BDJ Team
MARCH 2016

MANAGING COMPLAINTS

in your practice

BDA
British Dental Association

March 2016

Highlights

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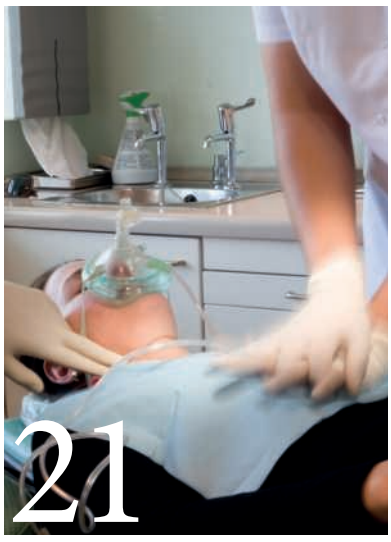
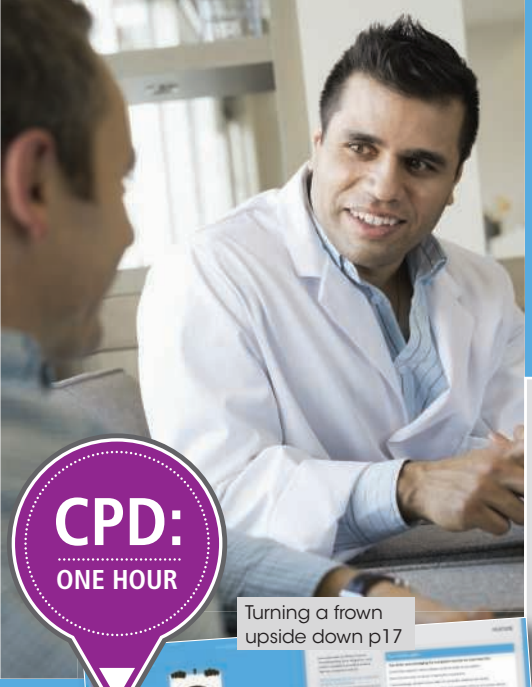




CPD: ONE HOUR

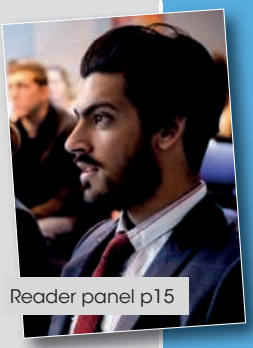
Ed's letter

Have you ever complained about a service you have received? These days, we love to write reviews and rate restaurants, products and services online – the Internet has proved quite the outlet for the traditionally reserved British customer. But when a patient makes a complaint about a treatment they have received or about an individual within your dental practice, you may be taken aback.

So what is the best way to deal with **patient complaints** in an increasingly litigious society? First of all, it is essential that you have a complaints policy in place, and that you deal with complaints in a professional and objective manner. Read more from the king of dental practice management, **Michael R. Young**, on page 17 (with CPD). We have two more articles in the pipeline from Mike, and would like to thank him for sharing his expertise with *BDJ Team* readers.

Turning a frown upside down p17

As with complaints, dental teams are advised to refresh their **medical emergencies** knowledge on a regular basis. A recent issue of the *BDJ* contained posters to put on the practice wall on medical emergencies in the dental practice, and emergency drugs in the dental practice. We publish them again here for *BDJ Team* readers, so make sure you read them closely (pages 21-24). Don't wait until a patient has an anaphylactic shock to put your reading glasses on and hurtle over to the notice board.



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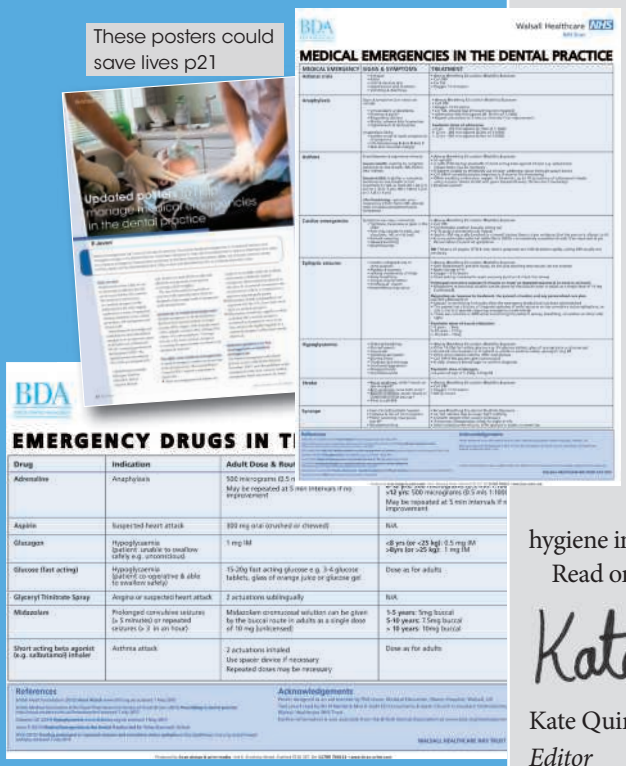


These posters could save lives p21

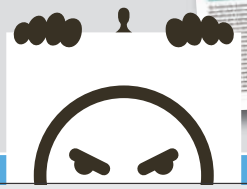
Direct access has been a hot topic for dental hygienists and dental therapists in recent years. Although few may have changed the way that they work, research has been carried out in various contexts into how direct access could improve access to care. The article on page 9 looks at what proportion of dental hygienists and therapists could deliver simple dental treatments to **residents of care homes** – individuals who may require a little longer than other patients to treat and whose day-to-day carers may struggle to incorporate oral hygiene into their routine.

Read on, for the March issue of *BDJ Team*.

Dentistry in care homes p9

Kate

Kate Quinlan
Editor
k.quinlan@nature.com



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THE TEAM

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Editor-in-Chief
Stephen Hancocks OBE

Editor
Kate Quinlan

Production
Art Editor: Melissa Cassem
Production Editor: Sandra Murrell
Digital Editions Production Controller: Natalie Smith

Advertising
European Team Leader – Academic Journals:
Andy May, +44 (0)20 7843 4785, a.may@nature.com

Publishing
Publisher: James Sleigh
British Dental Journal
The Macmillan Building
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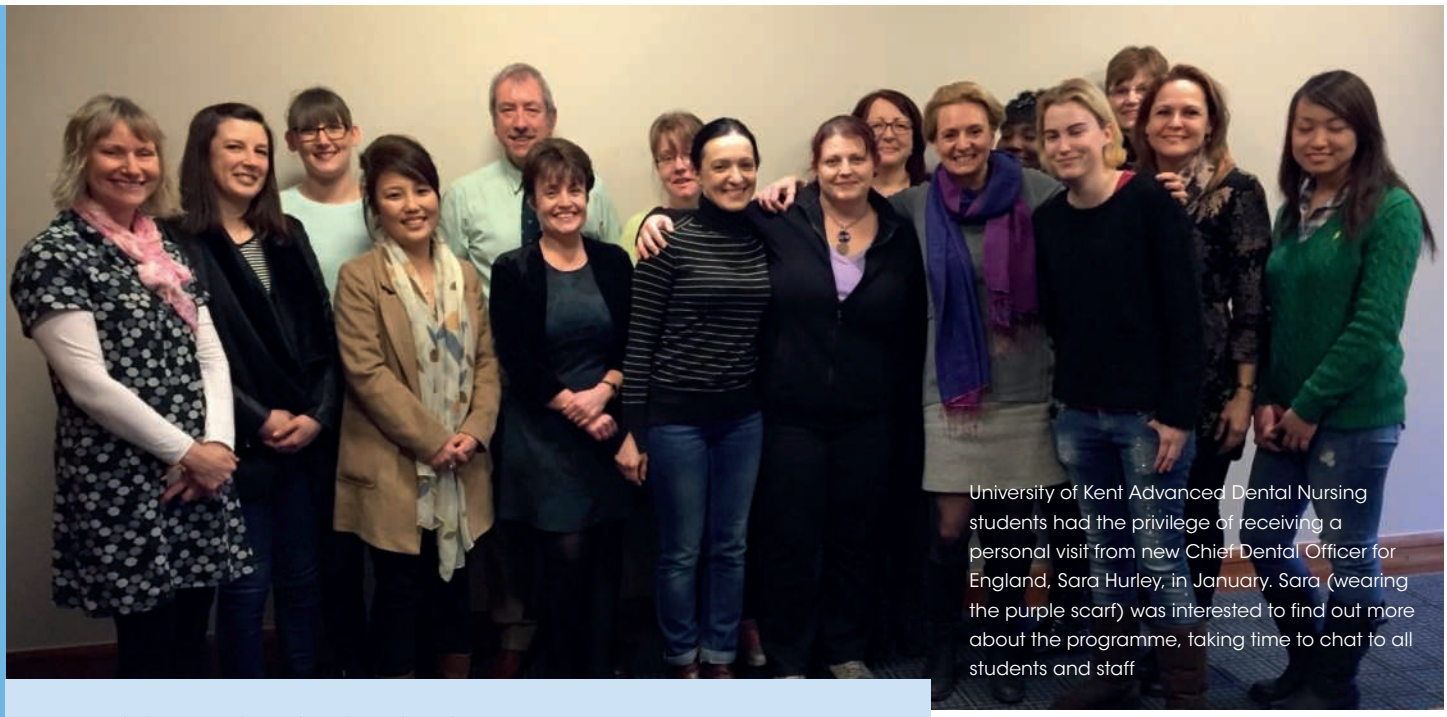

University of Kent Advanced Dental Nursing students had the privilege of receiving a personal visit from new Chief Dental Officer for England, Sara Hurley, in January. Sara (wearing the purple scarf) was interested to find out more about the programme, taking time to chat to all students and staff

HEKSS HAS LOTS TO OFFER CAREER-MINDED DCPs

Health Education Kent Surrey and Sussex (HEKSS) is planning to run two Post-Registration Radiography qualifications commencing in May 2016 and is holding their 5th Annual DCP Conference in July 2016. HEKSS will also be running scope of practice courses for DCPs and is recruiting for the Dental Nurse Foundation Degree.

