BDJ Team
AUGUST 2014

MEDICAL EMERGENCIES: equipment and principles

BDA
British Dental Association

Training Essentials

BDA
British Dental Association

Oral cancer: the dental team's responsibility

LONDON | Friday 17 October 2014

The number of cases of oral cancer across the UK continues to increase with latest figures showing that 6,000 new cases a year are diagnosed*

Furthermore a growing number of patients are subsequently accusing their dentist of missing the signs and taking legal action. Early detection is the key and can improve chances of survival from 50 per cent to 90 per cent*. This one day course helps define the dental team's duty of care, offering information and advice on how to manage oral cancer effectively and sensitively.

**Data from British Dental Health Foundation*

By the end of the course you will:

- have learned what the risk factors of oral cancer are and be able to identify patients at increased risk
- be able to carry out a thorough examination with knowledge of the signs and symptoms
- know the criteria for referral following NICE guidelines
- be able to communicate to your patients how oral cancer can be prevented
- understand how the whole dental team can successfully implement a management strategy for oral cancer.

Speakers

Saman Warnakulasuriya OBE
Professor of Oral Medicine,
King's College London Dental Institute

Richard Cook
Senior Lecturer in Oral Medicine,
King's College London Dental Institute

Course fees:	BDA members £215	Non members £315	DCPs £135

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CORE

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Build an enthusiastic, motivated and engaged team and improve practice communications.

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All BDA members can now access the BDA Good Practice self-assessment via the BDA website.

Allow four to six months to work through all of the requirements.

Make an application

When your team has completed the practice self-assessment, download, complete and return the application form together with the fees:

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- BDA Good Practice membership: £300 (per year)

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August 2014

Highlights

Regulars

In this issue

COVERS TO COMMEMORATE **THE GREAT WAR**

Left: A WWI field treatment tent
Right: WWI kit bag with toothbrush

BDJ Team's partner publication, the *British Dental Journal*, has commissioned a series of 12 stunning covers to commemorate the centenary of the start of the First World War. They will be published from July to December this year.

The cover of Volume 217 issue 1 depicts a WWI field treatment tent. Artist Philip Banister, who is creating all 12 covers for Volume 217, has produced this original watercolour based on a black and white photograph supplied by the BDA Museum.

Casualty clearing stations during the First World War were usually a mix of tents and huts with only a minority of beds in buildings. The dental 'surgery' tent was equipped to provide for extractions and basic restorative work.

The cover for issue 2 shows a WWI kit bag with toothbrush. British troops were issued with a toothbrush as part of their kit along with a button brass, a razor, a shaving brush, spare leather boot laces, a knife, fork and spoon. Records suggest that some solders' toothbrushes were used to clean boots rather than brush teeth.

Cover number 3, published on 8 August 2014, depicts Major Sir Auguste Charles Valadier, who established a face and jaw unit in a converted sugar store near Wimereux, France, during the War. While treating bullet wounds to solders' face and jaws, Valadier developed techniques to deal with them which facilitated the later progress of plastic surgery.

(Left) Major Sir Auguste Charles Valadier, who treated over 1,000 jaw and facial injuries during WWI

UPDATED ORAL HEALTH GUIDANCE PUBLISHED

Public Health England has released the third edition of the *Delivering better oral health* guidance.[1] It provides dental health professionals with evidence based interventions and advice that can improve and maintain patients' oral health.

The guidance highlights the positive impact a healthy lifestyle has on oral health, in particular the role played by good toothbrushing habits and a healthy diet, stopping tobacco use and reducing alcohol consumption.

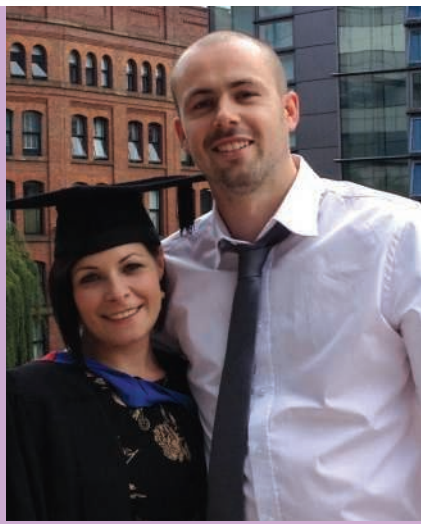
Professor Kevin Fenton, National Director of Health and Wellbeing at Public Health England, said: 'Dental teams have a really important role in advising their patients about how they can improve and maintain both their dental and general health. We must all work together to ensure that good oral and dental health is protected and promoted and the prevalence of tooth decay is reduced'.

The British Society of Paediatric Dentistry spokesperson Claire Stevens said that keeping the guidance up to date, both reflecting the latest evidence as well as what is recognised good practice, was helpful to all working to combat dental disease.

The Dean of the Faculty of Dental Surgery at the Royal College of Surgeons, Kathryn Harley, said: 'We strongly support this guidance, which reinforces the positive impact a healthy lifestyle can have on oral health. Dental erosion and caries are entirely preventable diseases. Sugar and acid in food and drink play a key role in causing these diseases. It is therefore critical to provide dental teams with all the evidence based information they need to provide patients with the best practical advice they can'.

1. Public Health England. *Delivering better oral health: an evidence-based toolkit for prevention.* 12 June 2014. www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention (accessed 21 July 2014).

TECHNICIAN SAM SCORES DEGREE AND NEW JOB



Samantha Farrell, who featured on the cover of the final issue of *Vital* (November 2013),[1] has graduated with a BSc (Hons) Dental Technology from Manchester Metropolitan University.

Sam also started a new job working at Prime Orthodontic Studio in Leicester in June. After a trial day in the lab she was offered a permanent job as an orthodontic technician.

When Sam was interviewed for *Vital*, she wanted to be a ceramist, but told *BDJ Team* in July: 'During the second year of my course I really enjoyed orthodontics so I decided to head in that direction. I managed to get a job in a fantastic ortho lab and I'm so pleased it has all worked out!'

BDJ Team extends its congratulations and continued success to Sam.

1. Quinlan K. 'I'm determined to succeed.' *Vital* November 2013; 16-21. Available at: http://nature.com/vital/journal/v11/n1/full/vital1763.html.

Do you have a news story that you would like included in BDJ Team*? Send your press release or a summary of your story to the Editor at bdjteam@nature.com.*

DCP COURSE DIRECTORY 2014

WALES

Compiled by Kate Quinlan[1]

Cardiff Metropolitan University
Cardiff School of Health Sciences

BSc (Hons) Dental Technology
Foundation Degree in Dental Technology (FdSc)
MSc Dental Technology
Location: Llandaff Campus, Cardiff
Length: Three years full time for the degree; three years part time for the Foundation degree; distance learning for the MSc
Details: http://www3.cardiffmet.ac.uk/English/health/dt/Pages/Courses.aspx/
Telephone: 029 2041 6899
Email: rjwilliams@cardiffmet.ac.uk

Cardiff University Dental Hospital

Level 3 Diploma in Dental Nursing
Telephone: 02920 748303
Email: penny.barker@wales.nhs.uk

Cardiff University School of Dentistry

HE Diploma in Dental Hygiene
Length: Two years full time, starting September
Details: http://courses.cardiff.ac.uk/undergraduate/course/detail/B750.html
Places available: Typically 10
Telephone: 029 2074 2468
Email: dentaladmissions@cardiff.ac.uk

BSc in Dental Therapy and Dental Hygiene
Length: Three years full time, starting September
Details: http://courses.cardiff.ac.uk/undergraduate/course/detail/B752.html
Places available: Typically 11
Telephone: 029 2074 2468
Email: dentaladmissions@cardiff.ac.uk

