SECTION 1

# What is risk management?

Receiving a complaint from a patient or a solicitor's letter informing you of a patient's intention to sue for an alleged act of negligence is very upsetting. For many dentists, such events are devastating. After trying to provide the best service possible to their patients, to get a '*Dear Sir, on behalf of my client . . .*' in the post is guaranteed to occupy your thoughts and provide some sleepless nights!

The increasingly litigious population, combined with Government and media encouragement to complain has resulted in a spiralling number of patient complaints and claims. One thing's for sure – it'll get worse!

Sorry to be so depressing – but it's time to get real. Risk management is about getting real. Looking at the real risks and addressing them in a real, sensible and methodical way.

Good medical indemnity insurers will encourage you to risk manage your practice and the really good ones will find a way of helping you to do it.

OK, so what is risk management?

Try this:

*Risk Management is an insurance and quality control related discipline comprising activities designed to minimise the adverse effects of loss upon a healthcare organisation's human, physical and financial assets through:*

- Identification of Loss Potential
- Loss Prevention and Reduction
- Loss Funding and Risk Financing
- Claims Control.

Oh, grim reading! It's the last pompous bit in the book, we promise. Forget that, look at it like this:

1 Identify the risk – establish what is actually likely to go wrong.
2 Analyse the risk – find the chances of something going wrong, its consequences and the potential importance.
3 Control the risk – establish what can be done to reduce, minimise or eliminate it.
4 Cost the risk – calculate the cost of getting it right as opposed to the cost of getting it wrong, i.e. not dealing with it.

One thing's for sure, risk has an impact in all areas of practice:

- clinical activity and awareness of best clinical practice
- the staff
- the premises
- health and safety
- financial assets
- personal risks – reputation and ability to practice.

## Complaints

Let's get this stuff out of the way, right from the start. You're bound to get a complaint sooner or later, so here's how to deal with them with the minimum loss of sleep.

In 1996 a new system for complaints about the NHS replaced the existing system. It was supposed to be better because it:

- gave easy access for complainants
- was simpler than the old system
- separated complaints and disciplinary matters
- made it easier to learn from errors
- created fairness
- provided speedier resolution.

Ho, ho! Ask any dentist who has gone through the grind of an NHS complaint and they will tell you it is, 'cumbersome and difficult'. That is, if they are polite. They are more likely to say, '*&^ %$ ££ ##//>!!!@'!

Here's a quick teach-in on the NHS complaints procedure:

Stages of complaints procedure:

1 Local Resolution including Lay Conciliation (optional)
2 Independent Review
3 Health Service Commissioner (Ombudsman) – not part of the formal process.

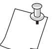
The Complainant **has the right**:

- to be heard and taken seriously
- to request the assistance of the Community Health Council
- to receive a full explanation of facts and events
- to request an Independent Review
- to complain to the Ombudsman if dissatisfied with the outcome of the complaints process.

(The complainant may also complain to the GDC. It used to be a requirement that the complainant swore a statutory declaration of truth when making a complaint. This is no longer necessary.)

The complainant **has the responsibility**:

- to provide a statement of the complaint
- to explain why if still dissatisfied
- to respond within time scales
- to have respect for the process.



## Make a Note

The complainant **does not have the right**:

- to have an independent review
- to have non-NHS work investigated under the NHS procedure
- to restart the process if still dissatisfied
- to demand any particular action or result.

Timescale: the original complaint must be:

- within six months of the event, or
- within six months of becoming aware of a cause for complaint, provided it is within twelve months of the event.

There is discretion to extend.

Local Resolution. The purpose is to:

- investigate, resolve and/or take action
- respond to complainant as quickly as possible.

The Complaints Manager:

- maintains the timetable
- organises responses
- advises complainant on rights, process and timescale
- makes notes of meetings
- tries to find mutual resolution.

The Lay Conciliator:

- is part of the local resolution process
- **is available to either party**
- reviews correspondence
- speaks to complainant and respondent
- investigates and seeks additional information
- writes full and informative letter to the complainant and respondent.