Radiography (Course id 1711 or 1712)
The NEBDN Certificate in Dental Radiography course will be delivered at The Education Centre at Eastbourne District General Hospital and at The Education Centre at Princess Royal Hospital, Haywards Heath. The course will lead to an examination in March 2017. HEKSS are offering full support from a qualified Dental Nurse Tutor who holds the NEBDN radiography qualification. The theoretical aspect of the course will be delivered using e-learning and classroom sessions and the practical aspect will take place in your own workplace under the supervision of your dentist.

DCP Conference (Course id 1731)
The theme of this year's conference is 'oral pathology and pharmacology – what do I need to know?', which will take place on Wednesday 13 July at The Charis Centre, Crawley, from 9 am to 5 pm. All dental care professionals (DCPs) including dental receptionists and dental practice managers are invited to attend what promises to be an exciting event.

Scope of Practice (Course id 1732)
HEKSS will commence its 2nd annual training programme for registered dental nurses on the application of fluoride varnish (on prescription) to children and the elderly, in a variety of settings, in April 2016 at The Education Centre, East Surrey Hospital, Redhill.

To book a place on any of the above courses, visit the Dental Education Booking System (DEBS) at www.kssdentaltraining.co.uk and search for the relevant course id number. For any additional information, email team on dentalinfo@kss.hee.nhs.uk.

Foundation Degree in Advanced Dental Nursing
For dental nurses wishing to enhance their career in dental nursing, this two year course will commence in September 2016, combining home study and 11 three-day contact courses. The course will be provided by HEKSS and validated by the University of Kent. Students are likely to be eligible for tuition fee loans and grants from Student Finance England. For more information and to register your interest, visit www.kssdeanery.ac.uk/foundation-degree-advanced-dental-nursing.

BADT BACKS BAN ON JUNK FOOD ADS BEFORE WATERSHED

The British Association of Dental Therapists (BADT) is backing a call for a ban on junk food adverts screening on television before 9 pm.

In January the British Heart Foundation (BHF) called on the Government to introduce a ban on junk food advertising before the watershed as part of the Childhood Obesity Strategy.

The heart charity suggested that loopholes in regulations that mean that food companies can advertise foods high in fat, saturated fat, sugar and salt during popular shows such as 'The X-factor' and 'Hollyoaks' watched by children because current rules only bans them during children's programming. Any adverts falling in adult airtime is accepted.

During the most recent series of The X-factor, the BHF found over 90 adverts for foods high in fat, saturated fat, salt and sugar, such as Cadbury chocolate, Doritos crisps, Kinder chocolate, Chicago Town pizzas and Haribo sweets, all of which are banned during children's programming.

NEW EUROPEAN ALERT MECHANISM HAILED

Dental professionals are hailing the newly implemented European Alert Mechanism as it will give patients more protection from potentially unsafe practice and help improve the image of dentistry.

The system aims to make the European dental industry much more transparent, covering the whole European Economic Area (EEA). It gives regulators the power to identify dental professionals who have been banned from practising to their European counterparts.

The British Society of Dental Hygiene and Therapy (BSDHT) points towards the opportunity the system gives patients to be alerted to unsafe practitioners when having dental treatment in the UK and abroad.

President of the BSDHT, Michaela ONeill, said: 'As dental professionals, patients need to know that they can trust us to give them the best treatments we possibly can.

'We are thrilled at the implementation of this system as it allows for this to happen in a highly effective and wide reaching way, giving them much greater visibility and security when it comes to their oral health.

'I see this leading to better standards when it comes to dentistry and that means better practices and overall happier patients.'

The information which regulators will have access to includes the name, date and place of birth to help identify restricted DCPs. Alerts must also state the period that the restriction applies for and the date of the decision.

For more information on the European Alert Mechanism visit http://bit.ly/1KHEWJ2.

FLUORIDATED MILK APPROVED FOR BLACKPOOL CHILDREN

A proposal to introduce fluoridated milk to over 8,000 children in Blackpool to help reduce the risk of dental caries was approved by Blackpool Council's Executive on 18 January. The milk, which is recommended by the World Health Organisation,[1] is the latest in Blackpool Council's plans to tackle poor dental hygiene amongst children in the town. Figures show that almost half of 12-year-olds in the town have at least one decayed, missing or filled tooth – much higher than the national average of 33%.

Around 400 children in Blackpool are also admitted to hospital every year to have teeth extracted under general anaesthetic, at a cost to the NHS of thousands of pounds.

Councillor Graham Cain, Cabinet Secretary for Blackpool Council, said: 'Through a number of methods such as education in schools and children's centres, as well as giving away toothbrushes and toothpaste to children, we have managed to raise awareness of the importance of oral hygiene amongst Blackpool families.

'However, where some parts of the country can benefit from fluoride naturally appearing in their daily drinking water, in Blackpool we cannot.

'What we do have is a method through the free breakfast programme that allows us to reach all primary school children as they are growing up and make the fluoride milk available to them there. The scheme will be available to all primary school children but parents will have the option to opt out if they wish.

Michaela ONeill, President of the British Society of Dental Hygiene and Therapy (BSDHT), said of the decision: 'It is great that the local council has recognised that something needs to be done to address this huge problem and taken positive action.

'Other areas with similar levels of oral health problems have already introduced such schemes and this is an opportunity to show other councils that with a small, inexpensive change huge benefits can be had.'

1. Bánóczy J, Petersen P E, Rugg-Gunn A J (eds). *Milk fluoridation for the prevention of dental caries.* Geneva: World Health Organization, 2009. Available at: http://www.who.int/oral_health/publications/milk_fluoridation_2009_en.pdf (accessed January 2016).

MAKE A DATE WITH YOUR TEAM FOR MANCHESTER IN MAY

The British Dental Conference and Exhibition returns to Manchester on 26-28 May 2016 and will be packed with sessions and exhibitors relevant to the whole dental team.

With keynote speakers, lively panels, interactive forums, an address from a government minister, scientific lectures and smaller workshop style sessions, the conference has something for everyone. It provides comprehensive coverage of the key issues in the dental industry, and with over 130 sessions to choose from, conference attendees can grow their skill-sets to achieve better patient outcomes and develop their careers.

For dental care professionals (DCPs) there will be lots of sessions on core CPD, impression taking, periodontology, treatment planning, scope of practice, implants and communication in the dental team.

Some sessions require the purchase of a Conference Pass (either one day or three day), but the remainder are free to access in the Exhibition Hall. The Exhibition is free to attend – simply register at www.bda.org/conference.

The Exhibition itself provides an excellent opportunity to meet leading suppliers and discover new ones.

Dental practice managers can benefit from the free Exhibition Hall sessions on patient marketing, complaint handling, child and adult safeguarding and team management and much more.

If you haven't done so already, register now at www.bda.org/conference. Early bird prices are available until **7 March** only.

Want a free conference pass? Ask your dentist if they are a BDA Expert member. If they are, you and your colleagues may be able to come for free!

DENTAL THERAPISTS CALL FOR JOINED-UP THINKING ON CHILD DENTAL HEALTH

The healthcare profession and the government need to break down key barriers if we are to ensure 'efficient and effective' future dental care for the nation's children, according to Fiona Sandom, president of the British Association of Dental Therapists (BADT), who was speaking in response to a call for a national oral health programme by dentist and Conservative MP, Sir Paul Beresford.

The MP led a debate in Parliament on 3 February on child dental health. During the debate, he claimed a targeted national oral health programme – rather than a sugar tax – was needed to tackle the rate of children's tooth decay.

He said a fluoride varnish scheme, involving an inter-disciplinary approach to child health, should also form part of this programme – a move supported by dental therapists.

Drawing on current statistics on caries in children, Sir Paul said that 'all healthcare professionals, such as midwives, health visitors and pharmacists, should be given the opportunity and training to apply oral health education, including in relation to persuasion on fluoride'.

The MP said: 'We need to invest in a national oral health programme. It should particularly target areas with problems of poor oral health. This should be done in nurseries and schools, with the backing of local authorities, which would need a small amount of funding from the Minister's Department. As part of a health professional programme, use of oral fluoride for children should be promoted to parents and children until such time as the water supply in the area in which the children live is fluoridated.'

Dental therapists believe the legislative framework will need to change in order to support such a scheme.

Fiona Sandom said: 'Everyone, but particularly children, should have access to preventive dentistry. We need to use the skills of not just the dental team, but also all healthcare professionals to help give the correct messages, advice and preventive care. It calls for joined-up thinking and, what we call in Wales, "prudent healthcare", focusing on the best outcome for the patient, with them having an active role in designing services that meet their needs as well as taking more responsibility for their own health and wellbeing.'

