IN BRIEF

- Provides a practical aid to the dental practitioner in selecting agency or temporary dental nursing staff.
- Can be used to identify training needs of your permanent or temporary staff.
- Clearly identifies an area of risk of harm to patients or staff in daily working practice.
- Includes a checklist for assessing the skills of temporary nursing staff.

An outline of appropriate risk management in the use of temporary dental nursing staff in practice

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It'll never happen, it might not happen, it shouldn't happen, it happened!

The risk of human error represents the greater threat to complex systems such as the delivery of healthcare rather than technical failure. Much of the legislation recently introduced in UK healthcare services, *Building a Safer NHS; An Organisation with a Memory* and *A First Class Service* evolved from a growing awareness of adverse incidents occurring in the healthcare setting. In general dental practice the absence of a trained skilled dental nurse with local knowledge of the working environment constitutes a risk to patient safety. Be this through the lack of appropriate selection, training, induction or clinical supervision of an appropriate stand in. Be it due to poor governance, audit or quality control the cost to the practitioner, practice, profession and patient can be high. To mitigate this risk a comprehensive risk management system will be needed in practice. Planning to prevent such risks requires understanding, analysing, managing and costing the risk. Success depends on robust systems for screening, contracting and training of staff within an educated team of safety orientated personnel supported by suitable frameworks for standards, resources, policies, protocols, processes and checks within a clearly identifiable chain of command.

INTRODUCTION

In this article I propose to look at the risk associated with the use of temporary or agency staff in general dental practice and outline a plan for managing that risk. For example as general dental practitioners we have all perceived the practical difficulties and highly skilled teamwork required to complete a molar endodontic appointment successfully. The increasing complexity associated with such procedures now routinely encountered in general practice places a duty of care on both the dental surgeon and nurse present to complete this

demanding work without incident or adverse event. A review of adverse incident reports originating from general medical practice, dental or other hospital environments suggests that inexperienced or less well-trained staff are, on occasions, involved.¹ Systems have now been developed for analysing the root causes of medical errors.² Little or no work has been reported looking at the causality of adverse incidents involving temporary dental staff. There appears an apparent unwillingness to accept or acknowledge responsibility for their actions in the workplace perhaps due to current working systems within the practice, lack of training opportunity in the practice for such staff, or perhaps a lack of loyalty towards this small group of dental staff in the willingness of dental practitioners to fund their training needs. This may be as a result of the current funding arrangements or lack of awareness of the responsibility of employers. Short notice to acquire

replacement staff puts a constraint on remedial action to rectify any deficiency in skill or training on the day in the absence of appropriate risk assessment and planning. Temporary staff whilst operating with the best intentions may not be aware of the systems or protocols in place locally to manage the risk associated with what should be simple practical procedures, eg when inappropriate medication has been administered to a patient,³ these procedures often having been carried out by the individual hundreds of times previously without an adverse outcome. I propose in this article to look at the risk management required for the temporary replacement of the dental nurse in the general dental practice.

Background

Much of the legislation, laws and Acts now governing the dental workplace are listed in Figure 1. In 1999 Government via the Health Act implemented policy in which

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Fig. 1 Legislation relevant to the use of temporary or agency dental nursing staff

In general in the dental practice

The Factories Act (1961)
 Health and Safety at Work Act (1974)
 The Workplace, Health Safety and Welfare Regulations (1992)
 The Provision and Use of Work Equipment Regulations (1992) amended 1998
 The Manual Handling Operations Regulations (1992)
 The Personal Protective Equipment at Work Regulations (1992)
 The Management of Health and Safety at Work Regulations (1992) amended 1999
 Health & Safety Display Screen Equipment (1992)
 Ionizing Radiation Regulations (1999)
 Ionizing Radiation (Medical Exposure) Regulations 2000
 Pressure Systems and Portable Gas containers Regulations (1989)
 Control of substance hazardous to Health (1988)
 The safe use of portable electrical apparatus
 Guidelines on the use of Laser Equipment in Practice [HSE HN (84) 16]
 Electricity at Work Regulations (1992)

In the administration of the practice

Access to Health Records (1990)
 Consumer Protection Act (1987)

Data Protection Act (1984)
 Employment Act (1989)
 Local Fire Regulations
 Sex Discrimination Act (1975)
 The Protection of Children Act (1999)
 Working time Regulations Directive (1998)
 The Consumer Relations Act (1999)
 Local Risk Assessments
 Reporting of Diseases and Dangerous Occurrences Regulations 1995