Tooth Fairies

Location: Cardiff
NEBDN National Diploma in Dental Nursing
City & Guilds Diploma in Dental Nursing
Impression Taking
Fluoride Application
Decontamination Lead
Cross Infection Control
Oral Health Education
CPR & Medical Emergencies
Health & Safety at Work
ILM Level 3 Management
Dental Receptionist
Legal & Ethical Issues
Child Protection & POVA
PDP Development
Manual Handling
Fire Safety
Appraisal Training
Study Day
Technician Study Day
Online Diploma dental nursing course
Online CPD programme for whole dental team
Trainee dental nurse positions
Details: www.toothfairieslimited.co.uk
Telephone: 02920 837433
Email: info@toothfairieslimited.co.uk

Wales Deanery (School of Postgraduate Medical and Dental Education)

Locations: Aberystwyth, Bangor, Cardiff, Haverfordwest, Penlan Road, Newport, Newtown, Porth, Denbighshire, Swansea, Wrexham
Undergraduate Certificate of Higher Education in Dental Nursing (two years part time, email dentalcert@cardiff.ac.uk)
Certificate in Practical Oral Health Promotion
Safe start dental nurse induction/return to work programme
Dental Receptionist course
NEBDN Certificates in Dental Radiography/Special Care Dental Nursing/Orthodontic Dental Nursing
ILM Endorsed Practice Managers course
Protection of Vulnerable Adults (POVA)
Extended duties: impression taking, fluoride varnish application, suture removal
CPD courses - core topics, in-practice training, human patient simulator training
Core CPD topics for dental technicians
Introduction to practice for dental therapists
Practice management programme
Aspects of professionalism
Introduction to special care dentistry
Health and safety
Details: http://www.walesdeanery.org/index.php/en/dentistry/1335-human-patient-simulator-for-the-dental-team.html
South Wales enquiries: Call Kath Liddington on 029 20687498, email liddingtonke@cardiff.ac.uk
North Wales enquiries: Call Rosemary Roberts on 01745 534587, email rosemary.roberts@wales.nhs.uk
Also see *The Essential Guide to educational activities for dental professionals*, published by Wales Deanery: http://www.walesdeanery.org/images/stories/Files/Documents/dental/CPD/resources/essential-guide-2012-web.pdf.

Wrexham Medical Institute, North Wales

NEBDN Dental Nurse Diploma
Summary: Accepting applicants from Wales, north-west England and the Marches. Registration evening 11 September 2014 at 6 pm. 'Safe Start' runs one Wednesday a month in October, November and December. Course starts February 2015, every Thursday afternoon during term times.
Email: postgrad8@aol.com

BDJ Team *also recommends checking your local colleges and online. In September we will focus on the south-west.*

bdjteam201485

[1]*Editor, BDJ Team*

‘I’ve had a *brilliant* first year’

In July 2013, dental hygienist **Shaun Howe** moved to the Shetland Islands with his family to take up a position with NHS Shetland. A year later, he tells *BDJ Team* how he is getting on.

THE ISLANDS

Shetland is a remote sub-arctic archipelago situated some 70 miles north-east of Caithness in Scotland and lies between the Atlantic Ocean and the North Sea. The population is around 23,000 who live spread across 14 (or so) islands but there are numerous uninhabited islands. The dental needs of the majority of the population are met by the Salaried NHS Dental Service which, despite the remoteness, strives to deliver a service that surpasses many expectations.

The service has for some time struggled to reach its full complement of dental officers and support staff; it is not hard to understand this as the remoteness of the islands is often seen as a barrier for many. However, once here, many find that the trappings of modern society are very much present yet everything is smaller and takes a little longer to get here.

The Salaried Service currently has 14 dental chairs spread across seven clinics of various sizes. The most northerly clinic is based in Yell and serves the population of Yell (one chair), Fetlar and the most northerly island in the UK, Unst. There is another clinic on the island of Whalsay (one chair). The remainder are based on Mainland (the largest island) – with a three-surgery clinic in the village of Brae and the rest in Lerwick, which is the island’s capital and has a population of over 9,000.

The islands have historically had travelling dental caravans but these are now a thing of the past: one caravan remains but it can no longer be moved. I get to work in this when clinic space is at a premium; some bemoan working in the caravan it but personally I love it as it suits dental hygiene perfectly.

MY FIRST YEAR

I’ve had a brilliant first year; I was warmly welcomed by all the staff and made to feel part of the team immediately. Dentistry in Shetland is like dentistry anywhere but we have to make certain considerations when doing laboratory work; there are no on-site labs and work has to be sent to mainland UK. This presents a problem as any breakages require work to be sent away by post, but also any adjustments to work yet to be fitted have

to go away in the post, meaning long waits for the patients to have work completed. We are served by a daily ferry from Aberdeen as well as cargo boats; there are numerous flights each day to and from airports in Scotland but these can be cancelled at very short notice due to extreme weather conditions. Occasionally, the boats may be delayed (more so in winter) which can (rarely) lead to shortages in consumables that may require some rationing to ensure essential and urgent needs are met.

THE RELOCATION

So why make the big move? I suppose it was driven by many factors but the need for a change was certainly in there. We used to live in Derbyshire and I worked in Nottingham and had been in that area since leaving the army in 1999. My wife Kerry has had many jobs over the years but eventually settled as a dental receptionist, a role she really enjoys, and has been lucky enough to gain a dental receptionist position in NHS Shetland. We have two kids, Danielle (19) and Harry (17). When we made the big decision to move Danielle was already 18 and decided that she did not want to go all that way and currently lives and works in Manchester. Harry has found work in Shetland; he started working in Frankie's, an award-winning fish and chip shop and the UK's most northerly, but has now moved on and works as a receptionist in a hotel.

Do I miss my old job? For sure; I worked there for ten years and miss the staff and patients terribly. I have been back a few times and have got a night out arranged in September with as many as turn up. I am regularly in contact with my old practice manager as she still wants to tap my knowledge of certain things and I am more than willing to oblige.

TRAINING DENTAL NURSES

A highlight for me over the last year was being invited to take on the training of student dental nurses. I had to dive into the NEBDN Diploma with some gusto as the students had received very few tutorials for the preceding year. I had no knowledge of the systems of teaching involved; it became a steep learning curve but we soon settled into a programme of teaching. I would like to thank all my friends and colleagues in England and Wales that helped me out. The service chooses to train its own dental nurses as recruiting trained individuals is understandably difficult, but like many dental services, retention is also tricky.

'WE ARE 34 MILES NORTH OF LERWICK WITH THE NEAREST SHOP TWO MILES AWAY AND THE NEAREST TAKEAWAY AND PUB 11 MILES AWAY.'

I would like to point out that unemployment in Shetland is rare. This is due to an increasing service sector serving tourism but also Shetland has the largest oil terminal in Europe, the largest gas terminal currently being constructed and soon will have a large wind farm that will provide electricity to 350,000 homes on mainland UK, and these all require huge manpower. For now, the mainstay of income remains the fishing industry supplemented by income from crofting and farming.

REMOTE CPD

Our CPD needs are met by the North of Scotland Postgraduate Dental Dean who provides speakers to visit the islands to deliver our training. Being such a small team, we can approach the dean and request the training that will serve our learning needs: an advantage I am sure that many readers would cherish! The deanery has asked me to deliver a presentation to my clinical colleagues here in Shetland and this will be repeated to hygienists, therapists and dentists in Inverness in February 2015. On the same day I will present an 'update on periodontology' for dental nurses, something I have never done before, but now relish the challenge of pitching the science of perio to my dental nurse colleagues.

We never get representatives of the large dental companies visiting us (hint hint) but we direct our patients to local shops (Tesco, Boots, The Co-op) or pharmacies to purchase oral hygiene aids. We are fortunate to have several oral health education-trained dental nurses that help support and reinforce the message we deliver.

Scotland's Childsmile programme is an integral part of NHS Shetland's long term plan to prevent dental disease in children and in later life; find out more about this ongoing programme at http://www.child-smile.org.uk/.

NORTHERN HIGHLIGHTS

As well as being privileged to work with the great team here in Shetland, those of us that live here are lucky enough to experience the northern lights (Aurora Borealis) in winter.