BADT's Amanda Gallie said: 'Because of legislation, we are unable to access children in schools and apply fluoride without a prescription from a dentist or a specialist in dental public health. We now need the legislative framework to carry out this "prudent healthcare" and prevent caries. It's what the NHS trains us to do.'

Currently, the BADT and the British Society of Dental Hygiene and Therapy (BSDHT) are working together in a bid to address the status quo regarding the prescribing rights of dental hygienists and dental therapists.

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CHEWING SUGARFREE GUM COULD SAVE THE NHS MILLIONS

A new study published in the *British Dental Journal*[1] (*BDJ*) has revealed that up to £8.2 million of costs to the NHS could be saved – the equivalent to 364,000 dental check-ups - if 12-year-olds across the UK were to increase their chewing of sugarfree gum as part of a good oral health routine to help prevent tooth decay.

The research demonstrates that if all 12-year-olds across the UK were to chew one additional piece of sugarfree gum per day the NHS could save up to £2.8 million on dental treatments per year. This cost saving rises to a potential £3.3 million if two pieces of sugarfree gum were to be chewed per day by all 12-year-olds and to £8.2 million for three pieces. This research is the first of its kind in the UK and was conducted by the York Health Economics Consortium and Peninsula Dental School, Plymouth University, with support from The Wrigley Company Ltd.

There is a strong evidence base that demonstrates that sugarfree gum can help prevent tooth decay. Independent clinical research proves that chewing sugarfree gum for 20 minutes after eating or drinking helps neutralise the plaque acid attacks that can cause tooth decay and contributes to removing food remains. Increased flow of saliva also promotes the remineralisation of tooth enamel, thus reducing one risk factor for developing tooth decay.

1. Claxton L, Taylor M, Kay E. Oral health promotion: the economic benefits to the NHS of increased use of sugarfree gum in the UK. *Br Dent J* 2016; **220:** 121-127.

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Letters

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PILLAGING FROM DENTAL HYGIENISTS

Dear Editor,

My IQ doesn't exactly break the bank but having racked my brains for far longer than most people would bother I still couldn't work it out. I mean there had to be a reasonable explanation, right? A perfectly logical answer?

Then I woke up in my dental chair (lunchtime snooze) and realised I was in a dental practice working with dentists. Cursing myself with the most penetrating expletive for even considering a reasonable explanation, I quickly reached the more realistic conclusion. It was pure greed.

I spoke to several dental hygienists to ask them if I was just being a bit stupid (as is usually the case). Was I missing something obvious and acting on hubris? According to them I was indeed a bit stupid but I hadn't actually missed anything. So many dental hygienists get paid such a low percentage of their earnings simply because the practice sets extortionate rates. The principals are apparently just greedy.

This answer conveniently tempered my initial confusion. After all, associate dentists understandably cost the practice a lot more in expensive materials, X-rays, laboratory bills, a nurse (they apparently don't cost very much judging by their wages) etc. But a hygienist has none of those costs, save for a few suction tubes and the little tablets that turn the rinse green. Some even bring their own instruments. So why should so much of their generated income be pillaged from them?

Speaking as a dentist (and I use the term loosely) who has happily covered for absent hygienists on many occasions I can testify to how impressive their work ethic is. To debride the average mouth, clean and disinfect the room, write up their notes and be ready for the next victim – er – patient, within the allocated time slot is quite a feat.

So many patients go in anxious and reluctant, and emerge happy and refreshed. The smiles they beam at reception clearly advertise the value that hygienists bring to the business. Stark contrast to the blood soaked screamer that I had to release after ripping their eyeball out through their sinus after extracting (and I use the term loosely) an upper wisdom tooth. So many patients now *volunteer* to see the hygienist. They volunteer to pay for the service. And yet somehow that means your hygienist is worth even less. Hmmm … confused.com.

Now, I realise that the practice is a business and the principal can set whatever rate they choose. It's a (relatively) free market. And the market is flooded with more hygienists and therapists than ever before, and they can always choose not to accept the practice's rate. There are plenty of hygienists working hard and making a decent income. More power to them.

A dentist would argue that if a hygienist wanted to earn more they should have studied to become a dentist or a periodontist or tried a different line of work entirely. Yeah, that's a *dentist's* answer, which means it's not so much an intelligent remark as an excuse. And it doesn't remotely speak to my point.

Are hygienists paid such a low percentage of their earnings because they are actually lesser mortals than dentists or specialists? Do they lack the requisite number of letters after their name? Is there some established professional prejudice against them akin to that against technicians and nurses?

I thought it was bad enough being an associate dentist but now I feel positively regal compared to hygienists. Whereas I once admired and helped anyone trying to advance onwards to become a hygienist, now I wonder what kind of slavery they'll find on the other side.

Not for me to tell practices what they should pay their associates or hygienists, but fair for someone to call them on their apparent greed. Yes, you live in a more materialistic time with ever more self-serving narcissism and insecurity fuelling your need to fund your golf club membership and other such vanity projects. I'm certainly not advocating that a plague of socialism infests dentistry. If that happens I'll be voting for Donald Trump faster than you can say '*I. Don't. Care.*' Even with a name like mine.

This isn't going to change anything or make dentists value hygienists any more. But the creepy undercurrent of avarice so endemic to this profession leaves a taste in the mouth more bitter than lignocaine.

Paying people a fair percentage these days seems to be heresy and it's probably only going to get worse with time. Today's crop of dental graduates knows far less about dentistry than they do about money. The nation's teeth and wallets will probably both be in deficient state. We'll have little choice but to borrow a little of Gabriel Oak's stoicism and accept our fate.

And while we do that, let's talk about our dental nurses' pay….

Sharif Islam

Reader panel member Shaun Howe RDH responds to Sharif's letter:

I read Sharif's letter with a wry smile and actually find his take on how dental hygienists are paid really quite refreshing. Sadly, the only reason it is refreshing is because it comes from a dentist. Many dental hygienists have told the same story for as long as hygienists have been working in general dental practice. Is it the principal dentists that are to blame or is it the profession of dental hygiene or indeed, is there a third party that is implicated?

For me, it has been a long term problem that has yet to be addressed and may well be in the near future as further empowerment of dental hygienists continues. We have direct access, we are allowed (now) to diagnose including using radiographs to assist this and I see that the BSDHT and others are engaging with the Department of Health regarding prescribing rights for dental hygienists.

As for poor pay and even poorer working conditions, well, I have been public and vocal about this in the past and feel that when a dental practice chooses to engage the services of a business coach well, there can be only one answer: someone has to lose out to increase margins and let's look to see who has the target on their back.

Lo! The dental hygienist is an easy target. Self-employed (usually), works alone with little or no support (despite this being contrary to GDC Standards) yet still delivers care to the practice patients (and this is not used loosely) and unbelievable value to the practice but, as Sharif correctly observes, in his lunchtime postprandial snooze, there really is only one winner.

'DENTAL HYGIENISTS KNOW EXACTLY HOW MUCH THEY ARE WORTH TO A PRACTICE.'

Dental hygienists know exactly how much they are worth to a practice. It is not rocket science to count how many patients you saw in a given time period and then multiply it by the fee and hey presto, the income to the practice (not taking into account the goodwill generated by the dental hygienist because patients 'emerge happy and refreshed' from the smallest surgery in the practice).

Practice principals certainly can set their own levels, but I simply ask they learn to not be blinkered by business or indeed by those that tell them they can increase their own margins by forcing lower percentages on great, undervalued assets.

Well done Sharif, sadly stating the obvious, but well done.

Do you have an opinion on something published in *BDJ Team* or on working in the dental industry? Do you need advice from an expert that we might be able to help you with? Just email bdjteam@nature.com.

Letters may be edited for space. Opinions expressed do not necessarily reflect those of the editorial team or the publishers.

bdjteam201648

What proportion of dental care in **care homes** could be met by direct access to dental therapists or dental hygienists?

By N. P. Monaghan[1] and M. Z. Morgan[2]

BACKGROUND

There is considerable oral disease requiring preventive care, active monitoring and occasional intervention among residents of care homes in Wales[1,2] and in other countries.[3-5] The UK decennial Adult Dental Health Surveys (ADHSs) commencing in 1968 through to 2009 have reported increasing numbers of older people retaining some natural teeth, even though they are often heavily restored.[6-10] Unfortunately, access to dental care for care home residents is not always straightforward.[11] Poor access to care means limited opportunity to manage problems by a combination of monitoring, preventive action and intervention. The need for extra time for oral health care among this vulnerable group makes it more expensive than that for the wider population.[12]

Many care home residents require simple dental treatment, complicated by the need for extra time to deliver dental care.[13] Although there is a large volume of need for improved oral hygiene, scaling of teeth, application of fluoride, and restorations among residents of care homes, relatively little of this need requires a specialist in special care dentistry.[13] Much of the care only requires a professional with either some special care experience or generalist level experience.[13] In addition, a considerable proportion of the disease present does not require aggressive interventional treatment.[12]

A Cochrane review of the evidence on the effectiveness, costs and cost-effectiveness of dental auxiliaries in providing care traditionally provided by dentists identified just five studies.[14] Four of these were over 20-years-old, all five were at high risk for bias and no conclusions were drawn from these studies. Recently the General Dental Council (GDC) proposed direct access for patients to members of the dental team without requirement for prior examination,

'MANY CARE HOME RESIDENTS REQUIRE SIMPLE DENTAL TREATMENT, COMPLICATED BY THE NEED FOR EXTRA TIME TO DELIVER DENTAL CARE.'