**Make a Note**

Be prepared to work with the conciliator.

Ask for conciliation if the patient is difficult or the complaint is incomprehensible. Co-operation with the conciliator may avoid an independent review at a later stage.

Timescale 2:

- oral complaint – manage on the spot or refer

- acknowledge complaint within two working days or make a full response within five working days (if no acknowledgement)
- full response – ten working days.

**Hazard Warning**

It's not over when you think it's over . . . complainant can apply for Independent Review within 28 calendar days of receipt of response to Local Resolution.

The Convenor. A lay non-executive member of the health authority (health board in Scotland):

- must act without bias
- considers the issues surrounding an application for an Independent Review
- takes clinical advice on clinical issues
- decides whether Independent Review would **add value** to the resolution.

Lay Chairman. Nominated by the Regional Office on behalf of the Secretary of State:

- advises Convenor
- takes responsibility for the process after Independent Review is accepted
- chairs the Independent Review
- writes and circulates draft and final reports after the Review.

Who sits on an Independent Review panel?

- Chairman
- Convenor
- Lay Member
- Two dental advisers.

What happens?

- complainant and dentist are usually seen separately
- each questioned by panel members
- complainant or dentist may make a statement.

**Hazard Warning**

Dental advisers may ask questions and advise the panel but take no part in the decision.

After the Independent Review:

- draft report produced by Chairman and sent to dentist and complainant for comment
- final report to CE of health authority
- report sent to dentist and complainant
- CE decides if there is a need for disciplinary action. If so, a Dental Disciplinary Committee Hearing may be convened.

**Hazard Warning**

Unless you are Perry Mason, (and even if you think you are) never attend an Independent Review alone. You may be accompanied by a friend (LDC representative or defence organisation adviser) but not by a solicitor.

Dental Disciplinary Hearings are similar to the old-style Dental Service Committees.

Timescale 3:

- if Independent Review is requested, Convenor must acknowledge in two working days
- the Convenor must decide on an Independent Review within ten working days
- if panel agreed, Convenor must make the decision within ten working days
- appointment of panel members within ten working days of decision to create a panel
- draft report within 30 working days of formal appointment of panel
- final report within ten further working days
- report sent out to all parties within five further working days.

The Health Service Commissioner (Ombudsman) may investigate:

- dentist/patient hardship or injustice
- out-of-time decisions
- decision to refuse Independent Review.

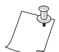
Will not investigate:

- on-going complaints
- disciplinary matters
- those complaints where a claim has been instigated.

**Hazard Warning**

Cases are selective and the Ombudsman only investigates a small percentage. They may take up to a year to achieve an outcome. The Ombudsman has been known to adopt a name-and-shame policy for dentists who remove patients unreasonably from their lists or who fail to apologise when considered appropriate.

The best tip of all: if you receive a complaint, let your medical indemnity insurers know and they will advise you on the best way to deal with it.



**Make a Note**

COMPLAINTS FROM PRIVATE PATIENTS

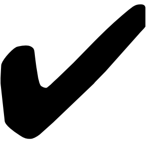
At present no unified system exists for private patient complaints. For most issues that arise within the practice, the same principles apply as for NHS complaints and a similar system can be employed.

Watch out for the impact of the Human Rights Act. This is new territory and no one really knows how it might impact on complaints procedures. As a rule of thumb the process should be independent, known to both sides in advance, transparent and allow for an appeal.

There is a great book on the topic, published by Radcliffe Medical Press, called *Understanding the Human Rights Act* by, well . . . guess who?

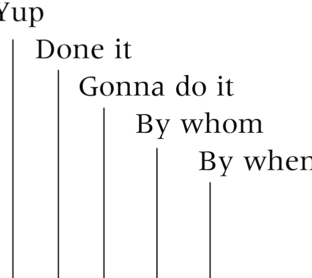
## Complaints checklist

Get this lot right and you can sleep a bit easier!



