevate a retained root resulting in instrument fracture). For every human error in the causal chain, there must have been a corresponding reason. It is the cause of the error which then leads to prevention-based strategies, not the error itself.

One simple and effective method to reduce error incidence is to use checklists. Checklists can be easily designed according to evidence-based and personal working preferences to include pre-procedure elements (such as a list of required instruments, patient consent or the need for a pre-operative radiograph assessment), in-procedure elements (this may include patient communications and adherence of clinical protocols) and post-operative requirements (patient advice and follow-up care requirements, for example).

DO CHECKLISTS WORK?

In his book, The Checklist Manifesto, Atul Gawande, Professor of Surgery at Harvard Medical School, draws on his experience as a surgeon and notes that checklists "not only offer the possibility of verification but also instil a kind of discipline of higher performance."

He discusses errors of ignorance (lack of knowledge), and errors of ineptitude (we don't make proper use of what we know) and suggests that clinical procedures are now so complicated that mistakes are inevitable in the stress of the moment.

In everyday decision making in clinical practice, we rely on our experience and lean towards what has been described as "fast thinking" by Nobel Prize winner Daniel Kahneman. His work on human judgment and decision making is based on the premise that people have two systems of thought – fast and slow – which are described as system one and system two thinking.

TWO SYSTEMS OF THINKING

System one – fast thinking – is largely automatic and intuitive, whereas system two – slow thinking – is more deliberate and effortful. Most of the time we rely on system one thinking; we could not cope with everyday life if every decision and act had to be logically thought through. In the context of clinical care, he surmises that physicians are taught to toggle between system one and system two thinking.

He contends that workload pressures may make this very difficult to achieve, forcing us to default to system one based judgments and diagnoses.

What then is the connection between Gawande and Kahneman? The discipline of using checklists forces us towards system two thinking. It means that our decision making and intervention are fully thought out and rational.

Whilst checklists can serve as useful "aides memoire", we must remember they are not a panacea and do not replace process simplification and critical reflection.

RESOURCES

1. Atul Gawande, The Checklist Manifesto: How to get Things Right, Metropolitan Books; 2009
2. Daniel Kahneman, Thinking, Fast and Slow, Penguin Books; 2012

IS IT **ME**?

Dr Susie Sanderson looks at the positive benefits of being asked a potentially difficult question

CAN I JUST HAVE A QUIET WORD WITH YOU?

Guaranteed to create a surge of adrenaline in even the least insightful of us, those words mean that it is likely that someone has given a huge amount of consideration to what they are about to say.

In the category of 'information I never want to receive' is the conversation with a colleague who thinks you are underperforming as a dentist. Unless the communication is inappropriately driven by malice or personal gain, the approach will not have been taken lightly. Nor should it be dismissed lightly, although an immediate reaction of denial, anger, hurt, betrayal and bewilderment is entirely understandable.

If you are the messenger delivering such news, you will have carefully examined all the available facts beforehand, but then things are never as simple as they see.

A CRITICAL MOMENT

Such conversations are extremely uncomfortable for both parties. The good news is that one colleague has discharged an ethical obligation by alerting the other one to their concerns. The exchange between colleagues has been done quietly, in confidence at this stage, and deserves respect and professional courtesy. This is also a valuable opportunity for the other registrant to listen calmly to the concerns, explore why they have been raised and address them swiftly if that becomes necessary.

This episode could be an opportunity for the same colleague to suspend frustration, delay denial and take an honest look at themself to see if there could possibly be some shortfalls in their professional development. A far riskier situation lies in not recognising the possibility.

IS IT ME?

Although it's hard to believe in this age of digital connectivity, it is entirely possible for a practising dentist to be effectively isolated. Life events can sometimes overwhelm us and may last many years; relationships, home making, a growing family, responsibilities outside work feel as though they deserve our close attention.

During that time, it's easy to function on autopilot in our working hours and before we know it, everything has moved on without us. Dentistry is a dynamic area of healthcare moving at an astonishing pace.

Is it appropriate to continue using outdated procedures in automatic mode simply because we didn't question or even realise that there may be something better? Is it appropriate to rely on the comfort of "it's always worked for me" to justify a procedure that has a more effective or safer alternative?