[1] *Dental Public Health, Public Health Wales, Temple of Peace and Health, Cardiff,*

[2] *Welsh Oral Health Information Unit, Cardiff University School of Dentistry, Heath Park, Cardiff, CF14 4XY*

diagnosis and prescription by a dentist.[15] This is a new development for the UK. Effectively the introduction of direct access changes the position from dentists as gatekeepers of access to dental care to one where a number of members of the dental team are access points.

The proportion of care home residents' care which could be delivered solely by hygienists or therapists is unknown. The items of care which can be undertaken by the various members of the dental team are outlined in the GDC scope of practice guidance.[16]

Data collected in the Welsh dental survey of care home residents included traditional epidemiological measures of disease presence as collected by the ADHS 2009.[10] This was supplemented by collection of data on the clinical opinion of the examining dentist on:

- Likely treatment plan content using a checklist of items of care
- Presence or absence of complexity (based on the categories in the BDA special care case mix model[17])
- Need for generalist or special care dentistry care.

The treatment plan data were collected before the GDC announced the introduction of direct access to care from dental hygienists and therapists. The scope of practice document identified a list of specified items of care which could and could not be provided by hygienists and therapists. This analysis aims to estimate the proportion of care home residents' dental treatment needs which could be delivered wholly by hygienists or therapists.

METHOD

A retrospective analysis of the 2010 survey of Wales care home residents treatment plan related data were cross referenced to the GDC scope of practice document.[16]

Details of the ethical approval, sampling and oral examination are briefly summarised here as they have been previously reported.[12] The Multi-centre Research Ethics Committee in Wales agreed the study should include residents with and without capacity to consent. Data were collected between October 2010 and June 2011 by 12 examiners (dentists with some experience of special care dentistry) and recorders (dental nurses) working in the Community Dental Services in Wales. Prior to data collection they were trained in the requirements of the Mental Capacity Act 2005, consent, clinical criteria, data entry and adult safeguarding.

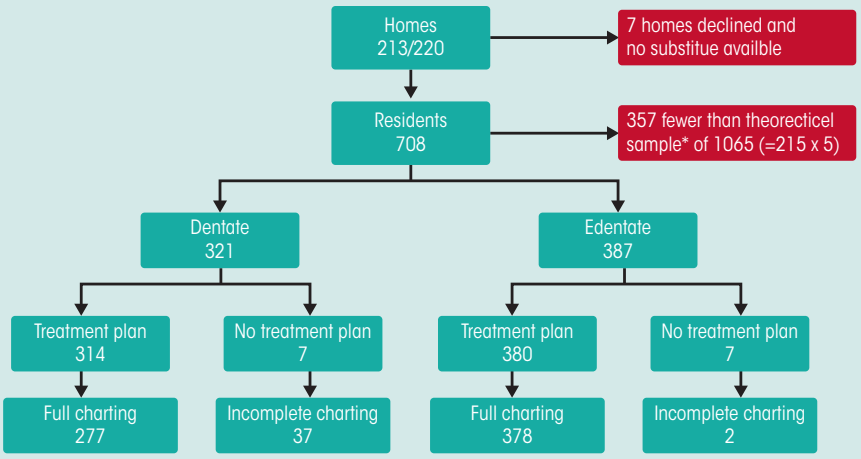
In total 228 care homes (residential, nursing, and combined residential and nursing) from 22 local authority areas were randomly selected to participate. Five randomly selected residents from each care home (or all residents where there were five or fewer) were invited to participate. Consent was sought from those residents able to consent. For those without capacity, consent was sought from a person with Lasting Power of Attorney or a Court Appointed Deputy. Participants were free to withdraw from data collection at any point when they felt unwilling or unable to continue.

Following each examination and using a checklist of treatments, the dentists were asked to propose a treatment plan to address the pathology identified and commensurate with the difficulty experienced during the examination. They were asked to indicate whether they expected presence or absence of complexity in delivery of that care, including the need for extra time, sedation or general anaesthesia. They were also asked whether that care would need to be provided by a generalist, special-care-experienced- or special-care-specialist dentist. Full dental charting and treatment plan data were collected for 655 residents (Fig. 1).

Details of the examination criteria, treatment plan list, complexity questions and special care experience questions can be found in the survey protocol available from the Welsh Oral Health Information Unit at Cardiff University.[18]

The treatment plan information was collected in sufficient detail and in a format which allowed individual plans to be cross referenced with the GDC scope of practice guidance published in 2013[16] – see Table 1.

Fig. 1 Study participant flow chart



Random sample 5 per home, no substitution for excluded (those lacking capacity, those unable to speak English/Welsh), also not all homes had 5 residents.

Key Excluded from analysis

Table 1 Scope of practice

Element of care	Hygienist	Therapist	Dentist	Clinical dental technician
Examination	Y	Y	Y	N
Radiograph/s	Y	Y	Y	N
OHI (to the resident or carer)	Y	Y	Y	N
Sub &/or supra-gingival debridement	N	Y	Y	N
Filling/s	N	Y	Y	N
Simple extraction/s	N	N for permanent	Y	N
Copy dentures	N	N	Y	FOR COMPLETE DENTURES ONLY
New denture/s, not copy F	N	N	Y	FOR COMPLETE DENTURES ONLY
Denture adjustment/repair	N	N	Y	FOR COMPLETE DENTURES ONLY
Soft tissue minor oral surgery	N	N	Y	N
Hard tissue minor oral surgery	N	N	Y	N
Sealing of root/s	Y	Y	Y	N
Supplemental fluoride	Y	Y	Y	N
Sedation*	N	N	Y	N
General anaesthesia	N	N	Y	N
Other treatment	N	N	Y	N

*with additional training hygienists and therapists can treat patients using inhalational sedation

This facilitated the identification of treatment plans with content which could potentially be wholly delivered by a hygienist or therapist.

Treatment plans requiring a dentist were filtered out by first identifying those which required a special care specialist or another specialist. Further plans requiring a dentist were filtered out by presence of treatments which could only be provided by a dentist (for example, extraction of permanent teeth). The remaining cases could potentially be cared for by a therapist with special care experience.

Selecting out those cases that a special care therapist could treat but which hygienists cannot (for example, placement of restorations in permanent teeth) left a series of cases who could be cared for by a hygienist with special care experience. Finally for each of these two groups, filtering out cases that required care from someone with special care experience identified those whose care could be wholly provided through direct access by a therapist or by a hygienist without such experience. A similar process was used to identify care home residents whose care could be potentially provided by a clinical dental technician with and without special care experience or extended duties dental nurses.

RESULTS

Of the 655 care home residents, 22% and up to 27% had treatment needs which could be wholly addressed by a dental hygienist or therapist respectively (Table 2). For hygienists or therapists with special care dental experience the proportions of residents who could have their care needs wholly addressed by a dental hygienist or therapist were 43% and up to 53% (Table 2), respectively. The uncertainty on the upper limit of cases whose care could be provided by a therapist relates to the proportion of restorations that also require endodontic treatment. This is explored further in the discussion section. While dentists with special care experience could provide all aspects of care for 90% of residents, a dentist without such experience could only provide all care for 39% of residents.

The potential role of extended duties dental nurses was so limited in the care home setting that there were no cases where they could wholly provide the treatment plan. The proportions of residents whose treatment needs could be wholly met by a clinical dental technician were 6% for a general technician, and 12% for a technician with special care experience.

With the exception of extended-duty dental nurses, having special care experience

Table 2 Skill mix requirements of care home residents examined in Welsh dental care home survey 2010-11

Percentage of 655 residents who potentially could be managed by*:		
Dental team member	**Generalist**	**Special care experienced**
Dentist	38.7	89.6
Clinical dental technician	5.7	11.5
Therapist	26.8	52.5
Hygienist	21.9	43.2

*No residents could have all their care provided by an extended duties dental nurse

typically doubled the percentage of patients whose care needs could be wholly addressed by each dental care professional (Table 2).

DISCUSSION

There are limitations of this analysis. Dentists were not calibrated in assessing treatment need, so the collective findings are reflective of a range of clinical opinions. The findings are relevant for the UK where the GDC scope of practice applies. The data were collected by dentists indicating treatment that would be provided by a dentist with no experience, some experience or specialist ability in special care dentistry. The dentists were not asked to identify which elements of care were appropriate for a hygienist or a therapist. Fortunately, data collection had been in a format which allowed cross referencing of treatment plans with the GDC scope of practice.

Data were not specifically collected on endodontic treatment need. Dental therapists can provide restorations in permanent teeth but not endodontic treatment. Dental hygienists cannot provide restorations. The difference in the estimates of work which could be done by therapists but not hygienists relate to restorations (Table 2). In some cases these might have required endodontic treatment. If it is assumed that half of all the individuals requiring restorations also required endodontic treatment (which we consider a high estimate) an estimate of the proportion of 655 cases whose care could be wholly provided by a therapist with or without special care experience would be 48% and 24% respectively. These still constitute a high proportion of care home residents.