Additionally, in the summer we experience 'Simmer Dim', the longest day of the year, where the sun is above the horizon for 19 hours and the northern sky never darkens during sunset. The wildlife is also worth a mention as we get many migratory birds as well as perennial visitors such as puffins.

Whilst the dentistry remains the same, our lifestyle has changed. I live in a remote part of Shetland. We are 34 miles north of Lerwick with the nearest shop two miles away and the nearest takeaway and pub 11 miles away, yet we have adjusted well and got used to the very long days in summer and the very short days in winter. As you can imagine, living in such a remote area means that all the neighbours get to know each other and will look after each other's interests. We have not locked our front door in over a year and we can certainly call on neighbours if we need something. Most communities have a communal hall that is used for social events and a common feature are Sunday Teas where the community contribute cakes, sandwiches and fancies to be bought by those that go along; not necessarily good for teeth but given that they are usually for charity, all is forgiven.

If you ever need an epiphany, moving to a remote place may help you. It has me.

bdjteam201486

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IS ONLINE TRAINING the way forward?

BY MARK FOSTER[1]

As a company we've been involved in providing face-to-face and online safeguarding courses to dental practices for over six years and are often asked 'what are the advantages and disadvantages involved?'

In our case, we are uniquely positioned to answer such a question as we offer both child protection and vulnerable adult training courses to dental staff in both online and face-to-face form. The courses are essentially the same, with just the method of delivery changing.

In this article we have detailed the pros and cons of both approaches. In doing so we have assumed you would employ a trainer to come to your practice but many of the points below are equally valid if you send staff to external courses to be trained.

Face-to-face training

The primary advantage of face-to-face training is that the trainer can deal with any questions and tailor their approach to the participants. However, this does depend somewhat on the quality of the trainer employed. In our own case we employ only current practitioners who are qualified trainers - but that isn't the case across the board. We would therefore advise dental practices to engage only established reputable training companies and where that isn't possible, to check the credentials of any trainer before engaging them.

Face-to-face training also gives you the ability to effectively 'sheep dip' everyone at the same time, particularly if you have a trainer come into your practice, so you know everyone's training is bang up to date. Unfortunately this approach can have its drawbacks as if someone is ill or unable to attend the training session on the day, then your training costs effectively double, as you'll need to get the trainer back in.

In the safeguarding sector, it is common for face-to-face course certificates to have three-year validity rather than the two-year validity of most online courses.

Online training

We have been involved with online training since 2008 but it was only with the onset of the recession that this method of training really took off, mainly because the costs per head for online training are so much less. Obviously this depends on how many staff you need to train and the maximum course size as dictated by the training provider.

As an example we charge £495 plus trainer's expenses plus VAT for any of the four safeguarding face-to-face courses we offer. The maximum number of participants is limited to 15 as we've found that, beyond this number, the learning experience is compromised. Doing the maths, if your practice had 15 staff and assuming trainers expenses of around £100 (to keep the numbers simple) then the per-head cost would be around £40 plus VAT. This compares with the equivalent online course cost of just £16.50 plus VAT per person. Obviously this price differential widens if, like many practices, you have fewer

[1] *Head of Marketing Operations, ChildProtectionCompany.com*

than 15 staff to train or need to train staff in two batches so the practice can remain open.

As well as being more cost effective, your staff can also take an online course at a time that suits them. This is not only more convenient for them but can save the practice money too, as you don't have to have the staff in out of hours, or close the practice for a training session to take place. Interestingly, because online training can be taken at any time of day and generally started and stopped as needed, we find dental staff taking courses at quite unusual times – 3 am on a Christmas morning being a case in point!

The cost savings also extend to travelling expenses for your staff if the training is offsite: there simply aren't any to be reimbursed with online training.

Some online providers allow staff access to the online course content for three years should they need to refresh their memory at any time. This effectively serves as your staff's course notes and the reputable companies will keep these up-to-date.

If your practice is small you may not have a room of sufficient size to host the face-to-face training in and that will entail more cost to hire somewhere suitable. There's no cost for this with the online approach.

Finally, there's no waiting to get your staff trained. Pretty much, you can purchase online training and take it on the same day. No awkward synchronising of diaries and issuing a three line whip to make sure everyone is present.

Certificates

Evidencing to the Care Quality Commission (CQC) that your staff have taken the appropriate training and retained the knowledge is the main driver for most dental practices.

With most online training courses you get the peace of mind of knowing they've retained the knowledge via the requirement for them to pass an online assessment following the course. In our case retakes are also free with standards being maintained through the assessment changing each time. This is in contrast to a face-to-face course where, even if staff are issued a certificate, it just effectively signifies that they attended the course, not necessarily that they learned anything.

Child protection training

For courses taken with the ChildProtectionCompany.com, each successful participant also receives a personalised and portable certificate valid for two years for an online course and three years for a face-to-face course. However, with the plethora of software packages now available in the market place, it's very easy for someone to produce a 'fake' certificate that appears authentic. To counter this, many online training providers, ourselves included, now issue uniquely numbered certificates so prospective employers and CQC can check the certificate is both authentic and applies to the individual named.

Keeping track of everyone's certificates is another big bugbear for practices. To help evidence staff training to CQC, we provide a single central training record that allows you to monitor everyone's progress through a single screen and provides duplicates of everyone's certificates should anyone demand it. It gives full visibility of your staff progress at all times plus when their course certificate expires. The system also sends out automatic reminders before certificates expire to make sure no one's training inadvertently lapses in two years' time. Although we offer this system for both our face-to-face and online courses, we are fairly unique in doing so; most face-to-face training providers will just provide a paper certificate for the individual to keep. This sometimes applies to some online providers too, so it's best to check what management systems come with the training and where available, whether they're an additional cost.

Summary

Quite simply, dental staff and practices have voted with their feet and moved en masse to online training. Consequently, although we train thousands of dental staff every year, none of them are now via face-to-face courses. Every practice chose online training instead. In fact, we haven't had a face-to-face course run at a dental practice in the last two years.

Although cost is obviously a big factor in this decision, practices and dental staff are also rightly concerned that any course meets the stated CQC outcomes, is easy to use, provides CPD hours (with ours you get three per course for example) and is immediately available.

Of course not all online training courses are equal but with the better courses – those that are dental specific, meet CQC stated outcomes, provide management reporting and enable you to roll out the courses now and pay later – why would you pay more and opt for face-to-face training?

ChildProtectionCompany.com

The ChildProtectionCompany.com provides a range of safeguarding services for individuals and organisations in line with current child protection and vulnerable adult legislation. Anyone who works directly or indirectly with children, young people and families can be trained in around an hour.

'WE FIND DENTAL STAFF TAKING ONLINE COURSES AT QUITE UNUSUAL TIMES - 3 AM ON A CHRISTMAS MORNING BEING A CASE IN POINT!'

Backed by a multi-agency team of experienced safeguarding professionals, ChildProtectionCompany.com has been in the business of providing high quality, value for money safeguarding courses and support since 2008, providing over 25,000 courses to date.

It is recommended that dental receptionists and admin staff take the Introductory level course 'Introduction to Adult/Child Protection' and that dentists, dental nurses, dental hygienists and dental therapists take both the Introductory and Further course 'Further Adult/Child Protection'.

Both courses have been approved as meeting the educational criteria required for verifiable CPD and each represents three hours of verifiable CPD.

Visit https://www.childprotectioncompany.com/CPC/page_auth?PAGE=DentalTraining or call 01327 223283 for more information.

BDJ Team offers ten free hours of verifiable CPD online this year!
Visit www.nature.com/bdjteam/cpd to find out how you can complete ten hours of CPD in the comfort of your own home or workplace.

bdjteam201487

CORE CPD: ONE HOUR

Medical emergencies: the drug box, equipment and basic principles

By **M. Greenwood**[1] and **J. G. Meechan**[2]

INTRODUCTION

Medical emergencies in dental practice are uncommon but can occur at any time. All members of the dental team need to be aware of their role in the event of a medical emergency and should be trained appropriately with regular practice sessions.