Yup
Done it
Gonna do it
By whom
By when

- Practice has a system for managing complaints?
- Nominated member of staff to manage the complaints process?
- Timescale for the complaints procedure known to the staff and the dentists?
- Dentists or the complaints manager try to meet any patient who complains to attempt to resolve the problem?
- Details of the complaints procedure published in the Practice Leaflet?
- Details of the complaints procedure displayed on a suitable notice in the waiting area?
- Complaints manager seeks advice about complaints from medical indemnity provider or the LDC?
- If dentist is called to an Independent Review ensure that a dento-legal adviser or an LDC secretary accompanies him.
- Dentist offers an apology if the situation warrants it?
- Practice has policy for refunding payments if the situation warrants it?




- Record kept of all complaints?
- Complaints audited and reviewed within the practice to decide whether there should be action or change and, if so, who should be responsible for it?

## CLAIMS

The risk of a patient making a claim against a dentist is over ten times more likely than it was ten years ago. Currently it is estimated that about one dentist in 30 will be sued by a patient in any given year.

That's just to get your attention! But, it does show how tricky this situation is getting.

However, there is some good news, of all claimant cases:

- three quarters result in no payment to the claimant
- one in five is resolved by negotiation
- only one in 20 gets as far as court.

Take a break and read this next bit – you need to know it and the fact that you do will impress your colleagues! It's all about the so-called Bolam test. Get up-to-speed on the Bolam test with this quick teach-in.

The test respects the fact that medical opinion is not homogeneous, that there is a range of decisions that may be taken in respect of a single patient, all of which may attract the support of responsible doctors. So, the fact that something has gone wrong does not prove negligence. Medicine cannot guarantee results. In order to win damages, the patient must prove that the error was *negligent*.

The principle of law is:

> *A doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . a doctor is not negligent . . . merely because there is a body of opinion that takes a contrary view* (Bolam v Friern Hospital Mngt Ctte [1957] 2 All ER 118)

Although Bolam related to a medical case, it applies equally to dental issues.

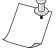
So, what to do if the '*Dear Sir on behalf of my client . . .*' letter from a solicitor turns up in the post, alongside the holiday brochures and the gas bill.

Here's what not to do.

- Don't throw away the solicitor's letter and book a holiday, because if you do they'll cut the gas off!

Here's what you should do.

- Don't panic.
- Don't respond to a solicitor's letter directly, send it to your dental defence company and let them reply – that's what you pay your fees for. And then . . .
- Collect together all relevant notes, correspondence and investigations.
- Do not deface, alter or destroy any of the notes or other records. If you wish to expand previous records for clarification or explanation do so as recommended in Section 7.2 Dental Records.
- Seek an early meeting with your insurer.
- Pay the gas bill.
- Pick a holiday . . .



## Make a Note

Insurers are set up to sort out complaints. They are good at it and that is what you pay the premiums for. They'll love you if you let them know, straight away, that you've got a problem. If you hide the problem then you'll have two problems to deal with, instead of one – the first problem with the patient and the second with the insurers. Insurers understand that even the best dentists and well-run practices will have complaints made about them. They don't see complaints as a black mark – they do see hiding a complaint as original sin!

Here's some other stuff to think about.

- Tell the truth to the person looking after your case, however embarrassing! It gives the best opportunity of achieving the least damaging resolution if they know the full facts.
- Do not let anger cloud your judgement. Stay calm and avoid the red-mist!
- Identify any witnesses that might be able to give evidence for you – practice staff, relatives of the claimant – and give their details to your defence adviser.
- Do not delay in providing required information. Timescales are much tighter under the new Civil Procedure Rules – *see below for an explanation.* ←

And, be prepared to have a discussion about whether or not to defend or settle the claim. Ouch! Yes, we know it hurts your pride. But let's be practical. The best of us make cock-ups from time to time. Is it time to put your hands in the air and say, 'Oops, sorry . . .'? Think about:

- the view of other experts (flick back to the Bolam pages and think again)
- the likely local damage to reputation through bad publicity
- the intensity of *desire to fight* whatever the consequences
- the fact that you are not the only dentist to suffer a claim. It happens to most dentists at some time.