In the surgery

COSHH (1988)
 Environmental Protection Act (1999) Waste disposal
 Medical Devices Act (1998)
 Use of UV light in the surgery
 Cross infection control (Maintaining standards GDC 2000)
 Mercury spillage
 Area or Local Child Protection Procedures and Policies (2003)

NHS Trusts could develop a framework of quality assurance measures that would promote patient safety in the workplace and the delivery of a quality healthcare system, in the form of the NHS plan.⁴⁻⁷ A growing awareness of adverse events occurring in healthcare along with other factors has led Government to develop a rapidly evolving dental healthcare policy strategy^{8,9} in recent years. Much of this policy is being used to formulate current procedures for employers in their registration, regulation and retention of staff. If we are to meet patient expectation regarding the standards of care they receive¹¹ and upheld in the UK by the General Dental Council¹² all these recommendations will eventually have to be implemented in full in the general dental practice. These policies build on a number of previous guidelines such as the Code of Practice for employing nursing staff in the NHS^{13,14} which included guidelines on dental staff from other countries and new guidelines such as amendment 6 to the NHS Dental Terms of Service¹⁵ which sets out good practice arrangements for NHS trusts and the new (Primary Care Trusts) PCTs when employing dental staff. One of the primary roles of The National Institute for Clinical Excellence (NICE) in medical healthcare delivery has been to define best practice guidelines partly in response to adverse incidents. General dental practitioners are beholden to establish and implement similar working practices based around guidelines currently being developed for NHS dental hospital departments. The Department of Health¹⁰ has also established a

framework of guidelines or pre-employment checks when employing staff and these are readily adaptable to use in the general dental practice sector. This includes a recommendation for specific training for those responsible for interviewing and selecting staff. The individual private dental practitioner unfortunately rarely possesses these skills nor has had formal training in these disciplines.

THE LOCAL ENVIRONMENT

In the general dental practice the common scenario is when a temporary member of staff is required to cover the work of a permanent contracted member of staff. This is usually to cover annual leave or sickness. Recommendations with regard to chaperoning made by the General Dental Council in its publication, *Maintaining Standards*¹² have made the role of the dental surgery assistant vital, not only with regard to assisting the dentist in increasingly complex procedures in practice, but also maintaining accurate and contemporaneous record keeping and the provision of appropriate care to the patient. It has now been identified that human risk represents the greatest threat to complex systems such as the delivery of healthcare rather than technical failures even in industries like aviation.¹⁶ The clinical risk associated with the absence of an individual and failure to replace them are well documented.

Vincent,¹⁷ looked at the different roles in a workplace and by relating these to best operating practice, identified circumstances in which they may be compromised

(listed below). An individual role in the dental workplace if incorrectly performed would present an opportunity of harm to the patient, themselves, other members of the team or even visiting members of the public:

- *Routine violations*, eg deliberately corner cutting due to boredom
- *Optimising violations* to appear to do something well and quickly for want of praise
- *Situational violations* 'to get the job done today', and
- *Local risks* most minor slips, trips and omissions.

Organisational risk was seen as the most fundamental factor in the sinking of the Herald of Free Enterprise (Zebrugge).¹⁸ Examples of this also exist in dental practice, eg where a principal who routinely works single handed or fails to employ temporary staff for sickness cover. A clear example of a latent failure in management leading to unacceptable risk in that practice. The damaging consequences of failure to have a policy to manage staff absence may leave open for a prolonged period of time factors which when combined with local factors on the day can trigger an adverse event.

RISK MANAGEMENT SYSTEMS (IDENTIFY AND CONTROL THE RISK)

Systems to minimise risk in the healthcare workplace are readily being embraced by organisations and industries where clinical governance, quality assurance, ISO 9001 (2000) and Investors in People have been

implemented but this only extends to perhaps a hundred of the 8,000 general dental practices in the UK.

As a starting point I decided to poll a group of general dental practitioners, private and NHS, (a local peer review group) and the two FFGDP Effective Dental Management and Leadership module student groups at York University, a total of 44 dental practitioners with a selection of questions relating to the use, training and employment of temporary dental nursing staff. Replies were received from only 32% of practitioners but of these almost 100% require a temporary nurse on a regular basis several times per year. Certainly results of my questionnaire suggest there is a need to better assess the skills and abilities of the temporary staff with only 47.5% having been checked for a criminal record (Fig. 2). There was no systematic approach to assessing their abilities or suitability nor a means of identifying any training needs they require. There was little awareness that training of temporary staff as a local policy was practicable

