All dental professionals are expected to meet stringent standards of infection control.
The DDU Journal is published for members in the UK and Republic of Ireland. The dento-legal advice in the DDU Journal is for general information only. Appropriate professional advice should be taken before acting or refraining from action based on it. Opinions expressed by authors of articles published in the DDU Journal are their own and do not necessarily reflect the policies of the DDU. The photographs used in this publication are selected from stock images, posed by models or have been specially commissioned by the MDU, unless otherwise stated.

†The Dental Defence Union (DDU) is the specialist dental division of The Medical Defence Union Limited (MDU) and references to the DDU and DDU membership mean the MDU and membership of the MDU. MDU Services Limited (MDUSL) is authorised and regulated by the Financial Services Authority for insurance mediation activities only. MDUSL is an agent for the Medical Defence Union Limited (the MDU). The MDU is not an insurance company. The benefits of membership of the MDU are all discretionary and are subject to the Memorandum and Articles of Association.

MDU Services Limited is registered in England 3957086. Registered office: 230 Blackfriars Road, London SE1 8PJ. © 2013 JNL202-1304
Support when you need it most

We come into our own when our members need us most. In 2012, more of you had reason to seek our help.

The number of claims reported by members rose by 32% last year. One reason for this is that claimants’ solicitors have launched proceedings ahead of the changes to costs that will be introduced in April. And the GDC saw a rise in complaints of 44% in 2012 although in most cases, the dental professional’s fitness to practise was not found to be impaired. Meanwhile calls to our advice line increased by 12% in 2012 compared to 2011 (itself a record year).

It’s a shame that some dental professionals only really discover the benefits of being a member when something has gone wrong. There is so much more to our services than that.

You can complete our free online course in dental ethics and law and gain five hours’ of verifiable CPD. The course is available through our website theddu.com. Or you could simply read this issue of the Journal and gain about two hours of non-verifiable CPD. This issue addresses a range of dento-legal concerns raised by members (see pages 4-7) and includes a member case with useful advice (see page 8). In addition, take a look at Learn and develop on our website. You’ll find our courses and educational resources for 2013.

Such training and development opportunities are intended to support you throughout your career and help you avoid the kinds of incidents that can easily result in a complaint or claim. And of course, you can always call our advice line if you have a dento-legal query and want to speak directly to one of our team of experts.

I mention this because I want members to reap all the rewards of membership. I am aware of the pressures that dental professionals are under: from inspections to the need to implement infection control measures (see pages 10-13) against a background of an effective NHS pay freeze for GDPs and the difficult economic situation.

As a not-for-profit organisation, our role is to help you practise with confidence by continuing to deliver the highest standards of service and support.

I hope you enjoy this edition of your Journal.

Rupert Hoppenbrouwers
Head of the Dental Defence Union

References

1 Statistics received from the GDC 31-01-13
My practice partners and I have decided to make our own custom-made bite guards for patients. Do we need to register with the MHRA?

As a manufacturer of custom-made dental appliances, you are required by the Medical Devices Directive 93/42/EC (MDD) to register with the Medicines and Healthcare Products Regulatory Agency (MHRA), and provide your business address and a description of the devices you produce. You can download a registration form at www.mhra.gov.uk

You will also need to produce a Statement of Manufacture for each device you make which includes the following information:
• Your name and business address.
• Identification details for the device.
• A statement that the device is a custom-made dental appliance, intended for exclusive use by a named patient.
• The name of the practitioner or other authorised person who prescribed the device and their business address (if different).

You are legally required to offer patients a copy of the Statement of Manufacture. Keep a record of whether your patient accepts a copy. If they don’t you should keep the Statement for the lifetime of the device.

The MHRA is responsible for enforcing the MDD but the GDC has said it will take action against dental professionals who don’t meet their legal responsibilities.
Inhaled filling

I replaced a large amalgam filling using an air turbine drill. My patient started coughing and then said that her throat felt very uncomfortable. I’m worried that she may have inhaled a piece of the old filling. What should I do?

As soon as you are aware that something may have gone wrong during treatment, you should take action to make sure the patient is not in immediate danger and is cared for until the issue is resolved. As soon as practicable, you should tell the patient what went wrong.

You should tell the patient that she may have inhaled a piece of the filling. If something has been inhaled it will need to be removed so an appropriate referral to hospital should be made for the necessary radiograph(s), other investigations and treatment. You should consider how the patient can get to the hospital and whether you need to arrange transport or call an ambulance.

Once the patient has been appropriately cared for, we suggest that you look into how it may have happened and what you could have done differently to prevent it from happening again.

We also recommend that you contact the patient soon after her hospital visit to check if she is well and to say sorry. If she makes a complaint to your practice, you should respond in line with the practice complaint procedure. You should acknowledge the complaint within three working days and aim to provide a full response within 10 working days.

Sharing radiographs with colleagues

I am treating a child who has been referred to me for endodontic treatment on a permanent tooth. The referral did not include the patient’s radiograph and on speaking to the referring dentist, he has refused to send me a copy on the basis of patient confidentiality. Is that right?

The radiograph is part of the information that should have been sent to you as part of the referral.

The GDC’s guidance, Principles of Dental Team Working is clear about dental professionals’ obligations when making referrals: ‘If you ask a colleague to provide treatment, a dental appliance or clinical advice for a patient, make sure that your request is clear and that you give your colleague all the appropriate information.’