The Civil Procedure Rules: (as promised) ←

The 26 April 1999 was a big day for the lawyers and, consequently, the rest of us! The most fundamental reform of the Civil Justice System since the 1870s took effect.

The new Civil Procedure Rules were the result of a long consultative process led by The Rt. Hon. The Lord Woolf, Lord Chief Justice and head-honcho of the law. They are known colloquially as 'The Woolf Reforms'.

The purpose of the reforms was to:

- ensure fairness allowing both parties to be on an even playing field
- minimise or avoid expense

- ensure that cases are dealt with in ways that are proportionate to value, importance and complexity
- ensure that cases are dealt with expeditiously.

Under the new arrangements a case has to follow a number of protocols prior to commencement of legal proceedings. These 'pre-action protocols' place onerous time limits on the dentist.

**Hazard Warning**

If you have a problem contact your insurer. This is all very tricky and the time limits are tight. You may be in more trouble by not moving quickly than from the complaint itself!

A so-called 'letter of claim' is sent by the claimant or solicitor once there is *an intention to sue*. The timetable requires that the claimant provides details before the process commences, including details of the claim, injuries, etc. A letter of acknowledgement **must be sent by the defendant**, that means you, if you are the dentist, but is in reality your dental defence adviser or their appointed legal adviser, **within fourteen days**. See why it is important not to sit on an ugly letter? Make a resolution to send anything like this to your insurers the day you get it – in the lunchtime post!

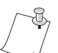
A letter of response must be sent by the defendant's team within three months of the letter of claim. It must state whether liability is accepted or denied, giving reasons. Copies of all relevant documents must be supplied to the patient. Either party can make an offer to settle.

Three months may sound like a long time but it's not if you take into account getting face to face with people, digging up documents, the state of the postal service and the price of chips . . .

There's more . . .

Experts may be instructed but they must be justified by the party providing the instruction.

If the defendant or the legal adviser does not respond to the claimant in full within three months, the claimant may then commence legal proceedings without fear that the costs will not be allowed on the basis that proceedings have been issued prematurely. So now you see why the insurers want to know what's going on. If there's a delay, they don't hit the timescales and the defence goes pear shaped. They are looking down the twin barrels of costs and costs – and they don't like that!



**Make a Note**

The Data Protection Act 1998, which came into force on 1 March 2000, entitles a patient to obtain a copy of all computerised and manual records held by the practice.

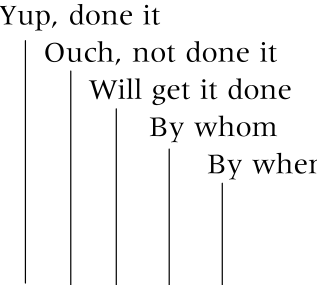
As with the previous data protection legislation, a copy of the dental records must be provided within 40 days of a request by a patient (or his or her legal representative). A reasonable charge may be made for this.

The Access to Health Records Act 1990 now only applies to requests for disclosure of the dental records of a deceased patient.

## Claims checklist

Get this right and you should be OK . . .

| | Yup, done it | Ouch, not done it | Will get it done | By whom | By when |
|---|---|---|---|---|---|
| • If a dentist is aware of an incident that might give rise to a claim is insurer notified? | | | | | |
| • Does the system allow for the earliest possible warning of any claim? | | | | | |
| • Does the dentist recognise the potential hazard in an unexpected outcome, e.g. brain damage, unexpected death, physical damage and iatrogenic injury? | | | | | |
| • Does the dentist know not to respond directly to a solicitor's letter but to contact the insurer immediately? | | | | | |
| • Does the dentist collect together all notes, records, investigations, X-rays and other documents as soon as there is a notification of a possible claim? | | | | | |