In December 2013, the Resuscitation Council (UK) provided up to date information regarding a minimum equipment and drug list for medical emergencies in dentistry. Quality standards for cardiopulmonary resuscitation (CPR) practice and training have been updated.[1] It is evident from the updated guidance that there is an increased emphasis on the importance of CPR in the dental setting.

Anticipation of potential medical emergencies that might arise should be highlighted by taking a thorough medical history. A risk assessment should be made by considering the patient's American Society of Anaesthesiologists (ASA) classification category. The ASA classification is summarised below. If medication is normally used, a check should always be made to ensure that this has been taken as usual.

- ASA I healthy
- ASA II mild systemic disease – no functional limitation

[1]*Consultant/Honorary Clinical Professor,* [2]*Senior Lecturer/Honorary Consultant, School of Dental Sciences, Newcastle University*

Table 1 Contents of the emergency drug box and routes of administration

Drug	Route of administration
Oxygen	Inhalation
Glyceryl trinitrate (GTN) spray (400 micrograms per actuation)	Sublingual
Dispersible aspirin (300 mg)	Oral (chewed)
Salbutamol aerosol inhaler (100 micrograms per actuation)	Inhalation
Adrenaline injection (1:1000, 1 mg/ml)	Intramuscular
Glucagon injection (1 mg)	Intramuscular/subcutaneous
Oral glucose solution/gel (GlucoGel)*	Oral
Midazolam 10 mg or 5 mg/ml (buccal or intranasal)	Infiltration/inhalation

*Alternatives: two teaspoons of sugar/three sugar lumps; 200 ml milk; non-diet Lucozade 50 ml; Coca-Cola non-diet 90 ml – if necessary this can be repeated at 10-15 minutes

Table 2 Suggested minimum equipment for medical emergency management (adapted from Resuscitation Council [UK])

Oxygen
Glyceryl trinitrate (GTN) spray (400 micrograms per actuation)
Dispersible aspirin (300 mg)
Salbutamol aerosol inhaler (100 micrograms per actuation)
Adrenaline injection (1:1000, 1 mg/ml)
Glucagon injection (1 mg)
Oral glucose solution/gel (GlucoGel)*
Midazolam 10 mg or 5 mg/ml (buccal or intranasal)

Table 3 The ABCDE approach to an emergency patient

A	Airway
B	Breathing
C	Circulation
D	Disability (or neurological status)
E	Exposure (in dental practice, to facilitate placement of AED paddles) or appropriately exposing parts to be examined

- ASA III severe systemic disease – definite functional limitation
- ASA IV severe disease – constant threat to life
- ASA V moribund
- ASA VI patient being ventilated for organ donation purposes.

THE EMERGENCY DRUG BOX

Patients should only undergo dental treatment in situations where appropriate equipment and drugs are available and have not passed their expiry date.

A minimum list of drugs to be included in the emergency drug box is summarised in Table 1. The list is based on that given in the Resuscitation Council (UK) document on medical emergencies and resuscitation in dentistry.[2]

The Resuscitation Council (UK) recommends that such kits should be standardised.[2] Wherever possible, they recommend that drugs in solution should be carried in a pre-filled syringe or kit. All drugs should be stored together, ideally in a purpose-designed container.

The intravenous route for emergency drugs is no longer recommended for dental practitioners. Formulations have now been developed that allow other routes to be used. These are quicker and user-friendly. Oxygen must always be available in a format that allows delivery at flow rates up to 15 litres per minute.

EQUIPMENT AND TRAINING

The Resuscitation Council (UK) has recommended the equipment shown in Table 2[2] as the minimum that should be available. Named individuals should be nominated to check equipment. This should be carried out at least weekly and audited.

It is a public expectation that automated external defibrillators (AEDs) should be available in the healthcare environment and dentistry is not considered an exception.[2]

All emergency medical equipment should be latex-free and single-use wherever possible.

STAFF TRAINING

Staff should be trained in the management of medical emergencies to a level that is appropriate to their level of clinical responsibility. This training should be updated on at least an annual basis. It is important that new members of staff have medical emergency training incorporated into their induction programme. A full record should be kept of training. Staff should know who to contact in the event of help being required and designated emergency phone numbers should be readily available.

THE 'ABCDE' APPROACH

Medical emergencies can often be prevented by early recognition. Signs such as abnormal patient colour, pulse rate or breathing can signal an impending emergency.

It is important to have a systematic approach to an acutely ill patient and to remain calm. The principles are summarised in the 'ABCDE' approach (Table 3).

Ensure that the environment is safe. It is important to call for help at an early stage – this includes anything from other members of the dental team to calling for an ambulance with paramedic support. A continuous reappraisal of the patient's condition should be carried out. The airway must always be the starting point for this. Without a functioning, oxygenated airway, all other management steps are futile. It is important to assess the success or otherwise of manoeuvres or treatments given, remembering that some therapies may take time to work.

If the patient is conscious, ask them how they are. This may give important information about the problem (for example, the patient who cannot speak or tells you that they have chest pain). If the patient is unresponsive, the patient should be shaken and asked 'Are you all right?' If they do not respond at all, have no pulse and show 'no signs of life' they have had a cardiac arrest and should be managed as described later. They may respond in a breathless manner and should be asked 'Are you choking?'[3]

Airway (A) – assessment and management

Airway obstruction is a medical emergency and must always be managed quickly. Usually, a simple method of clearing the airway is all that is needed. A head tilt, chin lift (Fig. 1) or jaw thrust (Fig. 2) will open the airway. Patients who are suddenly unable to speak are in real danger and establishing a patent airway is critical. It is important to remove any visible foreign bodies, blood or debris and the use of suction may be beneficial. Clearing the mouth should be done with great care with a 'finger sweep' in adults to avoid pushing material further into the upper airway.[3] Simple

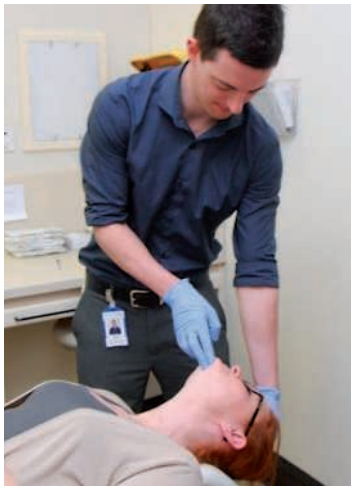


Fig. 1 The 'head tilt, chin lift' manoeuvre for opening up the airway

Fig. 2 The 'jaw thrust' manoeuvre for opening up the airway. Avoids neck extension

Fig. 3 Different sizes of Guedel oro-pharyngeal airways – to be used in the unconscious patient

Table 4 Signs of airway obstruction
Inability to complete sentences or speak
'Paradoxical' movement of chest and abdomen ('see-saw' respiration)
Use of accessory muscles of respiration
Blue lips and tongue (central cyanosis)
No breathing sounds (complete airway obstruction)
Stridor (inspiratory) – obstruction of larynx or above
Wheeze (expiratory) – obstruction of lower airways for example, asthma or chronic obstructive pulmonary disease
Gurgling – suggests liquid or semi-solid material in the upper airway
Snoring – the pharynx is partly occluded by the soft palate or tongue

adjuncts, such as oropharyngeal airways (Fig. 3) may be used. An impaired airway may be recognised by some of the signs and symptoms summarised in Table 4.

It is important to administer oxygen at high concentration (15 litres per minute) via a well-fitting face mask with a port for oxygen (Fig. 4) and a rebreathe mask. Even patients with chronic obstructive pulmonary disease who may retain carbon dioxide should be given a high concentration of oxygen. Such patients may depend on hypoxic drive to stimulate respiration but in the short-term a high concentration of oxygen will do no harm.