Although 90% of care home residents could have their care needs addressed by a dentist with special care experience, and less than 40% by a general dentist, a conclusion that dentists with special care experience are required ignores the potential efficiency gains of direct access. Direct access facilitates alternative models of care where a dentist is not the first point of contact with the dental team. Dentists are an expensive resource and should be deployed on work commensurate with their knowledge and skills and which cannot be delivered by other members of the dental team. The additional potential efficiency gain of direct access arises from individuals who do not need to see a dentist for any aspects of their care.

Given the limited evidence of dental auxiliaries' cost-effectiveness[14] or of the cost-effectiveness of direct access there is a need for further studies. It is important for patients that there is both good communication and continuity of care if a skill mix team are to be trusted.[19] Theoretically, direct access is likely to be an efficient model of care where there are large cohorts of individuals with treatment needs within the scope of practice for a hygienist or therapist. Care homes would appear to be an appropriate setting for direct access to therapists or hygienists with special care experience.

Direct access is not currently possible within the terms of the GDS contract without changes in either regulations (England and Wales) or primary legislation (Scotland and Northern Ireland).[15] It is currently possible to offer direct access from a skill mix team within the community dental services. In areas where there are hygienists and therapists working in care home settings, and therefore having some special care experience, the change to direct access could be considered.

In summary, a significant proportion of care home residents in Wales do not require care from a dentist. A potentially more efficient model would be to have individuals examined first by a hygienist or therapist who is less expensive to employ and is likely to be able to meet all of the care needs for many residents. Direct access to hygienists/therapists for dental care of care home residents should be piloted. Pilots will need to explore both training needs for direct access and training needs in special care dentistry. They will also need to evaluate whether staff are adequately prepared, and the experiences of a range stake-holders of direct access care. Further studies could then explore outcomes of care and of cost-effectiveness.

CONCLUSION

Hygienists and therapists could make a large contribution to addressing dental treatment needs of care home residents. Direct access, within a skill mix team, should be piloted to assess the effectiveness and efficiency of such a model of care.

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COMMENTARY

The demography of the UK population is changing in that people are living longer and retaining much, if not all, of their dentition into later life. This paper is timely in that it addresses a number of problems associated with the delivery of care to the residents of care homes, and explores the opportunities that have arisen as a result of direct access to patients without the need for referral by a dentist.

It is recognised that hygienists and therapists are a highly skilled group of professionals, and being granted direct access to patients is clear recognition of their clinical ability and competence. To be in a position to provide care directly to this priority group of elderly and often vulnerable individuals would be a major breakthrough in delivery of their oral care. Hygienists and therapists are able to diagnose and treatment plan within their scope of practice, and have comparable ability with dentists in the recognition of mucosal abnormalities, and appreciate the need to refer to specialists should the need arise.

It has been reported that care home staff are often untrained in oral care with the result that it is sadly neglected, potentially leading to further oral problems and reduced quality of life for their residents. As stated in this paper, much of the routine care required does not need the intervention of specialists or dentists. Oral hygiene, preventive therapies, treatment of periodontal disease and root caries, often exacerbated by xerostomia in the elderly, are all part of the routine care provided by dually qualified hygienist-therapists, as most graduates are today. There is also the ticking time bomb of those with complex restorative work, such as implants, who require high-quality maintenance and disease control.

Hygienists and therapists working in the community or public dental service are often heavily involved in special care dentistry, and are, therefore, experienced in care of the elderly, among other priority groups. In addition to clinical expertise, it is often patience, care and compassion which is required to treat elderly patients appropriately. If NHS list or provider numbers were allocated to hygienists and therapists, it would allow greater access for patients. In addition to this requirement, the removal of the restriction on the application of fluoride and the administration of local analgesia would enable these clinicians to exercise their full scope of practice in a care home setting. Surely this is an obvious course of action for hygienists and therapists to be used to their full potential, placing them in a position to address the unmet oral needs of this increasingly significant patient group.

'THERE IS ALSO THE TICKING TIME BOMB OF THOSE WITH COMPLEX RESTORATIVE WORK, WHO REQUIRE HIGH-QUALITY MAINTENANCE'

Margaret K. Ross, Senior Lecturer for Dental Care Professionals, Edinburgh Dental Institute

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Be proactive, honest and ambitious

In our third article from a member of *BDJ Team's* reader panel, **Shiraz Khan** discusses succeeding as a young dentist.

In the current climate, focussing on the dental profession, it appears that the likelihood of ascertaining a desirable post, whether it be in primary or in secondary care, is very low. There appears to be an uncertainty with regard to job security post-qualification that had never faced the profession before, with competition on the rise and an increase of practitioners arriving from abroad. However, rather than this meaning competing for posts, this is really an opportunity to strive and improve in order to gain the most out of our qualification.

There are relative merits to working in both primary and secondary care. Secondary care provides an excellent opportunity to hone in on skills that may not be readily exposed in routine primary care. For example, surgical third molar extractions allow for a structured, methodical approach to complicated treatment planning, as does undertaking more complicated forms of treatment, re-endodontic treatment and other removable prosthetic work. By comparison, primary care provides an excellent opportunity for learning volumetrically, namely undertaking numerous simple restorative cases, extractions and prevention amongst children.

There is a bias which really exists more in primary care provision than secondary care, which is the level of oral health amongst the patient base and surrounding area to a practice. For instance, as the Adult Dental Health Survey has found, there is proportional relationship with the socio-economic status of an area and the presence and severity of oral disease. Therefore the provision of care delivered is really related to the area in which you practise. Inter-Trust and hospital variation clearly also exists, however the discrepancy is more a feature of the type of hospital (teaching *vs* district general) and keenness of the individual than the catchment area as such. It is therefore relevant for individuals to assess, openly and honestly, experience that has been ascertained, and areas that could be subsequently improved on.

This brings up a salient point with regard to succeeding as a young dentist, and that is openly and honestly critiquing one's ability and planning for improvement. Use of personal development portfolios is a great way to formalise more shorter-term goals, and is a great method to monitor development and progression. With General Dental Council revalidation likely to affect our careers, it's good practice to commit to. The best way to demonstrate this is by an example. Hypothesise that you are about to root-treat an upper second molar, and you are unfamiliar with the access cavity design – this may lead to perforation, ineffective access, referral or even extraction. Repetition of this situation is wholly preventable, by noticing this weakness and working on it, whether it is through attending courses, literature and research or even practising on extracted teeth. The purpose of this approach is not to execute every item of treatment 100% of the time, as we are all individuals and will have a flair for differing treatments naturally. However, it is to allow for an opportunity to improve and prevent dire consequences.

'ENGAGING IN SOCIETIES, ACADEMIES OR PROFESSIONAL GROUPS IS IMPORTANT FOR SELF-DEVELOPMENT AND NETWORKING.'

[1] *Locum SpR Restorative Dentistry/ Associate Dental Surgeon, BDS, B(Med)Sc (Hons), MJDFRCS(Eng), PG Dip, PG Cert.*

Having a personal development portfolio should be a significant part of your overall portfolio. A clinical portfolio allows one to demonstrate competence, skill and variety of treatments that are offered. This not only allows the individual to market themselves, but also an opportunity for communication to patients about what is very much achievable with modern-day dentistry. Keeping a bank of clinical photos and cases is always a great idea, often with a one-page summary, of history, complaint, diagnoses and treatment plan which was completed. This not only shows that the clinician is proactive, but will also act as *aide-mémoires* when discussing the case.

Other items which may be housed within a portfolio would include lectures/seminars given, scientific writing/journals, totals of treatments undertaken on patients, any assessments taken by overseeing clinicians/mentors and a profile of the CPD activities you may be engaged in.

Engaging in societies, academies or professional groups in which you have interests is also an important aspect, not only for self-development but also networking. Professor Stephen Lambert-Humble MBE advised me of this, and stated that when interviewing for particular speciality posts, being part of such groups or societies shows a level of engagement which is genuine and beyond day-to-day practice.

Finally, avoiding stagnancy by formulating long-medium- and short-term goals will lead to optimising outcomes for that individual. The truth is that ensuring a plan exists does not mean that it has to be absolute or overtly prescriptive. As we are all aware with years passing and professional, clinical and personal experience increasing, plans are likely to change or modify, however, the provision of a plan allows for a driving force and direction to exist.

Overall continuously striving to improve and demonstration of competence and proactivity are all in the formula for success for the younger practitioners amongst us. It is clear that perhaps in previous decades this did not exist, however, proactivity always did. Ensuring that this is honest and individuals openly striving for success and regularly self-critiquing/appraising their competence will only lead to a body of professionals striving for high standards.

What is the secret to succeeding in your role as a dental care professional? Email bdjteam@nature.com or visit www.facebook.com/bdjteam.

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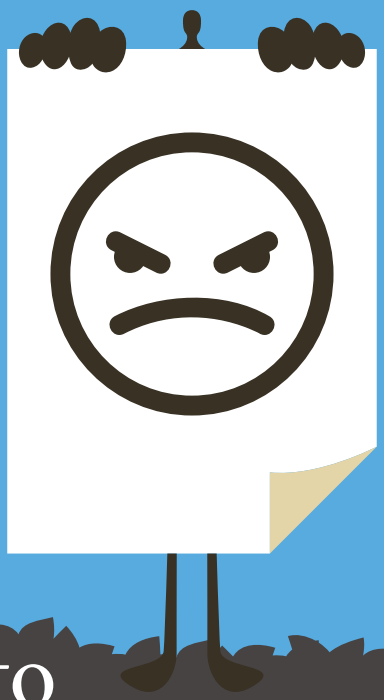

How to turn complaints into *compliments*

In the first of three extracts from the upcoming second edition of his book, **Michael R. Young**[1] explains how to manage patient complaints.