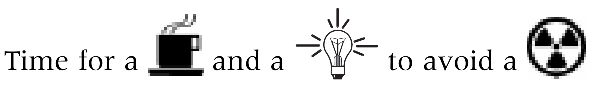

- Does the dentist meet with the case handler as soon as possible to plan the management of the case?
- Does the dentist ensure that he tells the case handler the truth no matter how embarrassing?
- Does the dentist keep all correspondence relating to a legal case in a separate file, not in the patient's dental record?
- Are all dentists and staff instructed not to discuss any claim or potential claim with anyone other than a representative of the insurer or lawyer instructed by them?
- Is all evidence of an accident preserved (e.g. needle broken during injection) in case of claim?
- Are immediate copies of records made to avoid any possible allegations of tampering?

## Consent

Who said you could do that?

Successful relationships between dentists and patients depend on trust and goodwill. When that goes, everything is missing. Preserving the relationship is crucial. However, the balance in the relationship is shifting. The view within the profession is shifting from the dentist providing the amount of information that a 'reasonable dentist' would give in the circumstances (that's the Bolam stuff again – see previous pages), to the dentist having to provide the amount of information that a 'prudent patient' would want to know – from a dentist-centred to a patient-centred emphasis.

Patients have the right to decide whether to undergo any dental intervention, even when refusal may result in harm to themselves. Crazy, but there's loadsa case law on this.




- Consent may be implied, oral or written.
- A patient who opens his mouth to allow a dentist to do an examination may be assumed to have consented to that examination.
- If a patient consents orally, a note should be added to the patient's record confirming the provision and nature of the consent.
- Written consent is not normally essential or a guarantee but provides a useful document if evidence is required months or years later.
- Consent based on clear explanations is essential, and particularly so in situations such as wisdom tooth extraction, sedation and general anaesthesia.
- The GDC requires written consent for GA and sedation procedures.

And . . .

- Patients must be given sufficient information to enable them to make an informed decision.
- The amount of information depends on a range of factors including the nature of the condition, risks and the patient's wishes.
- Patients may need more information about procedures with high risks or with serious personal, social or professional implications.
- Explanations should be given by a knowledgeable practitioner and ideally by the practitioner carrying out the procedure.
- It may be appropriate for the patient to bring a friend, relative, interpreter, etc.

So . . .

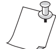
Ensure there is a consent form for any intrusive procedure or any other procedure where a documented record is essential or advisable. Information provided must or may include the following.

- Details of diagnosis and prognosis if the condition is left untreated.
- Uncertainties about diagnosis and options for further investigation prior to treatment.

- Options for management and treatment including the option not to treat.
- Other subsidiary treatments such as pain relief.
- Common and serious side effects.
- Benefits.
- An indication if the process is untested or for research purposes.

And, unless you are Mystic Meg, avoid making assumptions about patients' views. Discuss matters with them and seek information about their concerns. Give the patient a clear explanation of the scope of consent being sought.

- Ensure a system for providing the patient with time (and where appropriate a copy of the consent form). Ideally the patient should discuss the matter with family, friends, etc.
- Ensure that it is understood that 'serious harm' does not mean that the patient would become upset or decide to refuse treatment.
- Ensure that the patient is competent and make a suitable note in the record if you decide that the patient is not competent.



**Make a Note**

A dentist should refer to the patient's GP for a psychiatric or psychogeriatric review to assess competence if he or she is unsure whether the patient is competent.

Explanations may be enhanced by using brochures, diagrams, photographs, etc. Remember, what is routine to the dentist is a once in a lifetime experience for most patients. Once authority is obtained it is important not to exceed its scope – except in an emergency.

Consent must not be given under duress, either from family or the practitioner. A patient should be given time to consider the issue before finally consenting. If they say 'no' and they are competent to say 'no' then 'no' it is, no matter how daft it may seem to the dentist.