It is in the patient’s best interest that you have any existing radiographs so that you can carry out the treatment and that the patient is not subjected to a further unnecessary irradiation.

If the referring dentist will not send what you need, you could seek a signed authority from the patient’s parent and send that to the referring dentist, but this action may cause the patient avoidable delay. An alternative, so as to minimise the delay in treatment, would be to ask the referring dentist to call the parents so that they can confirm their consent to you having the radiograph.

You might want to consider a protocol for referring dentists which stipulates that all relevant information, including radiographs, should be provided and making clear it is their responsibility to seek the patient’s consent to their supplying this information to you.
Q Treating a patient with no teeth

I am a clinical dental technician and have just been called by a man who has lost all his own teeth but has had two implants. He’s asked me to make him a set of implant-retained dentures. When I asked if he had seen his dentist, he said there was no point as he does not have any of his own teeth. Is it OK for me to treat him?

A

While the GDC says clinical dental technicians can supply and maintain complete dentures directly to edentulous patients, people with natural teeth or implants must be seen by a dentist before any other treatment can begin.

The details of what CDTs and other dental professionals are trained and competent to do are set out in the GDC’s Scope of Practice guidance (April 2009). In the GDC guidance, it states: “You should only carry out a task or type of treatment or make decisions about a patient’s care if you are sure that you have the necessary skills.”

Going ahead with treatment without an appropriate treatment plan could lead to a GDC fitness to practise investigation if the denture fails and the patient makes a complaint. You are therefore advised to explain to the patient that because he has implants you will need to refer him to a dentist who can recommend a suitable treatment plan.

The patient may be frustrated and it is possible he may go elsewhere but this is better than risking a GDC investigation.

Q Reminder notices

Can I send reminder notices for members of the same family in a single envelope?

A

It is possible that you might not meet any objection from your patients, but if they have not given their consent they could justifiably complain that their confidentiality has been breached and you might even find yourself facing a GDC fitness to practise investigation.

The GDC regards all patient information, including appointments, as strictly confidential and expects dental practices to ensure all correspondence is individually addressed in a sealed envelope to protect patient privacy. The Data Protection Act 1998 requires similar precautions. However, where young patients are not yet Gillick competent, letters can be addressed to a parent or somebody with parental responsibility.

The only way you could send notices in the same envelope is if you had a system to obtain and record the specific consent of the patients concerned and keep this updated, but such a scheme may be time-consuming to administer.
**Failure to register with the GDC**

My dental nurse has revealed to me that since 31 July last year she has been working without being registered with the GDC because she forgot to pay her annual registration fee. Will I be criticised for not checking her registration?

It is illegal to practise while unregistered, even temporarily. Your nurse cannot assist you in the role of dental nurse until she has re-registered. The GDC has previously warned that if any registrant employs or manages an unregistered person they could be liable to fitness to practise proceedings and possible erasure from the register.

Your nurse will be asked by the GDC to complete a *restoration application form* and she will need to state whether she has been working in the UK while unregistered and to explain why she allowed her registration to end. It is possible that the GDC will approach your practice for more information about her working situation.

It is a good idea to review your practice’s arrangements for monitoring the registration of staff so that you can minimise your risk should you need to respond to the GDC.

It is important to check the registration status of all dental professionals working at your practice. This should be done when they first start work and shortly before their registration ends (31 December each year for dentists and 31 July for Dental Care Professionals). You could store a copy of each employee’s registration certificate along with other important documents, such as defence organisation membership, CRB forms and training certificates, in their personnel file.

The Care Quality Commission (CQC), which oversees quality and safety standards in dental practices, also expects providers to ensure patients ‘are cared for by staff that are properly qualified and able to do their job’ (*Essential Standards of Quality and Safety*, outcome 12). CQC inspectors may ask whether your practice has a system in place to monitor if your staff are up to date with Continuing Professional Development and the requirements of the GDC.

**Supervising a trainee**

I’m currently working in a small practice and the principal dentist is a foundation trainer. She’s going away for a few days soon and she has asked me to keep an eye on her trainee, who has been with the practice for about six months. I don’t mind, but I’m a bit concerned about who is responsible should something go wrong.

All dentists are responsible for ensuring that they do not attempt any treatment for which they are not trained and competent to carry out.

It is entirely appropriate for the principal to ask a fellow ‘seasoned’ dentist to keep an eye on a recently qualified dentist in their absence. It would be sensible to find out if there are any areas with which the foundation dentist might need support and the protocol in the event of an emergency.

You might want to consider sitting down with the foundation dentist and see if they have any difficulties in carrying out particular treatments. If they are worried about extractions, for example, it might be possible to avoid booking in patients for such procedures while their trainer is away.

Make sure you keep clear, accurate and contemporaneous records of any involvement you have with the foundation dentist’s patients while your colleague is away, including the course of action you thought appropriate and the consent discussion. If you are able to show that you acted in the patient’s best interests, you should not be vulnerable to criticism.