Even in a large multi-chair practice, a clinician can come and go on a daily basis with no professional interaction with peers. If that is coupled with little or no engagement with professional development or peer networking, the opportunity to see what is currently considered best practice might be lost.

AWARENESS

In dentistry, our awareness of an associated risk of harm to those people, who put their trust in us to look after them and their best interests, should be a constant niggle in our minds. Poor performance is not a calculated behaviour in anyone other than those with criminal or psychopathic tendencies.

More commonly, when accepted standards are not maintained, an underlying pattern can often be identified in retrospect. Burnout drives disinterest, poor motivation, isolation and ill health. Hubris can create an aura of unchallengeable confidence, particularly in situations in a small community where dentists can develop a self-perception of indispensability.

How many times do we hear our patients say to us, "I just don't know what I would do if you weren't here?" Such affirmations need to be heard with an understanding of the fickle nature of being indispensable.

> "There are no mistakes, save one; the failure to learn from a mistake"
>
> *Robert Fripp*

One risk is that a dismissive culture develops, where small mistakes and minor complaints are ignored as unimportant or blamed on staff members or patients themselves. Early warning beacons can be missed, especially in an environment where there is an autocratic communication and governance style.

Unfortunately, it may be that the first "light bulb" moment follows the raising of a concern about the practitioner to the Dental Board or Council. The process of investigating a dentist's fitness to practise can, in some cases, be lengthy, intrusive, demoralising and personally devastating in its outcome.

> You see a person when you look in the mirror that no one sees but you. Other people see a person when they look at you, but you're not that person, either
>
> *Roy H. Williams*

READ THIS ARTICLE TO :

- Understand the importance of self-reflection
- Find out why it is important to difficult conversations with colleagues
- Learn there is no shame is asking for help

Surely it is far better to employ a healthy, honest and energetic degree of insight and to do everything possible to demonstrate current knowledge, well-practised skills, continual use of self-audit and an openness to constructive criticism.

Dental Protection works with dentists in many countries, who find themselves under investigation, to assist them in planning and extending their professional development. A first step on the part of the practitioner is an honest reflection about the issues that have triggered the concerns. The process can provide powerful reassurance that there is light at the end of the tunnel

ASK YOURSELF

"Would anyone feel it necessary to raise concerns about me at the moment?"

In taking the first brave step to ask such a question, the wise and insightful practitioner is looking for a reality check to provide reassurance one way or another. There is absolutely no shame in asking for help to consider this from a trusted critical friend, colleague or professional mentor. Even an informal chat in a safe place over a cup of coffee can be a valuable experience.

The only way to mitigate the risk of unconscious incompetence is to put yourself in a position to know what you didn't know before. We are naturally curious and intelligent beings. In Dental Protection's experience, the re-awakening of the joy of learning is an unexpected pleasure described by members who have taken advantage of feedback from a colleague to reflect and improve their knowledge or behaviour.

It may be that a discussion with a mentor (formally or informally) will reassure you that it is simply a lack of confidence in your own skills and breadth of knowledge that has led you to question your own competence and safety. Or it may be that the realisation that there really is a problem provides you with the incentive to sort it out.

Getting to the bottom of the reasons for your concerns about yourself may be harder to achieve. If they involve health issues, then it would be wise to discuss these with your GP or an adviser from a confidential agency that supports the wellbeing of healthcare workers. In any event, taking time to reflect and plan your actions will pay dividends.

ADVICE AND ASSISTANCE FROM DENTAL PROTECTION

Dental Protection can offer advice and support and access to confidential counselling for members in any of these situations:

If you find yourself in receipt of information that may lead you to think that another registrant is repeatedly underperforming or is a risk to patients, you may wish to call and discuss the situation in confidence with one of our dentolegal advisers.

For members who have been alerted to concerns about their own professional performance, a conversation with one of our dentolegal advisers may help to give some direction to your next actions.