when the absence of staff is so unpredictable. Private individual practitioners appear currently to be acting in an uncoordinated way with each practitioner making whatever commitment they subjectively assess is valid for their perception of the risk. Little time was being set aside by GDPs in preparedness for this scenario (this ranged from a maximum of 1 day to a minimum of 10 minutes). This is despite the BDA in its recent discussion document from the Primary Dental Care Working Party¹⁹ having identified widespread manpower shortages. The Dental Defence Agency (DDA) seemed much better organised in its efforts to implement sufficient training to minimise risks associated with the use of all staff temporary or permanent. From the responses it would appear the DDA clinicians are not directly responsible for surgery assistant staffing but a separate training unit had been established and no dental nurse could work unsupervised without passing and completing the appropriate training prior to working in the patient clinics.

PLANNING FOR THE RISK (PREVENTION)

For the employer:

- Designate a member of staff or individual responsible for recruitment (including developing a delegation structure if that individual is absent)²⁰ to identify the aims of recruitment such as promoting professional standards, further develop recruitment standards, promote the importance of quality in recruitment into the practice, reduce the risk of bad selection, promote what the practice expects from temporary recruits.
- Appropriate training must be organised for that individual in recruitment (identify and rectify training needs) to identify appropriate agencies and individuals suitable to the practice.
- Set and adhere to minimum individual staff qualifying criteria with a job profile and person specification for each role in the practice. Checklists for core competencies and skills could be developed from The Teamwork²¹ manuals and the new NVQ level 3 Dental Nursing Train-

Fig. 2 Employing temporary nursing staff dentist questionnaire results

	FFGDP1	FFGDP2	PEER-RVW	COMMUNITY	TOTAL	%
Total forms sent out	15(DDA 4)	13(DDA 1)	15	1	44	
Total replies received	6(4)	1(1)	9	1	17	31.9
When employing temporary staff for annual leave or sickness do you?						
use an employment agency	3(3)	1(1)	2	1	7	41.2
Have you checked if the agency carries out appropriate check on personnel recommended?	1(1)	1(1)	7	1	10	58.9
use past staff	3(2)	0	6	0	9	52.9
use relatives	3(1)	0	4	0	7	41.2
use only qualified staff	4(4)	1(1)	4	1	10	58.9
Other	ex-service	0	experienced	0		
Do you keep with you or at home a list of temporary staff telephone numbers	3(1)	1(1)	6	0	10	58.9
Do you have an in house induction programme for temporary staff?	5(3)	1(1)	5	1	12	70.6
how long do you spend with a new member of staff before starting treatment?						
10 min	0	0	1	0	1	5.9
30 min	1	0	4	1	6	35.3
1hr	2	0	0	0	2	11.8
2hrs	1	0	1	0	2	11.8
1day	2	1(1)	2	0	5	29.4
Do you check if staff are appropriately qualified in the following areas?						
H&S policy	5(3)	1(1)	7	1	14	82.3
Ionizing radiation local rules	5(3)	1(1)	6	1	13	76.5
Manual handling training	4(3)	1(1)	5	0	10	58.9
crossinfection control	5(3)	1(1)	6	1	13	76.5
Appropriate Immunization	5(3)	1(1)	8	1	15	88.2
Do not have a criminal record	3(3)	1(1)	4	0	8	47.5
have had an adverse incident before	3(3)	1(1)	4	0	8	47.5
COSHH	5(3)	1(1)	6	1	13	76.5
RIDDOR	5(3)	1(1)	6	1	13	76.5
Mercury Spillage	5(3)	1(1)	7	1	14	82.3
CPR/emergency oxygen and drugs Kit	5(3)	1(1)	8	1	15	88.2
Registration and qualifications	5(3)	1(1)	7	1	14	82.3
Has that person had specific training in the above issues and responsibilities?	4(3)	1(1)	8	0	13	76.5
how often is that training reviewed?						
6 months	1	1(1)	7	0	9	52.9
annually	4(3)	0	2	0	6	35.3