Breathing (B) and circulation (C)

Look, listen and feel for signs of respiratory distress. This should be done while keeping the airway open and the clinician should:

- Look for chest movement
- Listen for breath sounds at the victim's mouth
- Feel for air on the rescuer's cheek with the rescuer's head turned against the patient's mouth

Fig. 4 Oxygen delivered from a 'D' type cylinder

- This should be done for no more than ten seconds to determine normal breathing
- If there is any doubt as to whether breathing is normal, action should be as if it is not normal that is, to CPR.

Agonal gasps refer to abnormal breathing present in up to 40% of victims of cardiac arrest. CPR should therefore be carried out if the victim is unconscious (unresponsive) and not breathing normally. Agonal gasps should not delay the start of CPR as they are not normal breathing.

If the unconscious patient is breathing normally the patient should:

Be turned into the recovery position (essentially on their side – best learnt as a practical exercise)

- Send for help or call for an ambulance
- Ensure that breathing continues.

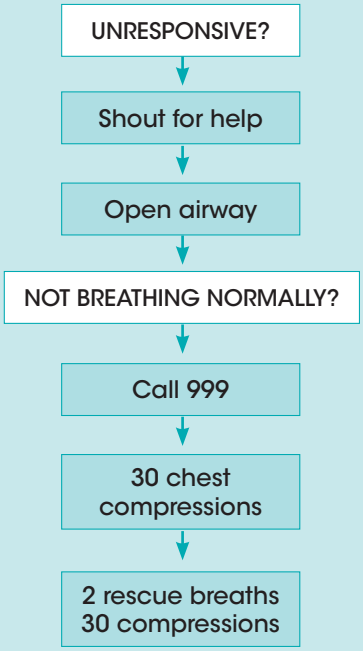
If the patient is not breathing normally:

- Ensure an ambulance is called, this may necessitate leaving the victim, but in a dental setting the practitioner should not be working alone
- Chest compressions should be started with the patient in the fully supine position on a firm surface:
  - Kneel/stand at the side of the patient
  - Place the heel of one hand in the centre of the patient's chest and the other hand on top of the first hand – it will usually be possible to do this without removing the victim's clothes. If there is any doubt, outer clothing should be undone/removed
  - Interlock the fingers of both hands avoiding pressure over the ribs, upper abdomen or the lower end of the sternum
  - The clinician should be positioned vertically above the patient's chest. With straight arms the sternum should be depressed 4-5 cm
  - After each compression all the pressure should be released so that the rib cage recoils to its rest position but the hands should be maintained in contact with the sternum
  - The rate should be approximately 100 times per minute (a little less than two compressions per second)
  - After 30 compressions the airway should be opened using head tilt and chin lift and two rescue breaths should be given. This may be carried out using a bag and mask or mouth-to-mouth (with the nostrils closed between thumb and index finger) or mouth-to-mask
- Practical skills are best learnt on a resuscitation course but certain principles are given below:
  - Inflations should make the chest rise. About one second should be taken to do this
  - The chest should be allowed to fall while maintaining the airway. Two breaths should be given
  - Hands should be returned to the sternum without delay to continue the chest compressions in a ratio of 30:2
- Only stop to recheck the patient if normal breathing starts, otherwise resuscitation should be continued until:
  - Qualified help takes over
  - The rescuer becomes exhausted.

If rescue breaths do not make the chest rise:

- Check for visible obstruction(s) in the mouth and remove it/them if possible
- Make sure that the head tilt and chin lift are adequate
- Do not waste time attempting more than two breaths each time before continuing chest compressions.

Fig. 5 Guidelines for post-exposure prophylaxis (PEP)



Carrying out these manoeuvres is tiring and if there is more than one rescuer CPR should be alternated between them every two minutes. The algorithm for adult basic life support is given in Figure 5.

Circulation (C)

Circulatory assessment should never delay the start of CPR. Simple observations to make a gross assessment of circulatory efficiency are given in Table 5. By far the most common cause of a collapse that is essentially circulatory in origin is the simple faint (vaso-vagal syncope). A rapid recovery can be expected in these cases if the patient is laid flat and the legs raised. Prompt management is required as cerebral hypoxia has devastating consequences if prolonged. Causes other than a faint must be considered if recovery does not happen quickly.

Checking the carotid pulse to diagnose cardiac arrest can be unreliable, even when attempted by some health care professionals.[4] Checking the carotid pulse should only be carried out by those proficient in doing this. The latest guidelines highlight the need to identify agonal gasps (as well as the absence of breathing) as a sign to commence CPR and lay no particular emphasis on checking the carotid pulse.

Disability (D)

The term disability refers to an assessment of the neurological status of the patient. Primarily it refers to the level of consciousness (in trauma patients a more widespread neurological examination is required). Hypoxia or hypercapnia (increased blood levels of carbon dioxide) are possible causes, together with certain sedative or analgesic drugs.

It is important to exclude hypoxia or hypotension as a cause for any alteration in conscious level. Attention to the airway, giving supplemental oxygen and supporting the patient's circulation (by lying them supine and raising their legs) will in many cases solve the problem. All unconscious patients who are breathing and have a pulse should be placed in the recovery position if they are unable to protect their own airway.

A rapid gross assessment can be made of a patient's level of consciousness using the AVPU method: are they alert? Do they respond to vocal stimuli? Do they respond to painful stimuli? Or are they unresponsive?

A lapse into unconsciousness may be the result of hypoglycaemia – if the blood glucose level is less than 3 mmol/litre when checked by a glucose measuring device (Table 2) then glucagon should be injected by the subcutaneous or intramuscular route.

Exposure (E)

Exposure refers to loosening or removal of some of the patient's clothes. For example, for the application of defibrillator paddles (in dental practice) or if the patient has been involved in a traumatic incident (usually in hospital) for examination purposes. It is important to bear in mind the patient's dignity as well as the potential for clinically significant heat loss.

Cardiac arrest can occur as a result of several causes. These are summarised in Table 6. It has been suggested[5] that cardiopulmonary resuscitation can be performed effectively in the dental chair.

Table 5 Simple methods of circulatory assessment

Signs
Are the patient's hands blue or pink, cool or warm?
What is the capillary refill time?*
Pulse rate (carotid or radial artery), rhythm and strength
Symptoms
Is there a history of chest pain/does the patient report chest pain?

*If pressure is applied to the finger nail to produce blanching, the colour should return in less than two seconds in a normal patient. Remember that local causes such as a cold environment could also delay the response

Interruptions to chest compression in resuscitation are common and are associated with a reduced chance of survival.[6] Chest compression-only CPR is a way to increase the number of compressions but is only effective for a period of about five minutes.[6] For this reason the technique is not recommended. The principle on which compression-only CPR works is that during the first few minutes after a non-asphyxial cardiac arrest (in an adult) the blood oxygen content remains high and therefore at this stage ventilation is less important than chest compression.

DEFIBRILLATION

Defibrillation refers to the termination of fibrillation. It is achieved by administering a controlled electrical shock to the heart, which may restore an organised rhythm enabling the heart to contract effectively. Early defibrillation is important. Ventricular fibrillation (VF) is the most common cause of cardiac arrest. It is a rapid and chaotic rhythm and as a result the heart is unable to contract effectively. The only effective treatment for VF is defibrillation and the sooner the shock is given, the greater the chance of survival.[7]

The provision of defibrillation has been made easier by the development of automatic external defibrillators (AEDs). AEDs use voice and visual prompts to guide rescuers and are suitable for use by lay people and healthcare professionals.[8] The device analyses the victim's heart rhythm, determines the need or otherwise for a shock and then delivers a shock. The wAED algorithm is given in Figure 6. CPR should not be interrupted or delayed to set up the AED.

Placement of AED pads

Use of the AED is a skill that requires practical training and experience. The victim's chest must be sufficiently exposed. Excessive chest hair can stop the pads adhering properly and if markedly so must be rapidly removed if possible. Razors are available in AED kits. Resuscitation should never be delayed for this reason.