“All dentists are responsible for ensuring that they do not attempt any treatment for which they are not trained and competent to carry out.”
A recently qualified dentist received a visit from a man in his 60s who wanted a set of complete dentures. The patient’s remaining teeth had been extracted by his previous dentist and he was finding it difficult to eat and speak. The dentist advised that he might experience initial discomfort from the dentures but they should feel better with time and he would be able to make any adjustments needed. He then carried out an examination and assessment and checked the soft tissues before taking the impressions.

The patient returned two weeks later for second impressions to be taken. During this appointment, the dentist also recorded the bite and the patient chose the shade for the teeth on his new dentures. The dentist completed the necessary paperwork and sent this to the dental laboratory, but the documentation was not retained in the patient’s records.

A month later, the patient attended for a ‘try-in’ appointment when he was able to experience the teeth in his mouth for the first time, albeit in a wax base. He confirmed he was happy with the fit. In the interim, the practice had changed dental laboratories so the dentist sent the denture to the new laboratory to be finished. This time, the laboratory form was filed in the records.

At his final consultation, the dentist fitted the dentures and advised him how to look after them. In line with his usual practice he checked the bite but did not record this. The patient commented that the dentures felt strange and he struggled to speak but did not raise any particular concerns. The dentist reiterated his previous advice about the need to get used to the dentures.

The dentist was on leave when the patient returned a few days later, complaining that the dentures did not fit and were cutting into his gums. The dentist who saw him found that the occlusion was incorrect and decided he had to begin the whole process again.

The patient sought a second opinion from a clinical dental technician who was critical of the initial treatment.

**Complaint**

The patient complained about the standard of care provided by the first dentist and demanded a refund. By then the dentist had joined another practice and was not aware the patient was unhappy until a few weeks later, when he heard from the Complaints Manager at his former practice.

Before he had had the opportunity to study the records and respond, the GDC
made contact to say it had received a complaint from the patient and was investigating. The dentist faced allegations that he had failed to provide a good standard of patient care when providing the dentures; had not checked the patient’s occlusion; and failed to maintain good records. The dentist contacted us for advice.

His DDU adviser recognised that the dentist had received limited mentoring in the early stages of his career and suggested he join the local BDA young dentists group and the Faculty of General Dental Practitioners (FGDP) to benefit from the peer support available.

Accepting he needed to address the deficiencies in his record keeping as well as his treatment of patients who required dentures, the dentist prepared a Personal Development Plan (PDP) at our suggestion, and with the help of the postgraduate deanery. As set out in the PDP, he then asked the clinical director at his practice to carry out an assessment and audit of his notes and signed up to CPD courses in prosthetics, record keeping and complaints handling.

In the detailed written response to the GDC’s Investigating Committee, our instructed solicitor emphasised the steps the member had taken to reflect on what had happened and the efforts he had made to remediate. The letter:

• Defended the member’s actions with regard to fitting the dentures, explaining that the timing of his holiday and move to another practice meant he had been unable to review the patient himself.

• Admitted that while the member had checked the patient’s bite at the try-in and fitting stages, he had not made a proper record and was sorry for this oversight.

• Said that the member now recognised that a patient new to dentures might find it more difficult to bite reproducibly and that in future he would be more careful in checking the occlusion several times.

• Included the member’s PDP and stated that he was also seeking support from the BDA and FGDP.

• Included an apology to the patient for not checking the bite properly, the discomfort he endured, and the way his complaint was handled, although this was outside our member’s control.

The GDC Investigating Committee decided not to refer the case for a full fitness to practise hearing in public. While it did not consider our member’s standard of care was poor, it was critical of his record-keeping. The Committee also recognised that our member had ‘complied with the investigation and responded positively to the allegations’ and apologised.

It stated: ‘This Committee has, in the light of the evidence of remediation, determined that the risk of repetition is low and has reminded itself that the purpose of the fitness to practise process is ultimately to ensure future acceptable conduct.’

The Committee decided a warning would be disproportionate. It closed the case with advice to the dentist about his record keeping and the need for him to undertake CPD in the provision of dentures.

John Makin
Dento-legal adviser

“The Committee also recognised that our member had ‘complied with the investigation and responded positively to the allegations’ and apologised.”

Points to consider

• It is important to be able to offer evidence of insight and remediation at the earliest possible stage of a GDC investigation. This can be a key factor in determining whether a case goes to a full hearing and can demonstrate that a practitioner’s fitness to practise is not currently impaired.

• It is essential to communicate effectively with patients, carefully manage their expectations and note any warnings given about the limitations of treatment in respect of the patient’s particular circumstances.

• Retain all documentation with the patient’s records when ordering dental devices.

• Engage with your peers. The ‘community of practice’ is important to prevent isolation during your career.

• Maintain your CPD and use reflective practice to identify your own learning needs.
Failure to employ adequate methods of cross-infection control would almost certainly lead to a charge of impaired fitness to practise. Sue N’Jie, dento-legal adviser at the DDU, reviews infection control within a dental practice.

Hygiene has always been a priority in dental practice but in recent years there has been an increasing emphasis on infection control procedures.

One reason was the concern surrounding blood-borne diseases such as HIV and Hepatitis B as well as concerns related to CJD. The public perception was that if it was remotely possible for these infections to be contracted through clinical treatment, healthcare professionals had a duty to do everything possible to prevent it. Another factor was the rise of hospital-acquired infections, such as MRSA, which focused attention on the need for scrupulous hygiene within all healthcare environments.