Fig. 3 Temporary dental nursing staff induction checklist

	Induction by	Date	Checked by	Training needed	Signed off by	Temp staff sig
Tour of Practice						
Reception						
Office						
Waiting Room						
Surgeries						
Staff Room						
Sterilizing Room						
Access & Egress						
Car Parking + emergency meeting Point						
Practice Start up-opening						
Practice Close Down						
Clinical Induction (Local Protocol and Policy)						
Surgery start up						
Cross-infection						
Clinical Waste & Sharps						
Intra-oral camera						
Panorex-equipment						
Digital x-ray sensors						
Stock ordering						
Patient information sheets						
Surgery close down						
Paedodontics						
Specific Procedures (local policy risk reduction)						
Crown and bridge						
Endodontics						
X-ray processing						
Laboratory procedures						
Pathological specimens						
Periodontal surgery						
Minor oral surgery						
Prosthetics						
Administration Induction (Local Protocol and Policy)						
Line management						
Areas of responsibility						
Patient notemaking						
Appointment book						
New patients						
X-ray administration						
Laboratory collection and delivery						
Filing, manual computer, archives						
Patient confidentiality						
Meetings, management, staff & training						
Patient information sheets						
Pricing+ payment methods						
Written estimates and treatment plans						
Notice boards						
Referrals (in and out)						
NHS administration						
Child Protection						
Health and Safety						
Local H&S Policy						
Fire drill						
CPR(+ local drill and policy eg location of laerdal masks)						
Emergency drugs kit						
Oxygen						
Dispensary						
Ionizing radiation local rules						
Immunization						
Mercury spillage						
Clinical waste disposal						
COSH						
Riddor						
Complaints procedures						
Heaters and electrical appliances						
Security-safestaff, burglar alarm & namebadge						
(Sedation Drugs+ specific risks)						
Clothing, jewelry etc.						
Hours of Working						
Local risk stairs- falling and lifting						
Registration+ certification						
In house training attendance record						

ing syllabus available from local education authorities.

- Develop an appropriate and clear advertising policy, relevant application forms and selection process to indicate the requirements of the job; activities of the practice; location, remuneration rate and length of tenure etc.
- Develop an appropriate and clear selection process including interviewee feedback. Follow up references and formal registration with the appropriate authorities and obtain interviewee medical records if needed. Sample medical questionnaires are available on the department of health website at www.doh.gov.uk in .pdf format. Where appropriate use an occupational health interview or questionnaire and complete and retain formal documentation. Carry out criminal conviction and English language proficiency checks. Obtain written agreement from the temporary member of staff to abide by the practice patient confidentiality policy.
- Induction: Closely follow the induction procedure outlined in Figure 3 to make sure the individual employed is appropriately trained in local practices and fully familiar with local risk scenarios. Preferably at a separate visit of at least 2 hours duration. Give the individual enough time before the first patient arrives at the clinic to fully reacquaint themselves with the fine detail of the whereabouts of instruments, etc in the workplace.
- Monitoring: During the clinical session the line manager must constantly review the quality of the performance of the temporary member of staff. If any under performance is suspected or evident, remedial action must be taken immediately.
- Exit interview: after each session a short exit interview should be carried out to ascertain if the individual encountered any difficulties or shortcomings. This would indicate areas where the team could improve policy or working practice.
- Prepare and maintain a register of the temporary or agency staff that have complied with all the requirements of the above recommendations. Try at all times to employ such competent individuals in the first instance.
- Patient survey on temporary staff days – did patients identify any weakness in the service associated with the use of temporary staff which were not immediately apparent to the line manager eg poor cross-infection control practices.

For the temporary employee:

- Use temporary contracts of employment incorporating minimum criteria.
- Occupational health assessment²³ to identify any obvious impediment to car-

rying out their main duties (eg poor eyesight)

- Induction training checklist (Fig. 3) – identify and rectify training and continuing professional development (CPD) needs.
- In house training awareness and availability – introducing temporary staff into the team structure is desirable to aid team building and communication, all temporary registered (bank) staff that have been successfully inducted should be welcomed to attend in-house training.
- External training needs: where appropriate suitable staff could be funded to attend courses where their core of knowledge is weak or out of date.
- Special arrangements when using agency staff. Despite contacting five commonly used agencies in the dental press there was little structure to any enquiry made of an applicant. No one was able to forward any checklist or pro-forma enquiry sheet used to pre-assess applicants. Some were checking the core requirement of registration with the appropriate agency and forwarding a CV to the interested employer. Sole responsibility therefore for employing a suitable applicant lies with the practitioner but agencies were worried about adverse publicity associated with any referral.
- Complaints management policy to reduce cost of adverse events. This policy should have core elements:
 - Empathise with the complainant
 - Take the complaint seriously
 - The complaints policy should be effectively administered through a recognised system
 - It should require a thorough and speedy investigation in an open and honest way, and
 - It should feed back into the performance and audit meetings to identify change and common pitfalls. This should help to minimise adverse event claims and costs.