One pad should be placed to the right of the sternum below the clavicle and the other in the left side mid-axillary line, centred on the fifth intercostal space. This electrode works best if orientated vertically. This position should be clear of any breast tissue.

ONGOING MANAGEMENT AFTER INITIAL TREATMENT OF A MEDICAL EMERGENCY

An ambulance with paramedic support should be called at the earliest opportunity as part of

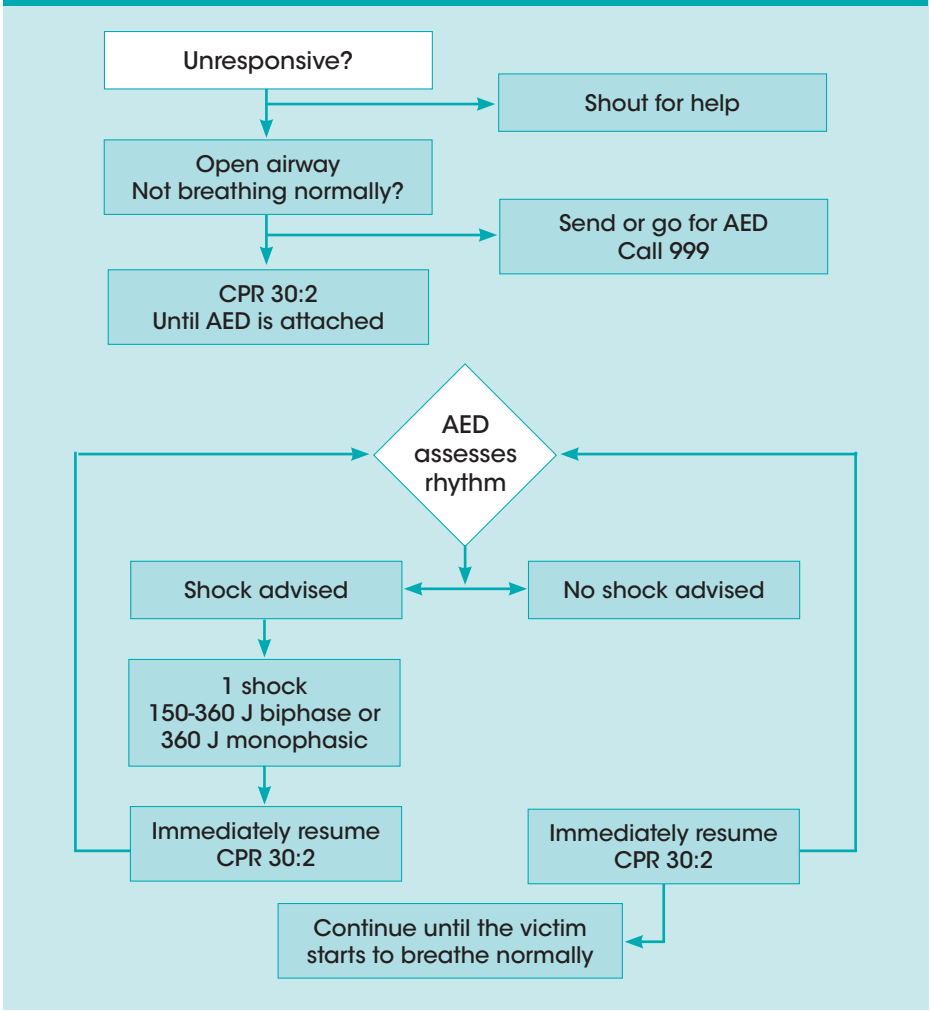
the management of any significant medical event. If the dental practitioner feels competent and confident that the emergency has been managed satisfactorily and the patient is stable they should still not be allowed to leave the dental practice unaccompanied or be allowed to drive a motor vehicle. The decision will be easier to take in some circumstances than others. For example, the patient who has an angina attack in the surgery responds very quickly to their normal GTN and who has a clear history of similar episodes and makes a complete recovery will usually be well enough to be allowed home.

If a patient remains unwell or there is any doubt at all, they should undergo assessment by a medical practitioner. Before any transfer is made the patient's condition should be stabilised so long as that does not delay ongoing treatment. It is important that a written summary is given to the receiving team so that the treatment that has been undertaken and its timing are made clear. A working party of The Royal College of Physicians published a report on a system for assessing acutely ill patients intended for use across the NHS in its entirety.[9] The National Early Warning Score (NEWS) considers six simple physiological parameters. These are:

- Respiratory rate
- Oxygen saturation
- Temperature
- Systolic blood pressure
- Pulse rate
- Level of consciousness (using the AVPU system mentioned above).

If the information suggested by this template can be provided by the dentist then it is helpful in the transfer process.

Fig. 6 An algorithm for resuscitation involving the use of an AED



SUMMARY

Medical emergencies in dental practice are not common but could occur at any time. Adherence to basic principles is critical for effective management. Such events are less alarming and best managed if they have been anticipated and if mechanisms are in place for dealing with them.

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'Local resolution is an *essential* part of complaints'

Head of the Dental Complaints Service, **Hazel Adams**, updates us on how best to deal with complaints.

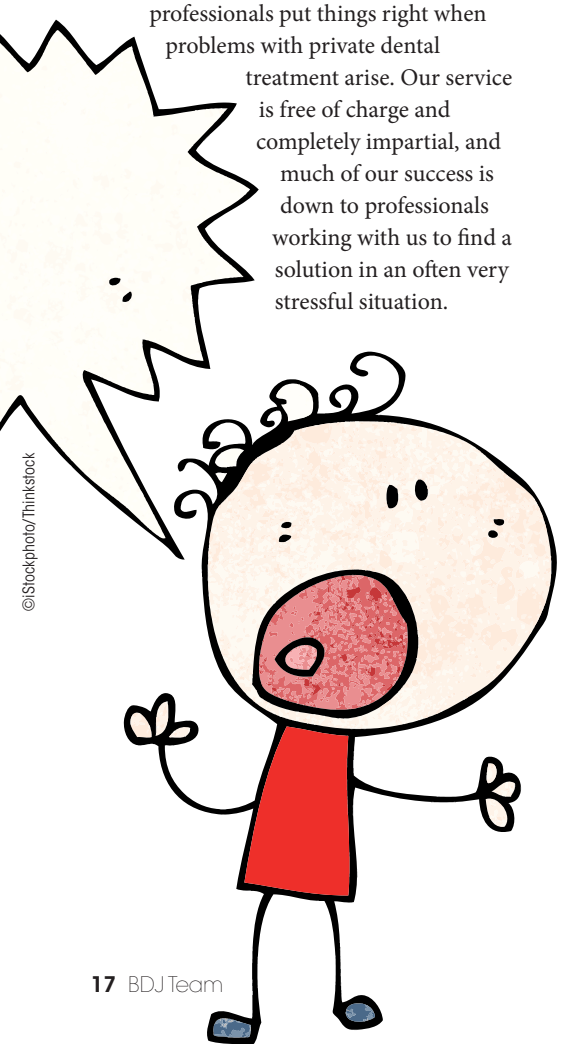
What is the Dental Complaints Service?

Before addressing the issue of complaints handling, I think it's important to set out for those that might not know, what the Dental Complaints Service (DCS) is and does.

Set up by the General Dental Council (GDC) in 2006, the DCS is now in its eighth year and has proven to be an extremely effective complaints resolution service.

Based in Croydon in south London, the service comprises of ten staff, including myself. We are supported by 75 trained volunteer panelists.

We're here to help patients and dental professionals put things right when problems with private dental treatment arise. Our service is free of charge and completely impartial, and much of our success is down to professionals working with us to find a solution in an often very stressful situation.



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It is a key role of all healthcare regulators to ensure the patient's voice is heard. Indeed, it is at the heart of the recommendations by Robert Francis QC in his report published in 2013 in the wake of the Mid-Staffordshire scandal. It's of great importance that bodies like the DCS are known to patients and the GDC works to ensure this is the case.

