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)

which may involve excluding other palliative treatments in addition to CPR.⁴

The numbers of DNACPR orders have increased globally and older people are the most common patient group to have these orders⁵ but it can also affect children⁶ and domiciliary dental patients.⁷ The medico-legal implications are very important since the outcome is essentially life or death. There have been reports of resuscitation being attempted despite patients having a DNACPR order in place and a UK cohort study looking at NHS hospitals reported 52 cases of inappropriate CPR on such patients.⁸

At present the recommended medical history forms from the BDA have no separate section on DNACPR orders or any of the alternatives used in the UK. Dentists should consider, if not already, adding such a section within the medical history in order to alert the dental team and also consider auditing this process to prevent potential medico-legal issues. It is important to note that DNACPR orders may be withdrawn and therefore evidence should be brought to dental appointments and regularly checked should there be a medical emergency.

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Oral health

Heart transplant recollections

Sir, reading the article *Oral health complications after a heart transplant: a review* (BDJ 2020; **228**: 177-182) brought back memories of two of my interactions with heart transplant patients.

In late 1968 I was a junior lecturer in periodontology and was asked by Cyril De Vere Green, consultant oral surgeon and dentist to the National Heart Hospital, if I would go with him to see one of the very early heart transplant patients who was fading fast. With most other possible causes eliminated the focus had gone to his mouth. It was obvious that the patient had several very carious teeth and wall to wall calculus overlaid with plaque. I suggested that he needed a scaling. This was a procedure that consultant oral surgeons did not do!

I was delegated the task, so back to UCH to collect a Cavitron, which was the size of a very large microwave, a chairside aspirator as the suction in the side ward of the hospital was not good enough, and two dental nurses. We squeezed into a taxi and then set up the equipment next to the patient in the side ward. The patient was semi-comatose but did apologise for the state of his mouth and was as co-operative as he could be with monitoring leads and drips etc all over the place. He did not have a pacemaker, but in those days the effect of the Cavitron electrics on pacemakers were not known. After 45 minutes we had cleared him of nearly all the supra and subgingival calculus and had stopped the bleeding from his gums. I identified four teeth for extraction. One of the transplant surgeons observed what we had been up to and that the patient looked cleaner. I could not resist, going far beyond my paygrade, telling him that it might have been better if someone had looked in the patient's mouth before the transplant and cleaned it before surgery. His reply surprised me when he said that a dental examination and emergency treatment would be in the protocol for the next patients. Needless to say I had to fight to get the taxi fare reimbursed, and sadly the patient died some five weeks later.

In 1988 I was asked to provide dental care for a patient who had a heart transplant in 1984. He had been

on permanent antibiotic cover and cyclosporine which had given him some gingival hyperplasia that was aggravated by poor amalgam interproximal restorations. Replacing the restorations improved the gingival contours. The patient had very good oral hygiene, a well-controlled diet and no new caries in the next ten years. He won a gold medal in the transplant games and said he had more trouble from the scar on his chest than the transplanted heart except that the fixed heart beating rate gave him a slight problem cycling up hills. When I asked him if he had any dental care prior to his transplant he said he had some care from a hygienist. So maybe my comments to that transplant surgeon did have some lasting effect!

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Paediatric dentistry

Paediatric dentists and cleft patients

Sir, the members of the Paediatric Dentistry Clinical Excellence Network group of the Craniofacial Society of Great Britain and Ireland welcome the paper *A general dental practitioner's role in treating patients with a cleft lip and/or palate* (BDJ 2020; **228**: 19-21) as this is an area that the Cleft Lip And Palate Association is working to promote at present.

We were disappointed to note, however, that the importance of the role of a paediatric dentist within the multidisciplinary team (MDT) was not highlighted in the paper and the important relationship between these specialist clinicians and the GDP.

Within the MDT in each region of the UK there is a paediatric dentist who attends MDT clinics that these child and adolescent patients visit, the frequency of which is determined by their specific care pathway. They will not usually be seeing this group of patients for routine recall appointments. The role of the GDP is highlighted to these families at such clinics in all regions from infancy onwards.

It is our aim that children in this high priority group are provided with enhanced prevention as per the DBOH toolkit guidance as well as high quality, local dental care from the time of eruption of their first tooth and throughout their patient journey. In addition, we would like to highlight that specialist paediatric