All dental professionals are expected to meet stringent standards of infection control and are responsible for ensuring that dental instruments are safely disposed of (if single-use) or cleaned and sterilised so they are safe to reuse.

Infected patients
When a patient reveals they have a blood borne infection such as HIV, you have an ethical duty not to ‘discriminate against them or groups of patients because of their sex, age, race, ethnic origin, nationality, special needs or disability, sexuality, health, lifestyle, beliefs or any other irrelevant consideration’ (paragraph 2.3, GDC Standards for Dental Professionals).

You cannot refuse to treat a patient with a potentially infectious disease on the grounds that it could expose you to a (negligible) risk, nor should you treat such patients unfairly, for example, asking them to attend appointments at the end of the day.

Such behaviour will leave you vulnerable to complaints, a GDC investigation and legal action under the Equality Act 2010.

“A common allegation
Perhaps the most common allegation made by patients about lapses in infection control is that unsterilised instruments have been used to treat them. An effective way of addressing this is to open the sealed bag containing the sterilised instruments in the patient’s presence. You might also want to cover the issue of infection control on your website and in your practice literature.
Standards of infection control are monitored by different organisations depending on where you are and whether you practise in the NHS or privately.

GDC guidance

The GDC does not specifically refer to infection control in its current guidance although in the Winter 2012 issue of the GDC Gazette it says:

‘The risk of cross-infection has always existed in dental treatment. Therefore, dental professionals have a duty to take appropriate precautions to protect patients and other members of the dental team from that risk.’

‘Detailed guidance on cross-infection control has been issued by the Department of Health.’

It adds that ‘failure to employ adequate methods of cross-infection control would almost certainly lead to a charge of impaired fitness to practise’ and it has previously taken action against dentists who have fallen short in this area.

Infection control is also part of the GDC’s core CPD curriculum: it recommends that all registrants carry out a minimum of five hours of verifiable CPD on the subject per cycle.

England

Standards

Standards were set out in Health Technical Memorandum (HTM) 01-05 issued by the Department of Health in 2009. This established two benchmarks: essential quality requirements and best practice. For example, the essential requirement is to separate instrument processing (cleaning, decontamination, inspection and sterilisation) from clinical work in a designated area which may be in, or adjacent to, the surgery. The best practice standard is for a separate decontamination room.

There is no national timescale for implementing the best practice standards but you should check whether your primary care organisation has its own policy. If you do not currently comply with best practice, the essential standards require you to have a detailed plan for achieving it.

Inspections

The CQC is responsible for enforcing Outcome 8 of the National Standards which concerns cleanliness and infection control. Inspections of both NHS and private dental practices are every two years and its inspectors’ remit includes ensuring practices have effective infection control policies and procedures in place in line with HTM 01-05 (and their plans for meeting best practice). The CQC has the power to cancel the registration of practices which fail to meet the national standards under its powers of civil enforcement. It can also issue warning notices and impose or change a condition of registration. In addition, it has the power to take action against practices under the criminal law, including prosecution. Bear in mind that the GDC is also likely to be notified if CQC sanctions are taken against you.

In its first market report, 94% of practices inspected by the CQC were found to meet standards for infection control but at the time of writing one practice has had its registration removed for reasons which included failure to meet these standards.

Wales

Standards

An amended version of HTM 01-05 has been published in Wales. Practices there should have met the _essential requirements_ contained within HTM 01-05 (Welsh Edition) by March 2012.

Inspections

Local Health Boards (LHBs) are responsible for ensuring that HTM 01-05 standards are met. Routine inspections are carried out by the Dental Reference Service (DRS) every three years. Non-NHS dentists are regulated by Healthcare Inspectorate Wales (HIW) although its inspections are also carried out by DRS inspectors.
When you consider how many patients we see every day, infection control is a massive undertaking. I suspect many patients are unaware of the lengths their dental practices go to protect them. Infection control is central to our practice, from the layout of the surgery, to managing our dental team. For instance, it is a core part of our induction training and I also engage an external trainer to visit the practice each year to ensure our processes are up to date. The toughest challenge is probably managing the time it takes to implement infection control procedures because they take up a significant chunk of each day. As well as spending the time I need with every patient and writing up my records from each appointment, I have to make sure the surgery is ‘as new’ when the next patient enters the room.

There’s also no escaping the fact that infection control is expensive. It’s one area of dentistry that requires a large budget to stay compliant. We have to maintain expensive equipment to manufacturers’ guidelines. And we have to buy more instruments to use to compensate for the downtime when other sets are being decontaminated and sterilised.

Infection control is about protecting patients and that is core to being a caring dental professional, even though it is challenging both financially and time-wise in a busy dental practice.

---

### Scotland

#### Standards

A series of infection control guidance documents, called *Decontamination into Practice*, were published by the Scottish Dental Clinical Effectiveness Programme (SDCEP) between 2007 and 2011. The standards differ in several respects from England. For example, a separate decontamination room is obligatory, as is a washer-disinfector. A further key difference in Scotland is that endodontic instruments must be treated as single use, even on the same patient (this rule was relaxed in England in 2010, provided specific conditions are met). All NHS practices that provide general dental services in Scotland were required to be compliant with the SDCEP decontamination standards by 31 December 2012.