The types of complaints about private dental care being dealt with by the team at the DCS are not dealt with by any other organisation. Far from increasing the GDC's workload, we are dealing – very effectively – with complaints that might otherwise end up at the door of the GDC's much more costly Fitness to Practise department.

From July 2013 to June 2014 we've dealt with more than 8,500 calls. For the most part they've been from patients and have been about:

- Dentures
- Crowns
- Fillings
- Root canal treatments
- Bridges
- Pain, service and cost.

How we work

The first thing our advisers will ask any caller is whether they've tried to sort out the problem at the practice already. A clear in-house complaints procedure is key to allowing this to happen and many complaints will be resolved at this point. Indeed the new Standards for the dental team, which was launched last September, includes an entire, stand-alone principle about having 'a clear and effective complaints procedure' in place. Not having one in place could in fact become a Fitness to Practise issue.

But if this process has been gone through and either side still isn't happy, then we can step in to act as an impartial third party.

We will not contact a dental professional in relation to a complaint unless the patient has put their complaint in writing detailing their concern and how they would like the dental professional to resolve this.

As a general guideline we would advise patients to anticipate a response within ten working days.

If the patient does not receive a reply within this timeframe or is dissatisfied with the response received, it is at this stage that the DCS would step in to assist.

Our process

We would require a signed consent form from the patient giving the DCS authority to speak to the dental professional concerned. We would also request copies of any correspondence that had been exchanged between both parties.

The DCS will contact the dental professional, introduce themselves and give a summary of the complaint that has been raised. The dental professionals will be invited to give their view of the situation, and a discussion may then take place around how the complaint can be resolved.

The DCS would never insist on an immediate answer and will always suggest that the dental professionals contact their indemnifiers for advice. On occasion dental professionals have asked the DCS to contact their indemnifiers directly in order to progress the complaint.

In the majority of cases the complaint is resolved at this stage. However, if this does not

'IT'S IMPORTANT THAT, WHERE APPROPRIATE, COMPLAINTS ARE ROUTED TO THE DCS RATHER THAN TO THE GDC'S MUCH MORE COSTLY FITNESS TO PRACTISE DEPARTMENT.'

happen and if both parties are in agreement, a panel meeting would be held. This is the final stage of our complaints process.

The meeting would be held in a venue which is local to both parties. The panel consists of two lay members (one of these being a Chair) and one dental professional. They will hear both sides of the complaint and work towards facilitating an amicable resolution. If an agreement can't be reached, the panel will make a recommendation in order to resolve the complaint.

The recommendation could be:

- Closing the case with no further action
- Asking the professional to consider remedial work
- Asking the professional to make a contribution towards remedial treatment
- Asking them to offer an apology
- Asking them to offer a refund.

Further details can be found at: www.gdc-uk.org/sites/dcs/Pages/default.aspx.

Why are complaints increasing?

In the last four years Fitness to Practise complaints (FtP) to the GDC have increased by 110%. This is not the case with the DCS. Complaints to the DCS have been slowing down. That's despite it being an effective service with very high levels of satisfaction from both patients and registrants.

This decrease in complaints is a key reason for trying to ensure that patients and dental professionals know about the service. It's important that, where appropriate, complaints are routed to the DCS rather than to the GDC's much more costly Fitness to Practise department.

Awareness of the DCS is low; only 21% of the public had heard of the DCS in 2012 which was an increase from 13% in 2011.

Promotion and marketing of the DCS is not a new development; we regularly run campaigns to ensure the public and patients, as well as registrants and other advice bodies such as Trading Standards and Citizens Advice, are aware of the service it offers. It is a key role of any regulator (in this case the GDC) to ensure the patient's voice is heard.

At the moment, it would be fair to say that we don't accurately know why complaints to bodies like the GDC are increasing and there are likely to be a wide range of reasons. However, it's important to note that a rise in complaints doesn't necessarily mean a decline in standards – today's patients feel much more empowered to complain and helping them to find the right body to complain to is part of the GDC's work.

It is important to note that most other regulators of healthcare professionals have also seen a rise in the number of complaints since 2011 – including the General Medical Council, Health & Care Professions Council and The Nursing and Midwifery Council.

The GDC is committed to better understanding the reasons for the sharp upward trend in complaints and also ensuring patients have the right knowledge about where best to complain to.

It will look at why complaints are increasing and will be exploring with patients through research as to why this may be the case. There are likely to be a number of contributing factors including a change in attitudes from both professionals and patients – specifically an increase in patient expectations. This research will also feed into the work of the DCS.

Advice to dental professionals

In order to prevent complaints from escalating, our advice to dental professionals is to acknowledge that a complaint has been raised, provide a written reply within ten working days (if this is not possible, send a holding letter confirming the date of when a response will be received), follow through on any arrangements made and also consult with their indemnifiers for advice.

By the end of June 2014, the DCS had received a total of 80,514 calls to its local rate phone number since it first opened. Those calls have resulted in more than 12,000 complaints – an average of 28 complaints a week since we launched. The positive news is that two thirds of those complaints were resolved in less than a week.

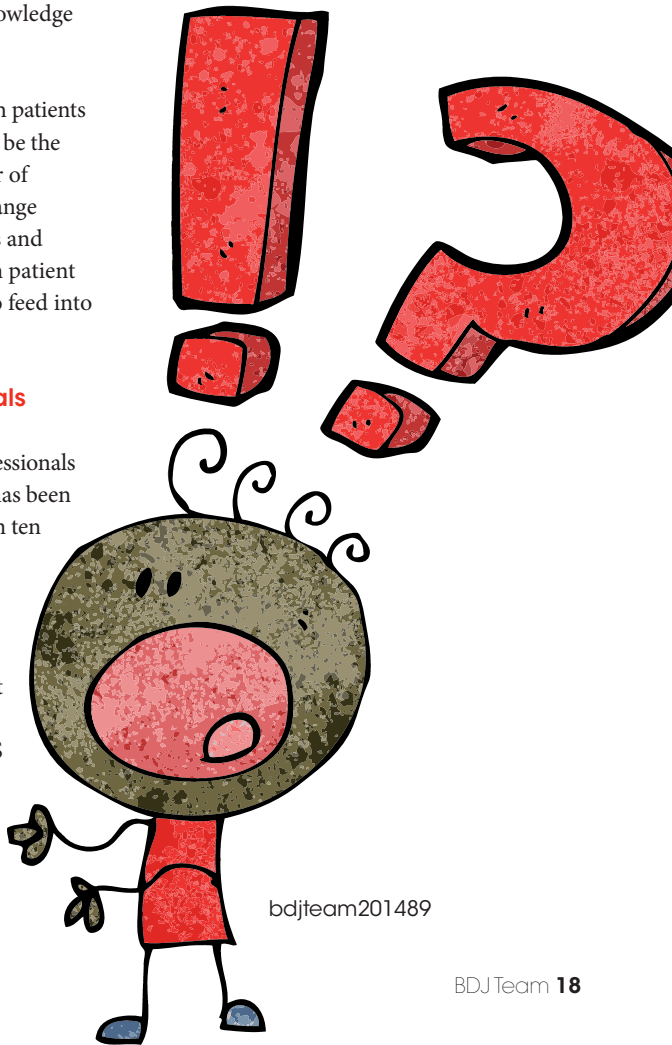
The prevention agenda

We believe local resolution is an essential part of any complaints procedure. When the DCS receives a call we routinely check whether the patient has sought to resolve the matter with the dentist or dental care professional (DCP).

The DCS will not take the complaint further until this first step has been undertaken and has failed to resolve the matter. You may not be aware that the majority of cases are resolved at this first stage.

The GDC and the DCS know how good local resolution can be and we actively encourage it. The GDC is working with NHS England and other stakeholders across the UK with a view to encouraging earlier, local resolution of complaints. It will also analyse patterns of complaints and where necessary, will be providing advice to the profession on how to prevent concerns being raised. We know that patients are confused about how to complain and we must have a system in place that works for them.

