their consensus for dental records, then recommended:

A. Four rankings for items that are: Essential, Aspirational, Conditional or Not-Required

B. Three types of dental appointment: New, Recall and Urgent

C. Two purposes for the NHS workforce: Maintenance and Improvement...but... strikingly:

D. One great absence (that feels like a presence)... the word 'consent' doesn't appear. Concerns have been published that relegating a patient's anxiety from the essential to merely aspirational, hinders patient care and this is at odds with GDC standards that demand an approach that is holistic, appropriate and individual to each patient.³

Clinical communication influences how information is understood, remembered and evaluated, with patients and dentists influenced by the way in which information is presented and recorded. Anxious patients are frequently unclear about the facts of their treatment and the risk of the framing effect becomes real should a nervous patient's anxiety be relegated, failing to be recognised and understood as essential.⁴ Such a paradigm may vitiate the established and excellent CERK standards while confounding the nuanced negotiation required for Montgomery Consent, as SNOMED-CT may appear not to afford the appropriate recognition to dental patients as autonomous decision makers.⁴

Despite such concerns, it is reassuring to note from the CRG research, that failing to follow what is considered essential does not imply records are inadequate.² That statement supports the FGDP CERK foreword that no practitioner should be censured for failing to meet the recommended guidelines and individual patients and circumstances must be considered on their own merits.⁵

One good turn deserves another, the GDC, NHS England and the FGDP can be reassured, following their use of Delphi, our use of **DELPHI** (and their framework) guides towards Montgomery consent as: **Dental Examinations List Pertinent Health Information!**

J. Laszlo, London, E. Mills, Truro, UK

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Medical emergencies

ABCDE – what?

Sir, we are all aware of what those letters mean. They are constantly drilled into our healthcare professional brains, and we mumble them at the sight of a medical emergency. We have all sat in training sessions where we are asked to one by one name a step in the well-known basic life support (BLS) algorithm. But what was that first step 'check if it is safe to approach'? We often get through that one quickly, as we assume the meaning behind it is obvious.

On a Sunday afternoon, a middle-aged man who had fallen and sustained a head injury caught my attention. He was profusely bleeding from what appeared to be an arterial bleed from the scalp, mixing with the rain brought to us by Storm Dennis. I did what any healthcare professional would do in line with our duty of care. I promptly checked the man's surroundings for danger, approached him and found him responsive but non-verbal. This took me to the circulation (C) step of the BLS algorithm where I identified the bleeding point on his scalp, grabbed a handkerchief and applied targeted pressure to the pulsating artery. The bleeding completely stopped, however, an estimated 200 ml of his blood was covering my hands, arms and clothes in my attempt to control the haemorrhage by the time the ambulance arrived a few minutes later. The man was unkempt and intoxicated. He was taken to hospital whilst I was cleaning my hands and I lost track of his whereabouts.

On reflection, there was no information on this man's infection status. I believe my understanding of checking for danger prior to approaching is flawed. After a series of conversations and occupational health

checks, I realised that I had not examined myself for small cuts or open wounds prior to bathing myself in a stranger's blood ungloved. This led to many sleepless nights and countless minutes of staring at my nail cuticles wondering if I can get a glimpse of breach of skin barrier.

Learning points:

- Checking for safety of the scene also includes objects on the patient that may harm you, such as their blood – would I have done anything differently had I stopped to think? Probably not
- Keeping track of individuals following bodily fluid contact or exposure. Risk assessment is based on their infection status as well as your cover. If needed, follow them to where they are to receive definitive care and wait for consent to test their blood to be obtained if and when appropriate
- Familiarising yourself with the guidelines available online and how they can be applied to real life situations away from your usual structured protocols in hospitals and clinics. <https://www.resus.org.uk/resuscitation-guidelines/>.

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This letter was received before the current pandemic crisis.

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Live and let die

Sir, it is becoming increasingly more common for our patients to survive into older age and with comorbidities which may increase their risk of medical emergencies. Palliative patients are also becoming more common.¹

Since their inception in the 1970s, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders have been used to provide immediate guidance to healthcare professionals on the best action to take (or not take) should a patient suffer cardiac arrest or die suddenly.² DNACPR orders do not preclude the patient from receiving first stage treatment in a medical emergency (such as aspirin for cardiac emergencies) but should the patient require CPR this would have to be avoided due to the patient's wishes.³ Alternatives to DNACPR orders used in the UK include treatment escalation plans (TEPs), Unwell and Potentially Deteriorating Patient Plan (UP), Deciding Right and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)