#### Inspections

National decontamination standards are part of a new combined practice inspection (CPI) which is being implemented by local health boards from 2013, replacing the two separate inspections which were carried out by the NHS Boards and NHS Education for Scotland. Inspections will take place every three years and a Combined Inspection Checklist has been published. Practices that do not pass the CPI will lose their entitlement to the general dental practice allowance and reimbursement of practice rental costs. Healthcare Improvements Scotland (HIS) is responsible for independent dental practices.

---

### Northern Ireland

#### Standards

The Department of Health Social Services and Public Safety (DHSSPS) wrote to dentists in December 2012, reminding them that all dental practices in Northern Ireland should have achieved the HTM 01-05 best practice benchmark by November 2012 and setting out the more rigorous decontamination standards they were expected to meet.

#### Inspections

The Health and Social Care Board has a duty to commission services which meet required decontamination standards, and performance manage new and problem practices. The Regulation and Quality Improvement Authority (RQIA) assesses practices’ infection control arrangements. During a decontamination study day held by the NI Medical and Dental Training Agency in November 2012, the Deputy Chief Dental Officer gave an update on decontamination policy in Northern Ireland. It included an outline of how inspectors from the RQIA would assess practices’ infection control arrangements although a detailed inspection framework is expected.

---

**References:**

1. Decontamination in primary care dental practices, DH, 1 December 2009 ([dh.gov.uk](http://dh.gov.uk))
2. Essential standards of quality and safety, CQC, March 2010 ([cqc.org.uk](http://cqc.org.uk))
5. Decontamination in primary care dental practices - Compliance with essential requirements, Letter from the CDO (Wales), 1 May 2012 ([wales.gov.uk](http://wales.gov.uk))
6. Professional Estates Letter (12) 23, HTM 01-05 Decontamination in primary care dental practices, DHSSPS, 21 December 2012 ([dhsspsni.gov.uk](http://dhsspsni.gov.uk))
7. An update on decontamination policy and guidance in Northern Ireland, Simon Reid, Deputy CDO, 1 November 2012 ([dhsspsni.gov.uk](http://dhsspsni.gov.uk))
8. Decontamination into Practice (Part 1: Cleaning of dental instruments (2007); Part 2: Sterilisation of dental instruments (December 2011)), SDCEP ([sdcep.org.uk](http://sdcep.org.uk))
9. Re-use of re-usable endodontics files and reamers – note re: relaxation of the guidance provided in HTM 01-05, DH, 2010 ([dh.gov.uk](http://dh.gov.uk))
10. NHS Scotland, 21 Nov 2012 ([scottishdental.org](http://scottishdental.org))
CQC changes approach to dental partnerships

Dental partnerships no longer have to cancel and reapply for their Care Quality Commission (CQC) registration every time a dentist leaves or joins.

The CQC is now listing partners as a condition of registration in its Notice of decision and Certificates of registration. This means partnerships only need to complete a form to apply to vary the conditions when there is a change in personnel.

Partnerships will be able to move to the new registration format when they make their first partnership change. For details of how to change your condition of registration, see the CQC website1.

Countdown to CPD deadline for DCPs

Dental care professionals who began their 5-year CPD cycle on 1 August 2008 must have completed their 150 hours by 31 July 2013.

If you are in this group, you have until 28 August 2013 to declare your completed CPD on your eGDC account or risk losing your registration. You also need to keep a written record for five years, as well as your certificates for the required 50 hours’ verifiable CPD, in case you are selected for audit.

New-look DDU website

We launched our stylish new website in January. Visit theddu.com to see the transformation. You can customise your experience and ensure the advice and support you need is at your fingertips. We are already working on further improvements and we would love to hear your thoughts so please email us at feedback@theddu.com.

1 www.cqc.org.uk/organisations-we-regulate/registered-services/making-changes-your-registration
Membership

Dermal fillers and DDU indemnity

From 1 April 2013, we are asking members performing treatments with dermal fillers to ensure the filler is one which has been approved for use by the US Food and Drug Administration (FDA)*. We expect that practitioners will use fillers which also have a CE mark (which relates to production standards, not efficacy). After that date, it is unlikely that we will provide support or representation for any matter arising from a treatment or procedure carried out involving a dermal filler which is not on the FDA list.

We have taken this step in response to reports from indemnity providers in other European countries of increasing litigation in respect of the use of filler products. The FDA approved list of fillers was selected in the absence of any UK or European regulation of the efficacy of such products.

We have written to members affected by this change. The list of FDA approved fillers can be found on their website: http://bit.ly/approvedfillerslist. We appreciate that some of the fillers on the FDA list have slightly different brand names in the UK and confirm that we are happy for members to use the equivalent UK product where the name differs but the manufacturer and product are the same. We are happy to provide clarification on this point to any member with queries.

If members wish to continue to administer fillers which have not been approved by the FDA they are of course free to do so but they would need to review their indemnity arrangements for such work.

Submitting patient information to the DDU

Many members will be considered data controllers under the Data Protection Act 1998 and are required to inform patients how the data they hold about them will be used. This may include providing information about the patient and the treatment they received to us or other legal advisers in the event of a complaint or claim.

When seeking dento-legal advice from us, please remove or blank out information that would identify the patient’s concerned, unless we have requested original or copies of patient records. However, if anonymising data, please include the patient’s initials and date of birth to help identify the case.