MANAGE THE RISK

First and foremost is a local in-house reporting system for annual leave and sickness as part of the employment contracts. Practical information on how many days pro-rata annual leave is available, how much notice period is required, circumstances when leave can be cancelled in an emergency etc. This should be well understood and adhered to by both parties and not diluted or operated on an *ad hoc* basis. The contract is to be signed by each member of the permanent staff also indicating whom and when to notify in cases of illness. At my practice we are seeking to set high standards in all we do clinically,

administratively and for patients in the quality of service we deliver. Patients expect this from us; the whole team are made aware of this through our in-house fortnightly meetings at which any team member can raise safety issues. Temporary members of staff are encouraged to participate. We accept that good communication within our team plays a vital role in enhancing safety for all at the practice.¹⁶ It is at this forum we look at adverse incident reporting. This review is incorporated in our assessments of clinical performance through our in-house quarterly audit scheme that is part of our BDA Good Practice compliance. We have used a risk assessment tool kit²² to identify (core) basic competency standards in our clinical work and this theme is now being continued into the nursing role by identifying minimum standards of cross-infection control, and other routine procedures. A list of core competencies can be developed from the *Teamwork in Practice* manuals²¹ and developed further as the new NVQ level 3 courses for in practice training of dental surgery assistants. These can then be incorporated into the standard requirements at interview for all staff. Most commonly I use previously employed staff that we endeavour to keep in touch with.

COSTING THE RISK

Notwithstanding the moral and ethical requirements today on all practitioners to maintain the highest clinical standards we are now encouraged to have evidence to support the maintenance of those standards through contemporaneous documentation in all aspects of the service we provide. We have taken prompt appropriate action to remedy any findings of deficiency in the service within a rolling process of review and audit.¹⁰ The feature that is most worrying in private practitioner dentistry is the subjective rationalisation of cost (risk) against profit. In my formative practice years I had great difficulty rationalising, my loans, quality of service and clinical safety. There was an assumption, I think, by my patients, who trusted me, which was I was *always* working in their best interest. Any practitioner who works 'single handed' cannot reasonably be seen to be working in the patient's best interest. There is a *bias* in this scenario that quick mental risk assessments are made emotively and subjectively. The risk perceived is undervalued and then cast aside for financial reasons. All the aspects to employing temporary staff mentioned earlier can play a role in the reduction of the likelihood of an adverse event occurring in practice. Unfortunately this will never be reduced to nil by the very nature of the procedures themselves. Testing against core competencies as in the

aviation industry, practising adverse scenarios akin to simulator testing will eventually be the fundamental rationale on which an individual will be passed as competent to practise in their chosen career.

The costs to the practitioner and practice can be high. There is increasing evidence available from the British Dental Association Benevolent Fund and Medical Defence Societies that involvement for a dental practitioner in the litigation process can be highly stressful and have an adverse outcome in relation to their health, mental and physical and general emotional well being.²⁴ The Commission for Health Improvement (CHI) has been established to look at minimum standards of practice in medical workers and if underperformance is present to recommend appropriate action to remedy this in the form of re-training and appraisal through the newly formed National Clinical Assessment Authority. Their remit could readily be enlarged to encompass review of personnel providing dental services in the future.

If the outcome of any adverse event is unfavourable then the practitioner may be subject to civil action, a fine, a period of exclusion from the dentists register, or even erasure.²⁴ Some practitioners who do not change their ways may now be unable to find professional indemnity insurance cover and therefore can no longer practice.

The costs to patients can be measured by the ever-rising awards for dental negligence claims for both personal injury and consequential losses.

The cost to the practice and profession can be measured in the lowering of public esteem and trust in the profession as a side effect of widespread publicity of adverse events in the national press. It must also be recognised that such publicity is a significant driving force in the continual need to overhaul policy and change current practice in line with best practice.

CONCLUSIONS

Successfully employing temporary nursing staff in a general dental practice depends firstly upon robust systems for screening and contracting permanent and temporary staff, careful selection of individuals assessed against core competencies which are regularly reviewed and reassessed using appraisal in the workplace. A good working knowledge of local practices is essential, supported by an easily accessible, coherent training structure for all staff and importantly, up-to-date use of internal and external learning opportunities. The presence of appropriate training manuals, protocols, policies, guidelines and local rules for temporary staff to refer to is a must, as is information on where a temporary indi-

vidual member of staff can seek advice in the appropriate chain of command, ie who is the line manager on the day. Secondly and just as important is the encouragement of a team mentality that makes risk reduction and safety a priority over profit. The result will be a framework of standards, processes and checks that in return create a comprehensive risk management system.

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