No matter how well you think you are caring for your patients you are likely at some time to get complaints. Whatever the current protocols are for handling complaints under the NHS, or those from private patients under the Dental Complaints Service, it is good practice to have your own very robust complaints policy and procedure.

What is a complaint?

Basically it is an expression of dissatisfaction that requires a response. What do patients complain about? Basically, anything and everything. They will complain about:

- Treatment
- Service: cost, pain (continuing, or being ignored), conduct (including rudeness), getting access or not getting access to treatment, giving or not giving consent
- Communication: lack of it is usually at the heart of most complaints. Most complaints are about dentists, but some are about other members of the dental team.

> *'WHAT DO PATIENTS COMPLAIN ABOUT? BASICALLY, ANYTHING AND EVERYTHING…'*

What are people looking for when they make a complaint?

It might simply be an apology. There is anecdotal evidence that some complaints escalate because someone did not say 'Sorry' at the outset. An apology is not an admission of liability or guilt, so don't feel that you should never apologise.

People often want an explanation and want to know:

- What happened?
- Why did it happen?
- What will be done to put things right?
- What action will be taken to resolve the matter?
- What is being done to stop this happening again?

You have an ethical duty and an obligation to address any complaint, no matter

[1] *Michael R. Young is a former clinician, practice owner, and independent clinical negligence expert witness. His practice was one for the first in the UK to be awarded the British Dental Association* Good Practice. *He is now an author.*

how unfounded you think it may be. Notwithstanding these obligations, your practice complaints procedure must be rigorous, transparent and fair.

What should you do when a patient makes a complaint?

The first thing you must *not* do is treat it as if it is trivial and therefore not important. Your natural reaction might be one of anger and disbelief, but you must curb your feelings and remain objective. You might decide to categorise complaints as being either 'minor' or 'major', but I think that this can be misleading and potentially confusing. It is better to regard all complaints as serious.

> *I heard of a dentist who had so little regard for their patients that whenever they received a letter of complaint they used to throw it in the bin. I am not sure what happened to this particular practitioner, but this sort of behaviour is unacceptable.*

If the complaint is initially made verbally, ask to have it in writing (you need a permanent record for your file). If it is not clear exactly what the complaint is about ask for clarification. You do not, after all, want to resolve the wrong complaint. You should always set out to try to resolve complaints within the practice ie achieve local resolution.

Acknowledge receipt of the complaint in writing. You should state your interpretation of the complaint (this will preclude possible misunderstandings later), what you are going to do next and when they can expect to hear from you again. Your initial 'holding letter' (Fig. 1) should be sent as soon as possible and certainly within no more than five working days. Tell them that you will respond fully in no more than ten working days. However, if you feel that you will need longer then ask if they would mind if you extended this period. Always set time limits and stick to them. Nothing will infuriate the complainant more if you don't.

The next step is to investigate the complaint and to gather all relevant information. Do not conduct a witch-hunt or pre-judge.

Hold this thought: it is a sad fact that in any given event there are always three sides to the story: yours, theirs, and somewhere in between, the truth.

You must not be selective with your evidence gathering. Keep meticulous notes of all conversations you have with other practice members about the complaint.

Once you have completed your fact-find you can either report back to the patient in writing or, and this should always be your preferred option, at a face-to-face meeting. It is best to have, say, your practice manager or senior receptionist present to take notes. Suggest to the patient that they bring along a relative or a friend for support. This meeting could be crucial to the outcome of the complaint so it is important that you show the complainant that you are sympathetic to their point of view.

Hold this thought: the art of complaint resolution is conciliation, not conflict.

It is at this stage that you have the opportunity to show them that you are totally professional, reasonable and unbiased, which hopefully will impress them, and this then may greatly influence their opinion of you in the future. Conducting yourself well at this stage could not only help to (re-) build their trust in you as a dentist, but could also win their respect for you as a person.

End the meeting by agreeing what is going to be the next step. This may be the end of the matter or you may have to give an undertaking to change certain aspects of your practice's procedures so that the same thing does not happen again. You may choose to report any changes you make back to them. You may even want to thank them for drawing any shortcomings to your attention. Confirm in writing the main points of the discussion and any action points that arise.

Hold this thought: when responding to a complaint you must always address every point raised by the complainant.

The objectives of your practice-based complaints handling system should be:

- To enable your patients to express comments, suggestions and complaints to the practice whenever they feel dissatisfied with the service they have received
- To provide them with an explanation of what has happened and, where appropriate, an apology and an assurance that the practice has taken steps to prevent the problem recurring.

You can only successfully defend a complaint if you have comprehensive, contemporaneous records to support your case, and these begin with the patient records. A patient's notes or records should always contain comprehensive details about:

- Their personal details
- Their full, up-dated medical history
- A full dental history
- A social history
- Any current dental complaints
- Treatment plans and the likely cost
- Their consent to any treatment
- What treatment they have received and why
- The type, quantity and location of any local analgesia, general anaesthesia or sedation used
- What treatment they have refused and why
- Any advice they have been given
- Whether or not they accepted the advice
- Information about any referrals
- Details of any unusual discussions or conversations, not just between the clinicians and the patient, but also between the patient and employees
- Financial transactions.

Fig. 1 Holding letter

Your letter acknowledging the complaint need be no more than this.

[insert the patient's name, address, and the date of your letter]

Dear [insert name of person making the complaint]

I acknowledge receipt of your letter of complaint dated [insert date].

My understanding is that [insert outline of complaint]. If this is not correct please contact [name of person and their contact details] as soon as possible.

I am currently investigating the circumstances surrounding your complaint and you will hear from me again no later than [insert date].

Thank you for letting me know of your concerns, and for your patience while I explore this matter fully.

If you have any questions concerning this letter, or would like to discuss the complaint further, please contact [name of person and their contact details].

Yours sincerely

[insert name and job title].

Entries should be made in such a way that any employee reading the records would be able to see instantly what treatment the patient has had done, what is to be done next and why. Your nurse and receptionist should be authorised to make entries in the records when they think it is appropriate, and they should get into the habit of doing so, having first been told that anything they do write can at any time be read by the patient. Sometimes patients will say things to them that they would never say to you.

Poor records will make it more difficult for you to fight off a complaint. Excellent records won't guarantee you'll win, but they will make it less likely you'll lose. There is one message that constantly and consistently comes from the defence organisations, which is 'Keep good records!' It seems so obvious and yet some dentists refuse to heed their advice.

The majority of patient records are nowadays computerised, which may seem convenient, but it brings its own risks as far as litigation goes. The people who produce the computer programmes that allow dentists to hit one key and enter 'Scale and polish' in the patient's records, or hit another key and 'Local, prep, imps, shade' miraculously appear, again, in the patient's records, have no idea about how to write good records. You need to have absolute control over what you write, total flexibility, plus the ability to vary the narrative according to circumstances.

The first thing clinical negligence lawyers and their expert witnesses will home in on are poor clinical records when advising their client in a civil case. Computer generated records that are no more than a scant account, which are unclear, or which are barely comprehendible are the claimant's best friend.
Entries such as 'Exam. Scale and polish' say nothing about whether an examination was carried out or whether it was proposed, and the same goes for the scale and polish. It is better to write too much than too little.

Hold this thought: no records, no defence.

If despite your best efforts to resolve their complaint, the patient ends up leaving the practice, try to identify where you might have gone wrong. Sadly, it might be that the patient was never going to be satisfied with anything you did. If, however, they decide to remain at the practice, then make sure that your attitude towards them does not subtly change, and that there is no animosity, such that they no longer feel welcome. The fact that they have chosen to stay says a great deal about you and your practice.

Handling complaints can sometimes be extremely difficult and is always extremely stressful; this is why you must have a good system. Everyone in your team should be familiar with and understand how the system works.

There is always an expectation on the part of the complainant that something will be done to prevent the same thing from happening again, so see that it doesn't.

'HOW TO HANDLE COMPLAINTS EFFECTIVELY AND EFFICIENTLY SHOULD BE PART OF YOUR CUSTOMER CARE PROGRAMME'

The dentist/patient relationship is not all one-way traffic: don't feel that you can never ask a patient to leave your practice. Don't make your job more difficult than it already is by continuing to deal with people you may never be able to please.

Legitimate complaints identify weaknesses in practice procedures and gaps in staff training. Very serious complaints concerning possibly sensitive professional issues should remain confidential. Less serious ones should be discussed in staff meetings and used as a way of improving the practice. How to handle complaints effectively and efficiently should be part of your customer care programme and every member of your team should receive training in how to identify and diffuse potential complaints.