Free online CPD

Test your dento-legal knowledge by working through our new online dental ethics and law assessment tool. It contains various ethical and legal examples, can help strengthen your understanding through a multiple choice assessment and can provide you with five hours of free verifiable CPD. Visit Learn and develop on our website theddu.com.

New faces

We saw a 32% increase in claims in 2012 compared to the previous year. To ensure we are able to provide members with the same high standard of service, the claims department has taken on four new claims handlers.

- Adam Penny has worked for the MDU for seven years, first as a membership services adviser and more recently in a support role within the claims department.
- George Ducros has worked in general insurance for about nine years as a claims handler and underwriter. He joins us as a dental claims handler.
- Amelia Lunning graduated in 2010 with a law degree and initially worked in the clinical negligence department at a claimant law firm before joining the DDU.
- James Breese graduated in 2011 with a law degree before completing a Legal Practice Course. He has worked in city-based commercial law firms with large insurer clients.

In addition, the DDU’s parent organisation, the MDU, has a new president. Dr Peter Williams graduated in zoology from Cambridge University before changing career to become a GP and later a medico-legal expert. For the last five years he served as vice-president under Dr Chris Evans who stood down in September 2012.

Excellent service from the DDU

Our membership team has been accredited under the prestigious Customer Service Excellence programme, a recognised independent benchmark of excellent service.

The Standard tests in depth the areas that research shows are important to members – delivery, timeliness, accuracy, professionalism and staff attitude – and places great emphasis on how well we understand members’ experience of service.

David Cardno, head of membership, said: ‘The service innovations and focus on quality we have introduced over the last two-three years were critical to gaining accreditation.’

Following the accreditation, we also went on to reach the finals of the UK Customer Experience Awards 2012, in both Overall Customer Experience and Training categories.


Held at ExCel, London on 25-27 April 2013. We will be on hand to discuss any membership and/or advisory questions you may have.

For more information about the event visit www.bda.org/conference

*Insured cover for claim notifications arising from non-FDA approved filler use after April 2013 will extend up until the end of a current policy year.
I graduated from Liverpool Dental School last July and I have been a foundation dentist for the last six months, working in a two-dentist practice. It is located on the edge of an area with high dental needs so there is rarely a dull day.

As well as my dentist colleagues, I work alongside a dental therapist, four dental nurses and a practice manager. Meeting them all for the first time during my induction was pretty scary, especially when I considered how closely we would be working together. However, we went out to dinner later which was a great opportunity to relax and get to know the team.

When I saw my first patient the next morning, I remember being very nervous but it helped to remind myself that I wasn’t doing anything I hadn’t done before. That’s why in training you repeat procedures until they are second nature!

In these early days, I found the freedom from being a student to be exhilarating and daunting at the same time, but it’s amazing how quickly I adapted to the new weight of responsibility on my shoulders.

Before I became a foundation dentist, I thought I would be doing the same procedures I carried out as a student; such as fillings, prosthetic work and extractions. To an extent this is true but at the same time I am learning new techniques and different approaches to clinical scenarios. The experience and confidence I have gained has been amazing. My trainer says one of the reasons she works with foundation dentists is because she likes to see how we develop as dentists and I understand why.
Another of my early concerns was how I would be able to increase the speed at which I worked so I could keep up with everyone else. However, it’s important to remember that when you start out you will be unsure and slow compared to your colleagues. Efficiency doesn’t come overnight and your trainer is there to support you. I ask mine for help whenever I have concerns or need a second opinion.

Perhaps, one of the most difficult moments for me came when I examined a patient who had not attended in a while. My heart sank when I noticed a patch at the back of his mouth. After explaining to the patient that I had seen something unusual and I wanted another dentist to take a look, I consulted my trainer. She agreed there was cause for concern and we arranged an urgent referral for the patient to the local maxillo-facial unit. It was difficult to answer the patient’s questions but I managed it appropriately and helped to support the patient through what has been a life changing event.

Another challenge has been the lack of understanding among some patients about the dangers of neglecting their oral health and, sadly, their general health. I have had to learn to pass on information to people in ways they can understand and work with them to set and achieve realistic goals. It has certainly made me realise the importance of good communication skills in dentistry.

I have also realised the importance of learning to say ‘no’ to patients as part of your professional duty of care. Don’t carry out a particular treatment if you do not feel it is in your patient’s best interests. Seek advice instead. Your defence organisation is a great place to ring – there is a reason why the DDU has a 24-hour hotline.

My experience as a foundation dentist has inspired me to learn more about other areas of practice and I am now considering applying for a DF2 post. However, general practice also offers a good education and the opportunity to study.

My advice for newly-qualified dentists is that life after dental school initially feels a bit daunting. However, being a foundation dentist is incredibly rewarding and you should have a strong support network around you as your nurse, trainer, deanery and defence organisation are all there to help. Earning a salary doesn’t hurt either!

DDU adviser, John Makin

I share Jonathan’s enthusiasm for DF1 Training. Over twenty years’ experience in training new dentists has convinced me of its benefits to the trainee, the trainer, the profession as a whole, and our patients.

The DF1 year provides an opportunity to build upon graduates’ technical skills, knowledge and experience but it also demonstrates the fundamental importance of non-clinical elements of the curriculum such as communication and professionalism which are likely to form the basis for revalidation in the near future.