The practitioner should ensure that the patient is aware of any hazard which might cause the patient concern or to which significance would be attached. Any relevant information withheld from the patient should be recorded together with the reason for doing so. You'd better have a really good reason to withhold information. Usually it is in the area of, 'to provide it would cause the patient serious harm'.

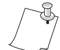
Some patients still hate a trip to the dentist – can't imagine why! Sometimes they don't want to know what you're doing, digging about in their mouth. If a patient declines to know details of their treatment or condition it is still necessary to provide basic information with the option of learning more.

Establishing capacity to make decisions: in legal speak, a person is deemed to have the capacity to make a valid decision to consent or refuse a treatment or other procedure if:

- the issues and information can be understood
- he or she can be believed
- the person can weigh the information in the balance to arrive at a decision.

There's loadsa case-law on this topic and it is a minefield. Common sense is a good guide, if in doubt don't do anything, get a second opinion and above all make really good notes about the decision you arrived at and why.

Remember: no one can provide consent on behalf of an adult, even if the person lacks the capacity to make a decision for him or herself. The existence of diagnosed mental illness does not automatically remove a patient's legal capacity to consent or refuse treatment. Just because a patient is the subject of a compulsory treatment order under a section of the Mental Health Act (1983) (or the Mental Health Act (Scotland) 1984), this does not remove the need to obtain consent for procedures which are unrelated to the mental illness.



### Make a Note

If a patient is not competent to make a decision, the practitioner may provide any investigation or treatment that he or she judges to be in the patient's best interests.

What about the kids then? Mmm . . . tricky this and getting trickier!

Children under 16 may be able to consent to investigations or treatment if they understand the nature, purpose and possible consequences of the proposed treatment and the consequences of non-treatment. They must not suffer duress from family or friend.

Here's a quick teach-in on some stuff you should know about – even if it is only to show off!

**Rights of 'Gillick' Competent Children**

Remember Mrs Gillick? Her daughter wanted to go on the pill. The Doc' said OK. Mum didn't know anything about it, and thought she should have been consulted about the matter. The roof came in and case law was made!

A child is 'Gillick' competent when he or she has sufficient maturity and understanding to consent to the treatment in question. Obviously, children may be capable of comprehending some treatments but not others and not all children develop at the same rate. Children must understand the risks, benefits and consequences of non-treatment and must not make a decision under duress.

However, so long as they are competent with respect to the *particular* procedure proposed, they too are entitled to information and the right to consent to it.

Here's the important bit: 'they are competent with respect to the *particular* procedure proposed'. Remember the recent case where a teenager didn't want heart surgery because she thought the process was too overwhelming and didn't want a life-time of dependency on pills and treatment? The court decided it was good for her and doctors might have been in the difficult situation where they could have forced treatment on a patient who didn't want it. In the end they were let off the hook because the teenager changed her mind and consented to treatment. Phew! Close shave for the Docs.

However, the approach to children is not identical to adults. Adults have the right to consent to, *or refuse* treatment. 'Gillick' competent children have the right to consent, but their right to refuse is more restricted.

The logic for this is that, with children, parents also retain rights to consent on their behalf. So even though a child may refuse treatment, lawful consent may be supplied by a parent.

This happened in *Re W (a minor): Medical treatment* [1992] 4 All ER 627. A sixteen-year-old girl suffered from a serious eating disorder and was at risk of suffering serious harm. She refused her consent to treatment. Her parents both consented. The Court of Appeal ordered treatment to take place in her 'best interests'.

Got all that! What does it mean for the dentist? Well, the short answer, it means the same for the dentist as it does the doctor. Treatment without consent is permitted in certain circumstances (principally life-threatening emergencies). These are highly unlikely ever to arise in dental practice and

should, in any case, be confined to the minimum intervention necessary to save life or to prevent an irrevocable deterioration in the patient's condition.

Pleased you became a dentist and not a doctor?

## Consent checklist

Get this right and you should be OK . . .