In all the years I was in practice I was fortunate never to have a complaint against my practice or me. I maintained all the records I needed for audit and conscientiously sent them off each year to the primary care trust, but my practice-based complaints system was never 'tested', and I was curious to see whether or not it would actually work if someone did make a complaint.
Together with my practice manager, we identified a patient, someone who had been with the practice for years, whom we knew was not totally happy with her new lower full denture. She had been back a few times saying that it rubbed her, but the feeling we had was that she just did not like the denture. We contacted her and encouraged her to make a formal written 'complaint'. We then went through the practice's complaints procedure to see if it worked. It did! The lady got a new denture that she was much happier with. I found out that my complaints system would work if it were ever put to the test.
I did have to ask a few patients to leave the practice. I always did this in writing. I simply told them that it had become obvious that my practice was no longer able to meet their expectations. Life's too short to bother with people who you will never please.

How can you turn a complaint into a compliment? By dealing with it professionally, quickly putting things right and making sure that the same thing never happens again.

I've noticed a trend among companies to use the word 'feedback' when describing what is obviously a complaint from a customer. They do this because they don't have to go to all the time, trouble and expense of dealing with and responding to a 'complaint'. All expressions of dissatisfaction are complaints and require a response.

It is an unwritten law that when something goes wrong with one person, things continue to go wrong with that same person. When a business makes one mistake for a customer, they continue making mistakes, compounding the original error. However, smart businesses have latched on to the idea that if, after the first mistake, they can recover the situation and impress the customer by putting things right quickly and without anything else going wrong, the customer will be so impressed that instead of never dealing with the company again, they become converts.

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As an oral healthcare specialist, Curaprox understands just how important it is to provide safe and effective solutions to those that need it the most.

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SUPPRESSING THE GROWTH OF BACTERIAL FLORA

As the Baby Boom generation reaches old age, greater numbers of people are retaining their teeth and the key issue for practitioners is controlling periodontal disease successfully.

When patients present with periodontal pockets, professional scaling and root surface debridement is of paramount importance to clear the subgingival areas of bacterial toxins.

Afterwards, and to provide continued preventative treatment in pockets >5 mm deep, practitioners can also rely on PerioChip as an effective adjunctive therapy. This intra-periodontal insert contains chlorhexidine digluconate that is able to eliminate harmful bacteria for up to seven days after placement.

PerioChip is also able to suppress the growth of bacterial flora in the treated site for up to 11 weeks, offering substantial ongoing therapy to assist the healing process.

PerioChip is available exclusively from Dexcel Dental. To order or for further information call 0800 013 2333 or email team@periochip.co.uk.

A TOOTHPASTE YOU CAN RECOMMEND WITH CONFIDENCE

In 2013 the Cochrane Oral Health Group carried out a review of triclosan/copolymer containing toothpastes for oral health. This review assesses the effects of triclosan/copolymer containing fluoride toothpastes compared with toothpastes containing fluoride only, for the long-term control of caries, plaque and gingivitis in children and adults. Thirty published studies were reviewed, involving 14,835 patients who had been randomised to receive a triclosan/copolymer containing fluoride toothpaste or a fluoride toothpaste not including triclosan/copolymer.

The evidence produced shows the clinical benefits of using a triclosan/copolymer fluoride toothpaste twice daily when compared with a fluoride toothpaste (without triclosan/copolymer). The results showed a 22% reduction in plaque, 22% reduction in gingivitis, 48% reduction in bleeding gums, and 5% reduction in tooth decay.

This evidence led to the authors concluding 'Fluoride toothpastes containing triclosan and copolymer reduced plaque, gingival inflammation and gingival bleeding when compared to fluoride only toothpastes.

'*Delivering better oral health - an evidenced based toolkit for prevention*' cites this systematic review in section 6, 'Improving periodontal health' quoting the authors' findings. The toolkit also identifies Colgate Total as the only toothpaste available containing triclosan with co-polymer.

To download the Cochrane review visit www.colgateprofessional.co.uk/products/colgate-total-toothpaste/overview.

Updated posters to help manage medical emergencies in the dental practice

P. Jevon[1]

Medical emergencies can occur in the dental practice. The posters 'Medical Emergencies in the Dental Practice' and 'Emergency Drugs in the Dental Practice' have been designed to help dental professionals to respond effectively and safely to a medical emergency. These posters, endorsed by the British Dental Association (BDA), are included with this article. Further copies can be downloaded from: https://www.walsallhealthcare.nhs.uk/medical-education.aspx.

Duty of care

Dental practices have a duty of care to ensure that an effective and safe service is provided to their patients. The satisfactory performance in a medical emergency in the dental practice has wide-ranging implications in terms of equipment, training, standards of care, clinical governance, risk management and clinical audit.

Maintaining the knowledge and competence to deal with medical emergencies is an important aspect of all dental care professionals' (DCPs') continuing professional development (CPD).[1] The updated posters described in this article are designed to be *aide-memoires* to assist DCPs to safely and effectively manage medical emergencies occurring in their workplace.

The aim of this article is to provide an overview to the updated posters which are designed to help manage medical emergencies in the dental practice.

[1] *Multi-Professional Skills Manager, Medical Education Manor Hospital, Walsall*

Incidence of medical emergencies

Medical emergencies in the dental practice that have been reported include vasovagal syncope (63%), angina (12%), hypoglycaemia (10%), epileptic seizures (10%), choking (5%), asthma (5%) and anaphylaxis.[2] Vasovagal syncope is the most common emergency, accounting for approximately two thirds of all emergencies reported.[3]

The GDC and medical emergencies

A medical emergency could occur at any time in the dental practice. The General Dental Council (GDC)[1] states it is important to ensure that:

- There are arrangements for at least two people to be available within the working environment to deal with medical emergencies when treatment is planned to take place. In exceptional circumstances the second person could be a receptionist or a person accompanying the patient
- All members of staff, including those not registered with the GDC, know their role if there is a medical emergency
- All members of staff who might be involved in dealing with a medical emergency are trained and prepared to do so at any time, and practise together regularly in a simulated emergency so they know exactly what to do.

National guidance on the management of medical emergencies

The 'Medical emergencies in the dental practice' section of the British National Formulary (BNF)[4] provides guidelines on the management of the more common medical emergencies which may arise in the dental

Fig. 1 Poster 1: Medical emergencies in the dental practice

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MEDICAL EMERGENCIES IN THE DENTAL PRACTICE

MEDICAL EMERGENCY	SIGNS & SYMPTOMS	TREATMENT
Adrenal crisis	• Collapse • Pallor • Cold & clammy skin • Hypotension and Dizziness • Vomiting & diarrhoea	• **A**irway **B**reathing **C**irculation **D**isability **E**xposure • Call 999 • Lie flat • Oxygen 15 litres/min
Anaphylaxis	Signs & symptoms (can vary) can include: • Urticaria&/or angioedema • Flushing & pallor • Respiratory distress • Stridor, wheeze &/or hoarseness • Hypotension & tachycardia Anaphylaxis likely: • Sudden onset & rapid progression of symptoms • Life-threatening **A** &/or **B** &/or **C** • Skin &/or mucosal changes	• **A**irway **B**reathing **C**irculation **D**isability **E**xposure • Call 999 • Oxygen 15 litres/min • Lie flat, elevate legs (if breathing not impaired) • Adrenaline 500 micrograms IM (0.5ml of 1:1000) • Repeat adrenaline at 5 minute intervals if no improvement **Paediatric doses of adrenaline:** < 6 yrs - 150 micrograms (0.15ml of 1:1000) 6-12 yrs - 300 micrograms (0.3ml of 1:1000) > 12 yrs -500 micrograms (0.5ml of 1:1000)
Asthma	Breathlessness & expiratory wheeze **Severe (adult):** inability to complete sentences in one breath, RR>25/min, HR>110/min **Severe (child):** inability to complete sentences in one breath or too breathless to talk or feed, RR > 40 (2-5 yrs) or > 30 (> 5 yrs), HR > 140 (2-5 yrs) or > 125 (> 5 yrs) **Life threatening:** cyanosis, poor respiratory effort, fall in HR, altered level of consciousness/confusion, exhaustion	• **A**irway **B**reathing **C**irculation **D**isability **E**xposure • Sit upright • 2 puffs (100 micrograms/puff) of short acting beta agonist inhaler e.g. salbutamol; repeat doses may be necessary • If patient unable to effectively use inhaler: additional doses through spacer device • Call 999 if unsatisfactory/no response or if severe/ life threatening • While awaiting ambulance: oxygen 15 litres/min; up to 10 activations of salbutamol inhaler using a spacer device should also given (repeated every 10 minutes if necessary) • Reassure patient
Cardiac emergencies	Symptoms can vary; commonly: • Tightness, heaviness or pain in the chest • Pain may radiate to neck, jaw shoulders, left arm & back • Pallor& sweating • Nausea/vomiting • Breathlessness	• **A**irway **B**reathing **C**irculation **D**isability **E**xposure • Call 999 • Comfortable position (usually sitting up) • GTN spray 2 activations sub lingual • Aspirin 300 mg orally (crushed or chewed) (unless there is clear evidence that the person is allergic to it) • Ensure automated external defibrillator (AED) is immediately accessible (should it be required) as per Resuscitation Council UK guidelines **NB** If history of angina: GTN & rest; where symptoms are mild &resolve rapidly, calling 999 usually not necessary
Epileptic seizures	• Sudden collapse& loss of consciousness • Rigidity & cyanosis • Jerking movements of limbs • Noisy breathing • Tongue may be bitten • Frothing at mouth • Incontinence may occur	• **A**irway **B**reathing **C**irculation **D**isability **E**xposure • Safe environment: prevent injury, do not put anything into mouth, do not restrain • Note timings of fit • Oxygen 15 litres/min • Once jerking movements cease: recovery position & check the airway **Prolonged convulsive seizures (5 minutes or more) or repeated seizures (3 or more in an hour):** • Midazolam oromucosal solution can be given by the buccal route in adults as a single dose of 10 mg [unlicensed] **Depending on response to treatment, the person's situation and any personalised care plan,** call 999 particularly if: • Seizure is continuing 5 minutes after the emergency medication has been administered • The person has a history of frequent episodes of serial seizures or has convulsive status epilepticus, or this is the first episode requiring emergency treatment **or** • There are concerns or difficulties monitoring the person's airway, breathing, circulation or other vital signs **Paediatric doses of buccal midazolam:** 1-5 years - 5mg 5-10 years - 7.5mg > 10 years – 10mg
Hypoglycaemia	• Shaking/trembling • Slurred speech • Vagueness • Sweating and pallor • Blurred vision • Tiredness and lethargy • Confusion/aggression • Stroppy/moody • Unconsciousness	• **A**irway **B**reathing **C**irculation **D**isability **E**xposure • Offer 15-20g fast acting glucose e.g. 3-4 glucose tablets, glass of orange juice or glucose gel • Impaired consciousness or if patient is unable to swallow safely: glucagon 1mg IM • Once consciousness returns, offer oral glucose • Call 999 if the patient goes unconscious • If able, measure blood sugar to confirm diagnosis **Paediatric dose of glucagon:** < 8 years of age or < 25kg: 0.5mg IM
Stroke	• Facial weakness: smile? mouth or eye drooped? • Arm weakness: raise both arms? • Speech problems: speak clearly or understand what you say? • Time to call 999	• **A**irway **B**reathing **C**irculation **D**isability **E**xposure • Call 999 • Oxygen 15 litres/min • Nil by mouth
Syncope	• Feels faint/dizzy/light headed • Collapse & loss of consciousness • Pallor, sweating, slow pulse, low BP • Nausea/vomiting	• **A**irway **B**reathing **C**irculation **D**isability **E**xposure • Lie flat, elevate legs & loosen tight clothing • Consider oxygen (not usually necessary) • If becomes unresponsive, check for signs of life • Once consciousness returns, offer glucose in water or sweet tea