DF1 Training lays the foundations for career-long reflective and self-directed learning which is essential for all dental professionals. For example, the DF1 Personal Development Plan (PDP) is a carefully crafted educational tool that enables foundation dentists to identify their experience and learning needs in discussion with their trainers and to track their progress.
In the fourth of our series on career pathways for dental graduates, we focus on special care dentistry.

Special care dentists treat adolescent and adult patients who cannot receive routine dental care because they have a physical or mental disability or another medical condition. The GDC’s Annual Report and Accounts 2011 states that there are 309 specialists on the register of special care dentistry, which was established in 2008, and is the most recent speciality to be approved.

As a dentist in this specialty, you will be expected to take a holistic approach to the management of patients with complex needs and in general, your focus will be on the provision of oral care rather than specific dental procedures. Patients with special needs may benefit from behaviour management techniques, but may also require sedation or general anaesthesia before they can be examined and so care may be provided in a hospital as well as in a community setting.

Training
You can apply for specialty training in special care dentistry after completing two years’ dental foundation training. Additional qualifications, such as the Diploma of Membership of the Joint Dental Faculties (RCS England) are not necessary but will be helpful. However, you need to show you have covered the competency areas specified in the UK Dental Foundation Programme Training and be able to demonstrate a focused interest in special care dentistry.

You would usually expect to complete full-time specialty training in three years and your training post will provide supervised experience in a variety of hospital and community settings. The theoretical aspects of the training programme may be delivered through attendance at a university dental school or distance learning.

‘Less than full-time’ training options are available (ask your postgraduate dental dean) and there are opportunities to pursue academic training, research or undertake higher degrees through deanery approved integrated combined academic and clinical programmes.

Areas that you will cover in your training, as set out in speciality training curriculum,
Working in special care dentistry

Tim Friel is on the GDC’s Special Care Dentistry and Prosthodontics specialist lists.

I was eligible to join the GDC’s specialist list in Special care dentistry under its two-year ‘grandparenting’ scheme. After qualifying in 1988, I worked in the Community Dental Service for 17 years and completed an MSc at the Eastman Dental Institute. I currently teach at Barts and the London School of Medicine and Dentistry, where I also treat patients who have been referred for specialist dental care.

It’s a great privilege to work with patients who have special care requirements and I enjoy the challenge that each patient brings: problem solving and practical skills are as important in this specialty as technical expertise. You might have to arrange transport for the patient to the surgery before you can treat them.

A holistic approach to patient care is essential, which may involve networking with healthcare professionals and carers to meet their health and emotional needs, as well as their dental needs.

Another challenge is recognising what treatment is most appropriate for your patient. You might want to carry out complex treatment that you believe will transform a patient’s oral health, but sometimes you have to be pragmatic about what is in their best interests.

“I’m a great privilege to work with patients who have special care requirements and I enjoy the challenge that each patient brings.”

I would advise newly-qualified dentists with an interest in special care dentistry to get as much experience as you can in different aspects of dentistry first. This will enhance your professional skills and stand you in good stead if and when you decide to go for a training post.

As a past president of the British Society for Gerodontology, I also recommend looking at the websites of specialist societies such as the BSG and BSDH if you are interested in specialising in this area.

A copy of the specialty training curriculum in special care dentistry can be downloaded from the GDC website.
Avoiding complaints about fees

Dental fees are a factor in many of the complaints reported to us by members. Common reasons include a patient’s assumption that their treatment was being provided under the NHS rather than privately; concern that the actual cost of treatment was higher than expected; and anger about being charged for treatment which the patient believes has not achieved the desired result.

Many fee disputes stem from a breakdown in communication and unfortunately the outcome can be the loss of a valued customer, and in some cases, bad publicity.

It is in your own and your patients’ interests that fees are agreed in writing up front. It is part of the consent process, but it also helps reduce the chances of a complaint and demonstrates good practice in the event of a GDC investigation.

“Many fee disputes stem from a breakdown in communication”

Office of Fair Trading

In 2012 the Office of Fair Trading (OFT) investigated the dentistry market, including how dentistry services are sold and whether patients have access to accurate and impartial information. The OFT concluded that there wasn’t sufficient justification to refer the case to the Competition Commission but warned:

“Dental patients commonly have insufficient information with which to make informed decisions about their choice of dentist and the treatments they receive. We also found that each year around 500,000 patients may be provided with inaccurate information by their dentist regarding their entitlement to receive particular dental treatments on the NHS and, as a result, may pay more to receive private dental treatment”.

Leo Briggs, dento-legal adviser with the DDU, provides some useful tips on how to avoid complaints about your fees and treatment plans.

- **Set out your services and charges in practice notices and on your website.**
  As part of its investigation, the OFT carried out a market survey of 3,400 patients in England, Wales, Scotland and Northern Ireland. It found that 39% reported that NHS prices were not displayed and 56% reported that private charges were not displayed in practices that provide some private dental work.
  To avoid misunderstandings, be clear about the services available at your practice and the costs. Include, for example, whether you currently accept NHS patients (or private capitation schemes or provide treatment on a private basis); and payment arrangements, e.g. whether you expect patients to pay for their treatment up front or on completion. If you offer treatment on the NHS, it’s a good idea to download the NHS dental charges leaflet and poster from the NHS Business Services Authority website and display these in your practice.