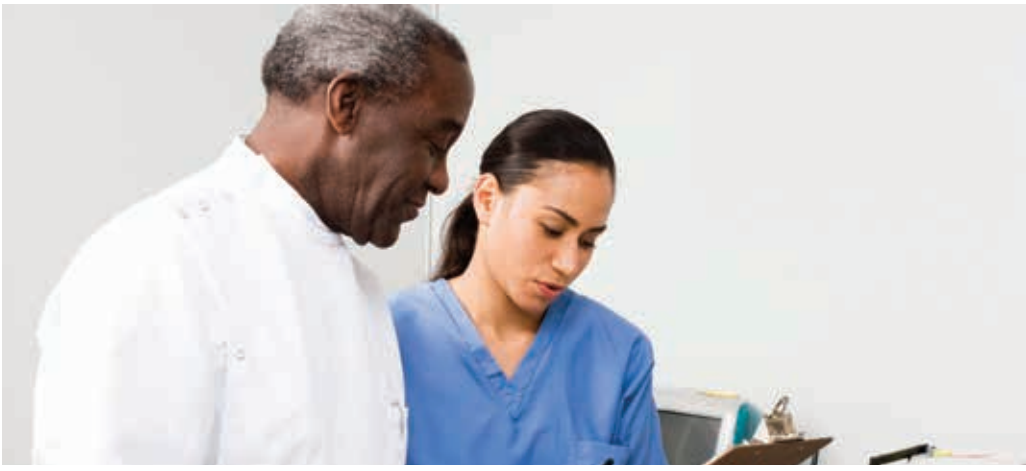
If you are concerned about your own professional performance, please take advantage of this benefit of membership, or perhaps discuss the issue with your own doctor.

For more information go to: **dentalprotection.org/au**

RESOURCES

Dental Protection's risk management courses and learning material are available at: **dentalprotection.org/prism**

For a range of advice booklets look under the Advice tab at: **dentalprotection.org**



A COMPLICATED EXTRACTION

A young adult female patient with a congenital heart defect for which an appointment for cardiac surgery was imminent, attended a new dental practice as she had become dissatisfied with her recent dental care elsewhere. Tooth 27 was grossly carious, painful and required extraction. The patient was on Warfarin and had been prescribed a course of antibiotics for dental infection by another dental practitioner.

A periapical radiograph was taken, and in an attempt to accommodate the patient in view of the impending surgery, an urgent appointment was arranged for the patient at the end of the day.

The INR had historically been stable between the levels of two and four, but was not checked in the 72 hours prior to the scheduled dental extraction. The clinical records did not demonstrate that careful radiographic evaluation had taken place.

The extraction procedure was fraught with difficulties and unexpectedly prolonged. After 50 minutes it became apparent that the functionless, periodontally-involved tooth 28 was acting as an obstacle to extraction/potential collateral damage, and would need to be extracted in addition to the original tooth due to their close approximation.

A second dentist was called into the surgery to assist with the procedure and the extraction of tooth 27 and 28 was completed after a further 20 minutes. The patient was told of the complication and did provide verbal consent to the extraction whilst in the chair during the procedure. Haemostasis was achieved prior to the patient leaving the surgery.

In the post-operative period, the patient had a bleed at home and contacted the surgery due to this dental emergency, but unfortunately the practice emergency system was not reactive enough to pick up the call. The patient therefore had no option but to attend the local Emergency Department where she was kept for over eight hours until she was deemed fit to leave, having had the wound cleaned, packed and sutured by the on-call clinician for OMFS.

A letter of complaint was received from the patient, in which she raised the issue of a lack of consent for the extraction of tooth 28 and that she would not have agreed in advance to the extraction of a wisdom tooth so close to her cardiac surgery. She was dissatisfied and alleged poor clinical care, poor aftercare and demanded a full refund. The patient felt badly let down and was very critical of the treatment she had received.

LEARNING POINTS

This case highlights the importance of the following:

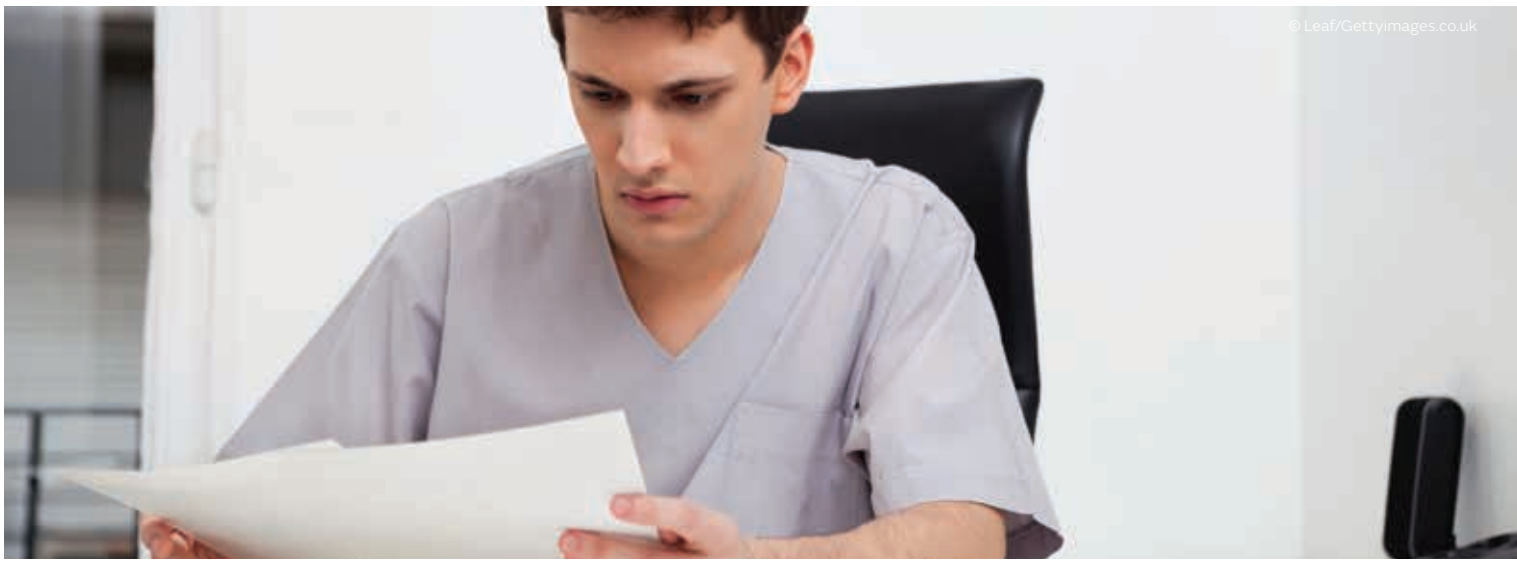
- Thorough preoperative assessment with due adherence to the local medical protocols for managing patients who are on anticoagulants such as Warfarin.
- Awareness that antibiotics may alter the INR level and ideally an INR record should be available in the 24 hours prior to the procedure if there is any suspicion of instability.
- The optimum timing of extraction procedures in patients who are likely to bleed.
- When endeavouring to accommodate patients, it is important that there is nothing to be gained by taking shortcuts. If complications arise you will attract criticism.

There are vulnerabilities in this case with regard to the above and additionally in relation to:

- the quality of the pre-operative case assessment and a careful consent process
- the quality of the actual clinical care provided
- the sufficiency of the clinical records, the lack of written evidence of radiographic evaluation

- the practice's out of hour's emergency arrangements.
- Had the patient pursued this matter, there were multiple vulnerabilities which would have resulted in further scrutiny and stress for the member.
- Fortunately, the way the complaint was handled was probably the only part of the interaction with the patient that went well for the member. After consultation with Dental Protection, a swift empathetic response was sufficient to defuse the matter.
- The practice responded in a timely fashion providing a full apology with an expression of sincere regret and provided a full refund of the private fees.
- The patient was reassured that action was taken within the practice to improve the emergency system with the aim of preventing a similar situation happening again.
- The cardiac surgery proceeded as scheduled.

WHEN YOUR NUMBER IS UP



Dr W was a recent graduate and looking for a permanent practice role. He had given a lot of consideration about the type of practice he wanted to work in.

He was seeking a group practice with plenty of other practitioners as he was concerned about professional isolation. Dr W was keen to be surrounded by like-minded colleagues to enable him to develop and grow. The practice did not have a principal dentist, but rather a 'flat hierarchy' of practitioners and a non-dentist practice owner.

On assessment, Dr W formed the view that the contract seemed fair and the practice seemed reasonably well equipped. The other dentists were all welcoming, and said that they had a good flow of patients, particularly new patient examinations, so made a good income.

