Interpretation of guidelines *varies* according to who is treating

Dental hygienist **Catherine Edney** argues that what's right for dentists should surely be right for dental hygienists and therapists?

A while ago a dentist posted a dilemma on a well known forum: 'My nurse has called in sick, there is nobody available to cover and I have a day full of exams and one or two emergency appointments.'

The resounding and overwhelming advice was: 'Cancel the day and move the emergency patients to a colleague.' Of course, there is good reason for this response. The GDC Standards document states: 6.2.2 You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting.

There are further considerations. Can the dentist appropriately perform an examination, chart the necessary information (remembering this includes taking indices and making periodontal diagnosis), communicate to the patient, sterilise the instruments, clean the room between patients AND keep contemporaneous notes? The widely accepted answer is NO - a GDP would not be able to work effectively in this situation.

Furthermore, the CQC has its own guidance regarding working without chairside support. The CQC would expect to see a risk assessment undertaken before this decision is made. To quote from the CQC myth busters: 'If our inspectors found a dental professional to be working alone without chairside support from a dental nurse, we would expect to see that a risk assessment had taken place. This needs to take into account how support or assistance would be provided in a medical emergency; for either the patient or dental professional.

While these guidelines are widely accepted and observed by the general dentist, why is it that dental hygienists, who most uphold the very same Standards and face the same clinical challenges when working alone, are often not afforded the same level of support?

It has been suggested that there are ways a dental hygienist can work alone, and that being 'supported at all times' could be interpreted as just having another GDC registrant on site. The truth of the matter, though, is that unfortunately if any clinician is working alone, in a time pressured environment (most hygiene appointments being around thirty minutes only) something has to give - and we are not talking just the clinician's spine!

One example is the age old difficulty a dental hygienist can have with aspiration; as per HTM01-05, aerosols are supposed to be aspirated by the high speed suction. This means the hygienist losing the mirror in order to suction and use ultrasonic or airflow hand-pieces. This is ergonomically impossible without adopting a damaging sitting position and putting the clinician at risk of serious long term health issues.

Emergencies can arise at any time and, if there is nobody else in the room with you, are you confident that you could get appropriate assistance in a time efficient way? Would you have to leave your convulsing patient (even if just to reach for the 'phone)?

The role of the hygienist is so much more than a simple scale and polish and the BSP guidelines state that a full mouth perio assessment is needed (not just 6ppc but mobility, recession, furcation and BOP) for any BPE 4 or unresolved BPE 3. The onus for recording these assessments and then appropriately treating the patient is often fully left to the hygienist for full patient periodontal management. Recording these indices alone can give rise to a huge margin for error, a much slower work rate meaning less time treating patients and less time supporting them to improve their oral health.

Aside from patient safety, there is also the consideration of chaperoning for the safety and security of every person in the room. DCPs are occasionally wrongly accused of misdemeanours, from chipping a tooth to sexual assault. Being threatened, verbally and physically abused, and sexually assaulted while 'trapped' alone in their dental surgery, while thankfully uncommon, are situations that do arise. It is in the interest of every clinician to make sure that all members of their team are appropriately chaperoned.

The guidelines are there for all to adhere to, yet they are being interpreted differently for different members of the team. The only fathomable reason for this is an economic one although under no circumstances should finance play any part in a risk assessment. To not supply a dental nurse for chairside support based on economic reasons is not acceptable and would not constitute 'exceptional circumstances' in a Fitness To Practise case.

Dental hygienists are valuable members of the dental team who are often left very little choice in the matter of the support afforded to them. So, to any dental practice owner who is asking the question: 'can a hygienist work without a nurse?' I would suggest they should first ask 'would I?'

Author bio

Catherine qualified from Kings College Dental Hospital in 2008 with a Distinction in the dual qualification of Dental Hygiene and Dental Therapy. Working alongside specialists in practice in Canary Wharf, Catherine prides herself on a gentle and empathetic approach. She is particularly interested in developing team working strategies within the Dental Practice and implementing these to provide a holistic approach to whole patient care by utilising each team member's full scope of practice.

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