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Stroke Association **FAST** www.stroke.org.uk (accessed 1 May 2015)

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Text proof read by Mr N Rashid & Miss R Joshi ED Consultants & Sarah Church Consultant Orthodontist, Walsall Healthcare NHS Trust.

Further information is also available from the British Dental Association at www.bda.org/medicalemergencies

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practice. Further information is also available from the BDA (if your principal is a member) at www.bda.org/medicalemergencies.

Specific guidance is also provided by other authoritative bodies including the British Thoracic Society (asthma), the British Heart Foundation (cardiac emergencies), the National Institute for Health and Care Excellence (NICE) (epileptic seizures), the Stroke Association (acute stroke), Diabetes UK (hypoglycaemia) and the Resuscitation Council (UK) (anaphylaxis).

The Resuscitation Council (UK) no longer provides specific guidance on medical emergencies in the dental practice (formerly provided in their publication *Medical emergencies and resuscitation standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice*). This was superseded in November 2013 by its publication *Quality standards for cardiopulmonary resuscitation practice and training in primary dental care*, in which the Resuscitation Council (UK) continues to provide helpful guidance on all aspects relating to cardiopulmonary resuscitation in the dental practice.[5]

Poster 1

The 'Medical emergencies in the dental practice' A3 poster (Fig. 1) was first produced in 2009 as an *aide-memoire* to assist dental staff to safely manage medical emergencies occurring in the dental practice.[6] It was updated[7] in 2012 and now revised again in 2015. The 2015 revisions include:

- Increased emphasis on the ***A**irway **B**reathing **C**irculation **D**isability **E**xposure* approach to the management and treatment of medical emergencies
- Inclusion of adrenal crisis in line with guidance in the BNF[4]
- New NICE guidance concerning midazolam administration for epileptic seizures (midazolam injection is no longer considered an option for buccal administration)[8]
- Emphasis on the importance of having immediate access to an automated external defibrillator (AED).[5]

The poster is intended to be placed on the wall in the surgery where it can be easily and quickly accessed should an emergency occur. The emergencies covered are listed in alphabetical order:

- Adrenal crisis
- Anaphylaxis
- Asthma
- Cardiac emergencies
- Epileptic seizures
- Hypoglycaemia
- Stroke
- Syncope.

The important signs and symptoms to look out for to help correctly diagnose each emergency are listed, together with the principles of safe and effective treatment. Where appropriate, the recommended doses of drugs (including paediatric doses) and routes of administration are also stated.

This poster can be downloaded from Walsall Healthcare NHS Trust's website: https://www.walsallhealthcare.nhs.uk/medical-education.aspx.

'ALL DENTAL STAFF SHOULD BE TRAINED AND RECEIVE REGULAR UPDATES IN THE MANAGEMENT OF MEDICAL EMERGENCIES AND POSSESS UP-TO-DATE EVIDENCE OF CAPABILITY'

Poster 2

The 'Emergency drugs in the dental practice' A4 poster (Fig. 2) was first produced in 2012 as an *aide-memoire* to assist dental staff to safely administer medications in the emergency situation.[7] This poster has also been revised in 2015 to incorporate the new NICE guidance concerning midazolam administration for epileptic seizures (midazolam injection is no longer considered an option for buccal administration).[8] The poster is designed to be kept in the emergency drugs box for quick reference. Further copies can be downloaded from Walsall Healthcare NHS Trust's website: https://www.walsallhealthcare.nhs.uk/medical-education.aspx.

Training

All dental staff should be trained and receive regular updates in the management of medical emergencies and possess up-to-date evidence of capability.[9] Running regular mock scenarios/drills involving the team approach is advised.[1] In the author's experience, some surgeries find it helpful to use the poster in the training session to increase familiarity in its use.

Conclusion

Every dental practice has a duty of care to ensure that an effective and safe service is provided for its patients.

This article has provided an overview to the updated posters designed to help manage medical emergencies in the dental practice.

The author is grateful to Najam Rashid and Ruchi Joshi, ED Consultants and Sarah Church, Consultant Orthodontist, Manor Hospital, Walsall UK for proof reading the poster and to Daniel McAlonan, Head of Health & Safety, British Dental Association for his suggestions and helpful advice.

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EMERGENCY DRUGS IN THE DENTAL PRACTICE

Drug	Indication	Adult Dose & Route	Paediatric Dose & Route
Adrenaline	Anaphylaxis	500 micrograms (0.5 mls 1:1000) IM May be repeated at 5 min intervals if no improvement	**<6 yrs:** 150 micrograms (0.15 mls 1:1000) IM **6-12 yrs:** 300 micrograms (0.3 mls 1:1000) IM **>12 yrs:** 500 micrograms (0.5 mls 1:1000) IM May be repeated at 5 min intervals if no improvement
Aspirin	Suspected heart attack	300 mg oral (crushed or chewed)	N/A
Glucagon	Hypoglycaemia (patient unable to swallow safely e.g. unconscious)	1 mg IM	**<8 yrs (or <25 kg):** 0.5 mg IM **>8yrs (or >25 kg):** 1 mg IM
Glucose (fast acting)	Hypoglycaemia (patient co-operative & able to swallow safely)	15-20g fast acting glucose e.g. 3-4 glucose tablets, glass of orange juice or glucose gel	Dose as for adults
Glyceryl Trinitrate Spray	Angina or suspected heart attack	2 actuations sublingually	N/A
Midazolam	Prolonged convulsive seizures (≥ 5 minutes) or repeated seizures (≥ 3 in an hour)	Midazolam oromucosal solution can be given by the buccal route in adults as a single dose of 10 mg [unlicensed]	**1-5 years**: 5mg buccal **5-10 years:** 7.5mg buccal **> 10 years:** 10mg buccal
Short acting beta agonist (e.g. salbutamol) inhaler	Asthma attack	2 actuations inhaled Use spacer device if necessary Repeated doses may be necessary	Dose as for adults

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Fig. 2 Poster 2: Emergency drugs in the dental practice

CPD questions March 2016

CPD ARTICLE: How to turn complaints into compliments

1. Select the **correct** statement made in this article:

a) apologising to a patient is an admission of liability
b) you can ignore a complaint from a patient who is a known troublemaker
c) dental professionals have an ethical duty and obligation to address any complaint
d) having a robust complaints policy is only important for private dental practices

2. When a patient makes a complaint you should:

a) regard it as serious, curb your feelings and remain objective
b) ask to have it in writing if it is initially made verbally
c) acknowledge receipt of the complaint in writing, stating your interpretation of the complaint
d) all of the above

3. Which of the following is **false**?

a) having a face-to-face meeting with a patient who has complained should always be your preferred option once you have investigated the complaint
b) it is important to show a complainant that you are professional, reasonable and unbiased
c) dental nurses and receptionists should not be authorised to make entries in patient records
d) DCPs should be able to make appropriate entries in patient records as sometimes patients say something to them that they would not say to the dentist

4. A. If despite your best efforts to resolve their complaint, the patient ends up leaving the practice, try to identify where you might have done wrong.
B. You can never ask a patient to leave your practice.

a) only A is correct
b) only B is correct
c) A and B are correct
d) A and B are incorrect

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