We can't just respond to complaints, we must understand the reason for the increase as well.



bdjteam201489

Litigation and complaints **in the dental practice**

By Dr Kerry Beynon[1]

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It is an unfortunate reality that dental practices and dental managers will receive complaints and be drawn into litigation at some point, from a range of sources and on several different topics. How they are handled from the start can determine very different outcomes.

This article will look at some of the most common complaints in dental practices and how they can be avoided, where possible.

The most common types of disputes relevant to dental practice are client care issues, contractual or partnership disputes (including the NHS), and those relating to your trading name or premises. The most crucial way of avoiding any (and all) of these is to ensure your records are meticulous, that your policies are clearly defined and that your staff are clear on these. The following information should provide some clear actions to ensure you are prepared should a dispute occur.

DISPUTE 1– Client care issues

This could involve service falling below the expectations (or perceived expectations) of your client. Try to outline the pros and cons of treatment by using information leaflets at the practice. Manage their expectations from the start and be upfront and clear about what is included within costs and procedures. Should a dispute arise following care, contact your insurance company before taking any other actions and certainly before responding to the complaint. They will advise if you are covered or have acted to manage expectations.

DISPUTE 2 – Contractual disputes with employees and self-employed people

The most important point with regards to this type of dispute is to ensure your practice manager is up to date with all employment law and all paperwork reflects this (and remember that by law all employees are entitled to a statement of terms of their employment). If a complaint is made, seek HR advice from a dental specialist at the earliest opportunity and ensure all conversations and agreements are documented.

DISPUTE 3 – Partnership disputes

Disputes between partners in a practice can be incredibly difficult and can especially be a problem where the partnership is one of an expense-sharing nature. Very often partnerships, particularly historic ones, are based on goodwill and 'gentlemen's agreements', but unless contracts have been laid down, the details can become murky. Partnerships must be formalised to ensure all parties are happy

'MAKE SURE YOU'RE ACTING LEGALLY AND WITHIN GOOD HR PRINCIPLES. TRY AND SETTLE ANY DISPUTE WITHOUT SEEKING TO GO DOWN THE LITIGATION ROUTE…'

[1] *Associate Solicitor and Head of Intellectual Property, JCP Solicitors www.jcp-healthcare.co.uk*

with their legal obligations and any unforeseen circumstances that could arise. Speak to a legal professional who specialises in dental practice to ensure that the partnership agreements are correctly formalised and that both parties are fairly represented.

DISPUTE 4 – Payment disputes with NHS

NHS payment is made to practices based on agreed target UDAs, and payments for NHS work are usually paid in advance. With this in mind, there are often payments to be returned or contracts to be negotiated if you were to terminate the work. In many instances the decision to relinquish NHS duties is the result of numerous factors including mounting UDA pressures, which in some cases is felt to reduce the standard and quality of care that can be given to each patient.

Keeping thorough records of all work completed and all payments made should assist you with any NHS disputes you may have. The terms of your NHS contract will determine any likely provision for claw back payments already accrued. Details such as these may well have a significant impact on your practice, so make sure that a professional deals with this from the outset.

DISPUTE 5 – Premises

Disputes with landlords can occur if you are occupying your premises under a lease. With the conversion to a limited company, you must consider including changing the terms of your property lease from a single leaseholder or partnership to a limited company. Ensure your landlord is aware of your business and any changes that are made and that these are amended in your tenancy agreement. Also, do not forget that most leases require your landlord's consent before alterations can be made to a building. Failing to get proper consent to any alterations from your landlord (and planning authorities if necessary) can lead to your lease being terminated.

DISPUTE 6 – Service provider disputes

Disputes with service providers to your practice can be tricky. Examples could include changing contractors but termination provisions already built into contracts can prevent this. The key here is good practice management. Ensure you keep a central database of contracts and key dates and arm yourself with as much information as possible.

DISPUTE 7– Disputes over trading names

It is surprising how common these types of disputes are. The key to avoiding them is to look for similar names but also sound-alikes as they're just as difficult. Registering your practice name is easy (if it fulfils the legal requirements for a registered trade mark) and registration costs are typically between £250-£350 plus legal fees. When registering, remember that you can only register a name that is distinct – you can't be descriptive, for instance using your location followed by 'dental clinic' forming the name of your practice. Even if you've been operating for years without ever registering your practice name, you still can have a case should someone open something that sounds similar – this is based on the reputation you have built.

It is always good to have a distinct brand identity – from competitors but also if you own multiple practices. Visit the Intellectual Property Office website at www.ipo.gov.uk for further advice and information on this.

My overarching advice to anybody with a private practice is to get your house in order – know what's what, who you are dealing with, what your contracts say, when contracts come to an end/can be terminated and where the documents are filed. Make sure you're acting legally and within good employment and HR principles. My advice is to try and settle any dispute without seeking to go down the litigation route – it can be costly.

bdjteam201490

The *BDJ Team* reader panel on COMPLAINTS

Shaun Howe, *dental hygienist*

'The problem for the profession is that patients have the right to complain direct to the GDC (not necessarily the DCS) and this is the primary reason for the increase in complaints... That said, perhaps we, as a profession, should be driving for awareness of PRACTICE complaints procedures rather than patients going direct to the GDC. There are also issues with those that handle cases at the DCS as they are not dentally trained and will refer to FtP if they do not understand the finer points of a complaint.'

Steph Horner, *dental nurse/ decontamination lead*

'Our patients are encouraged to present their complaint through the proper channel according to our practice policy. Complaints are very rare here and they have always been resolved within our practice.

The provision of NHS dentistry has changed since the introduction of UDAs. At the end of the day each practice is a business and needs to run as such. Previously each item of treatment had a fee, so practitioners were paid for any work they carried out. Now you have a lump sum awarded to you and you must spend it accordingly. Go over that budget and you're expected to treat patients for free. Go under the budget and your UDAs are adjusted the following year accordingly. It's quite possible that this has been a major contributing factor to the quality of patient care. Not treatment quality, but customer service. Couple this with the financial crisis over the last few years and you have the making of a very disgruntled public. I expect good service for my money as well as the next person. If I feel I haven't received such I will now complain rather than just pass it off.

This country has also been encouraged to jump on the American litigation bandwagon, in order to gain some type of financial compensation. It's not difficult to see why, what with the "no win, no fee" ambulance chasers.'

Jacqui Elsden, *Dental Education Facilitator*

'Patients are much more aware now than ever before due to the use of the Internet for "looking things up". Patient expectations are higher and our patients often "request treatment" such as cosmetic treatment/implants. If patient expectations are not handled adequately, complaints will follow.'

BDJ Team continuing professional development

CORE CPD: ONE HOUR

CPD questions – August 2014

CPD ARTICLE: Medical emergencies: the drug box, equipment and basic principles

1. In the American Society of Anesthesiologists (ASA) system of stratification of patient fitness, severe systemic disease with definite functional limitation is denoted by category:

A. I
B. II
C. III
D. IV

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2. In the ABCDE approach to the sick patient, 'E' stands for:

A. emergency
B. environment
C. evacuation
D. exposure

3. When carrying out basic life support, the rescuer should check for the presence of breathing for:

A. 10 seconds
B. 5 seconds
C. 15 seconds
D. no need to check if the airway is patent

4. The National Early Warning Score (NEWS) includes:

A. oxygen saturation
B. diastolic blood pressure
C. urine output
D. pupil size

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Topics covered so far

➤ March 2014: **The use of radiographs in clinical dentistry**

➤ April 2014: **Disposing of clinical and dental waste**

➤ May 2014: **Emergency oxygen therapy in the dental practice**

➤ June 2014: **Achieving a good bond in acrylic resin denture health**

➤ July 2014: **Needlestick and occupational exposure to infections**

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Q4	☐	☐	☐	☐

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