- **Provide a treatment plan which includes costs.**
  The OFT’s survey also found that 82% of patients who received treatment which they had to pay for did not receive a written treatment plan.
  The GDC’s *Principles of Patient Consent* states: ‘whenever a patient is returning for treatment following an examination or assessment, give them a written treatment plan and cost estimate’. Ensure the written treatment plan has been agreed and signed by the patient, and a copy kept in the records or scanned onto computer held records. It should specify the costs of treatment, including whether the patient has chosen to have some elements of treatment on a private basis and the charge for these.

- **Inform the patient if the cost changes during a course of treatment.**
  Inevitably circumstances may change and you might need to change your treatment plan. For example, caries may be more extensive than initially anticipated, which may necessitate root canal treatment.
  It’s a good idea to warn the patient if you believe further treatment may be required and advise them of the additional costs that might be involved. If you need to revise your treatment plan, you must inform the patient, obtain their consent and issue an amended written treatment plan and cost estimate (GDC *Principles of Patient Consent*, paragraph 1.7).

- **Don’t put any pressure on a patient to accept private treatment.**
  It is acceptable to tell NHS patients about the option of having treatment privately as part of your discussion about proposed treatments and you should respond fully to any questions the patient has about costs. However, dentists should not put pressure on the patient to accept private treatment. For example, it is not acceptable for a dentist to tell an NHS patient that they cannot carry out treatment available on the NHS such as root canal treatment, but then offer to do so on a private basis. Nor should the quality of NHS treatment be denigrated to encourage patients to pay for private care, such as claiming the materials used are less durable.

- **Be careful about offering discount vouchers for treatments.**
  Be wary of taking part in discount voucher schemes for treatments such as tooth whitening, as you are effectively committing yourself to providing treatment which may not prove clinically necessary, appropriate or in the patient’s best interest on examination. If the patient has paid for and expects a particular treatment which is not in their best interest, and you are obliged to disappoint them, it could prompt a complaint.

- **Ensure that patients are not ‘rushed’ into treatment.**
  Time-limited discount offers may be an effective promotional tool in some businesses to encourage customer take-up but encouraging this kind of snap decision-making is likely to be counter-productive when it comes to elective dental treatments. Instead consider providing a ‘cooling off’ period before expensive or extensive procedures begin, so patients have the opportunity to reconsider and don’t later feel they were rushed into a costly decision they regret, which could invite the allegation that valid consent had not been obtained.

References

1.*Dentistry: An OFT market study*, OFT, May 2012
2.*NHS dental charges April 2012*, NHS Business Services Authority website, accessed 6 January 2013
The GDC recommends that dental professionals update their knowledge of contemporary standards of practice regularly and keep up to date in legal and ethical issues and complaints handling by undertaking general or verifiable CPD.

These questions are based on articles in this issue. If you find that you have answered any questions incorrectly, you may wish to reread the relevant article. Answers can be found at the bottom of the page.

1. Which two of the following should be included in a Statement of Manufacture, under the Medical Devices Directive?
   - A. Your name and business address.
   - B. A statement that the device is a custom-made dental appliance, intended for exclusive use by a named patient.
   - C. A lifetime guarantee.

2. By what date should a DCP’s registration be renewed each year?
   - A. 31 December.
   - B. 1 April.
   - C. 31 July.
   - D. 1 January.

3. Can a clinical dental technician treat a patient with implants without a treatment plan from a dentist?
   - Yes ☐  No ☐

4. Which of the following might help demonstrate insight and remediation following an adverse incident?
   - A. A refund.
   - B. An apology.
   - C. Identifying deficiencies and undertaking further training.
5. What are the two benchmarks for infection control set out in HTM 01-05?

6. What is the name of the new inspection regime in Scotland and how often will practices be assessed?

7. How long is the CPD cycle for DCPs?
   A. Three years.
   B. Five years.

8. In what year did the GDC establish its special care dentistry specialist list?

9. Which one of the following should a written treatment plan always include?
   A. The cost of treatment.
   B. How the patient is paying for their treatment – debit card or cash.
   C. A disclaimer in case the treatment does not work.

10. Why are cooling-off periods a good idea before expensive procedures?

Answers
1. A and B
2. C
3. No. CDTs can treat edentulous patients without a dentist's prescription but this doesn't include patients with implants. A and C. You might decide to offer a patient a refund as a goodwill gesture but it isn't a substitute for reflecting on what went wrong and learning from your mistakes.

1. Essential quality requirements' and 'Best practice'. If you do not currently comply with best practice, you are expected to have a detailed plan on how you will achieve it. Combined practice inspection (CPI) scheduled inspections will take place every three years. 2. 2008. 3. A.

4. B and C. You might decide to offer a patient a refund as a goodwill gesture but it isn't a substitute for reflecting on what went wrong and learning from your mistakes.

5. A and B. You might decide to offer a patient a refund as a goodwill gesture but it isn't a substitute for reflecting on what went wrong and learning from your mistakes.

6. No. CDTs can treat edentulous patients without a dentist's prescription but this doesn't include patients with implants. A and C. You might decide to offer a patient a refund as a goodwill gesture but it isn't a substitute for reflecting on what went wrong and learning from your mistakes.