He took the job. For the first few weeks, he kept a tight eye on his billings, and indeed, he had a steady flow of patients and a good income. With the passage of time, Dr W became more relaxed at the practice, as he was happy there, and had formed good relationships with both colleagues and patients alike.

He was surprised to receive a letter from the Health Fund, stating that he was an outlier and requesting validation for the number of codes charged per patient, and, the number of five surface fillings came as a surprise to Dr W who could not recall having placed many five surface fillings. The practice owner reassured Dr W that they would manage this on his behalf stating it was likely that the front office staff had entered the codes on the wrong provider number – a common administrative mistake, and that they would look into this and respond. Dr W did not seek advice from Dental Protection as he believed the matter to be 'routine' and in hand.

The second Health Fund letter followed quickly, with similar allegations to the first. Dr W again contacted the practice owner to alert them to the issue and seek some assistance. However, this time the practice owner did not respond in a helpful way, and Dr W felt quite threatened by their reaction. At this point, Dr W contacted Dental Protection, who advised him to look a little deeper and see what patients' invoices cited. To Dr W's horror, the HICAPS transactions did not reflect his clinical notes, with two surface fillings being invoiced as five surface fillings, patients being charged for teeth adjustments that Dr W had not undertaken, and most alarming, a recent crown not being visible in the invoice stream, having been replaced with an invoice for eight x five surface fillings instead.

When Dr W challenged the front office staff, they were nonplussed, calling him naïve, and advising him that the only way to treat patients fairly was to maximise their Health Fund rebates. They confirmed that they were working under the direction of the practice owner, and that their 'fair billing' policy attracted many patients.

Dr W was alarmed by these statements, and even more so when he realised that because the billings had gone through on his provider number, he was solely responsible for the repayment of all monies inappropriately claimed, back to the Health Fund.

Dental Protection assisted Dr W in responding to the Health Fund and also in leaving the practice.

LEARNING POINTS

- You are responsible for all items charged under your provider number, and as such should regularly review your HICAPS billings.
- Take the time to close your provider number when you leave a practice to ensure that no inappropriate billings are put through on your number after you have left.

AN INCORRECT EXTRACTION

A patient attended a new practitioner for the first time and a routine examination was completed. The patient reported previous problems from both lower wisdom teeth which had caused discomfort, swelling and infection, for which antibiotics had previously been prescribed. However, the patient was not reporting any specific problems at that time.

As part of the examination the dentist took the view that an assessment of the wisdom teeth would be advisable, and after discussion with the patient, it was agreed that two periapical radiographs should be taken. The x-rays were processed and as was usual practice, the dental nurse placed the films into a plastic film envelope. The 38 was seen to be carious, however it was incorrectly recorded in the records as 48.

The 48 displayed an area of radiolucency around the crown of the tooth which suggested to the dentist that there had been repeated episodes of infection, and potentially in the future, this tooth would need to be removed. The patient was informed that the 38 was not restorable and needed to be removed.

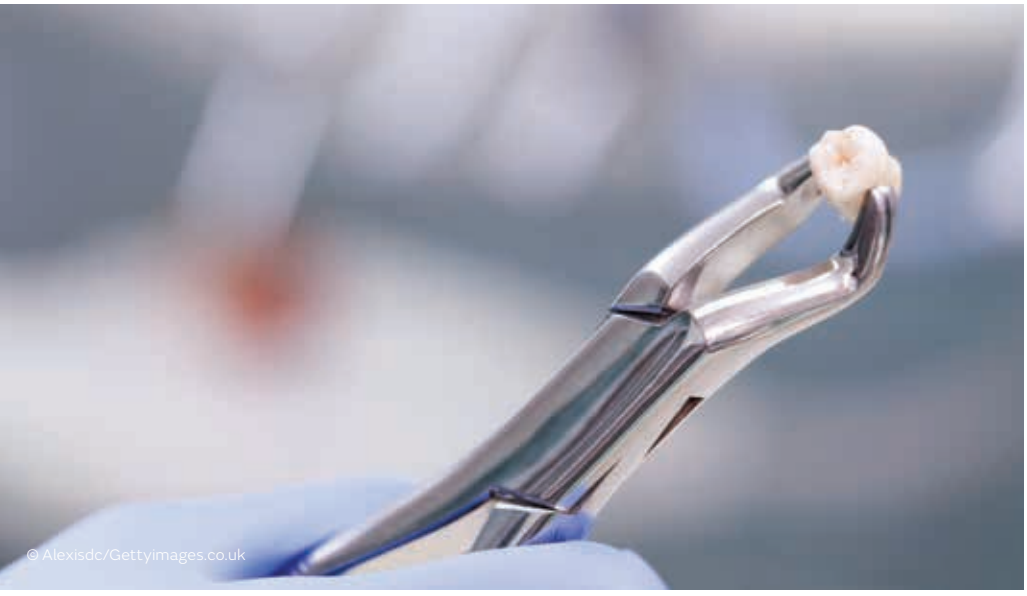
The patient was aware of the reason for removal and booked an appointment to return the following week to have the tooth removed.

One week later the patient returned and the dentist checked the records and x-rays, informed the patient what was involved in the procedure in so far as numbing the tooth and removing it, and of his impression that it would be a straightforward removal.

The dentist checked the records which corresponded with the x-ray and proceeded to numb the 48 and the tooth was removed without complication. Post-operative advice was given and the member checked the area for haemostasis. During the review of the socket and mouth, the dentist identified that the carious tooth was still present. The dentist checked the records and radiographs as well as the tooth that had just been removed and identified the mistake. The patient was informed immediately of the error and an entry of the same was documented in the records. The dentist apologised profusely and the patient understood and accepted the situation.

The dentist later called Dental Protection to seek advice on whether anything further needed to be done and how to follow up on the error made. As there was no complaint letter, the advice was that the patient should be contacted again to ensure that they were healing well and invited to attend a review appointment. The outline of a letter was drafted by Dental Protection offering an apology and explanation for the situation which had arisen.

The member was advised to discuss the issue at the next practice meeting and carry out a risk assessment and analysis to determine how a repeat situation could be avoided in the future. It was also recommended that a clinical incident form was completed in relation to the situation. The patient accepted the letter and there was no further outcome.



LEARNING POINTS

This case highlights:

- The importance of double-checking radiographs with an intra-oral examination.
- All records should be completed contemporaneously to reduce the risk of incorrect recording.
- To be honest and open with patients when treatment does not go as planned.

AN IMMEDIATE DENTURE

A dentist contacted Dental Protection for advice, after receiving a letter of complaint from a patient regarding the fit of his lower partial cobalt-chrome denture, which had been provided 18 months earlier. The patient had requested a full refund, stating that the denture was not "fit for purpose".

From the clinical records, it transpired that a lower molar tooth had been extracted, and a chrome lower partial denture had been provided two months later. This had then been relined at a later date, after the socket had fully healed, but the patient had struggled to use it.

Although the risks of post-extraction shrinkage were discussed with the patient and recorded at the denture fit appointment, there was nothing documented in the records reflecting that this issue had been discussed with the patient at the examination and treatment planning stage before treatment began and consent was given.

Equally, there was nothing recorded about the discussions had with the patient, outlining the choices available and their associated risks and benefits. An alternative approach would have been to extract the tooth, and then allow the space to heal completely before making a partial denture. The provision of what might be considered an 'immediate' chrome denture was high risk.

After taking advice from Dental Protection, the offer of a full refund was made to the patient. Such business decisions can avoid the complaint escalating, which would lead to more anguish for the clinician.

LEARNING POINTS

- This case highlights how important it is for the patient to be given all the treatment options at the earliest stage, and if the provision of an immediate denture is the patient's preferred treatment of choice, they need to be made aware of the consequences of the associated post-extraction shrinkage.
- The future need for relining the immediate denture or the provision of a new replacement denture, at the patients' cost, needs also to be discussed and documented.
- An advice sheet handed to the patient at the start of treatment can help improve communication and the fact should be recorded in the notes together with the title or number of the advice sheet given.

A LATE FITNESS TEST

A dentist 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 dentist decided to refer the patient so that the surgical treatment could be provided under conscious sedation. An assessment was arranged at a 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 dentist 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 dentist had suffered some eye damage the day before this episode so that when the operating lights were switched on; it became obvious that it would be impossible to continue working – her vision had been badly affected.

Rather than risking any harm to the patient, the dentist made her 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 dentist 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 dentist 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 her 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.

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