Yup, done it
Ouch, not done it
Will get it done
By whom
By when

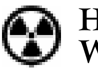
- Do the dentists and staff understand the concept of consent?
- Do the dentists obtain consent for any procedure which might be considered intrusive by the patient?
- Does the dentist seek written consent for more complex or intrusive procedures?
- Does the dentist understand that a refusal to consent to a procedure that would or might be beneficial is the patient's right?
- Does the dentist always obtain the patient's consent before supplying information to a third party?
- Does the dentist ensure that there is a signed consent for any post-marketing surveillance or research?
- If the patient does not sign a consent form does the dentist record consent in the dental record?
- Does the consent take note of the nature of the contract, i.e. NHS or private, and ensure that the patient is consenting to the appropriate treatment?
- Does the consent include an estimate of cost?

## Confidentiality

An ethical requirement of all dentists, confidentiality is the cornerstone of good practice. Patients have the right to expect that information learned during the course of professional duties will not be disclosed. Such confidential information should be protected from improper disclosure when disposed of, stored, transmitted or received. The patient has the freedom to decide which personal information should be made public or semi-public.

If information is not kept confidential:

- patients may be reluctant to, or may refuse to, disclose any information
- inadequate information may impede sound diagnosis or management
- patients may refuse to attend at all



**Hazard Warning**

All practitioners and employees have a common law and professional duty to protect the confidentiality of the patient.

The Caldicot review of Patient Identifiable Information recommended that NHS organisations should be held accountable through clinical governance procedures for continuously improving confidentiality and security procedures governing the access and storage of personal information.

**Hazard Warning**

When documents are destroyed they must be incinerated or shredded with appropriate safeguards for confidentiality throughout the procedure.

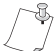
It's not just you – it's the others as well . . .

Dentists are responsible for breaches of confidentiality by those staff that they employ. Essentially **all** information should be kept confidential.

There are some exceptions.

- In the public interest, e.g. to avoid someone being exposed to serious harm or death.
- Where the duty of care to an individual overrides the duty of confidentiality to another.

These circumstances virtually never occur in the context of a dental practice. Or do they? Perhaps you know better!



### Make a Note

What happens when the Old Bill turns up and want to look at 'chummies dental records, guv, 'cos 'e's bitten a bloke's ear off in the pub'?

The police:

- do **not** have access to dental records
- do **not** have access to appointment books.

The answer is, 'sorry officer'. You see, if the police require information they should seek a judicial order under *The Police and Criminal Evidence Act 1984*, or through a court order in Scotland.

If you get a confidentiality issue wrong the consequences are likely to be:

- a complaint to the practice
- a complaint to the GDC – it could be serious professional misconduct
- a civil action.

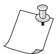
This may lead to:

- damage to personal relationships
- damage to the business
- . . . and a shed load of publicity you can do without.

So please try to get this one right.

### Hazard Warning

If a health authority is aware of an incident involving a breach of confidentiality it may itself refer the matter to the GDC or direct the patient to make a complaint.



### Make a Note

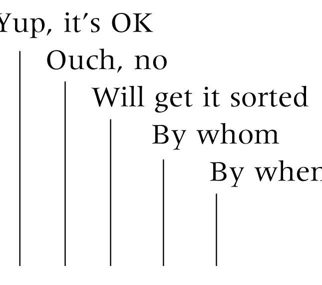
Overall it is usually easier to defend a *failure to inform* than it is to defend an inappropriate breach of information.

There's nothing like gossip!

The Dental Practice environment is a key area where confidentiality may be breached. Casually made telephone calls that may involve the release of patient information, conversations with patients in environments which lend themselves to being overheard and gossip may all result in breaches of confidentiality. Check the telephone environment – is it easy to overhear what's being said?

## Confidentiality checklist

Get this right and you must be nearly there!




- Do the reception staff understand the importance of confidentiality?
- Do the reception staff understand that a breach of confidentiality may result in a disciplinary procedure and could lead to instant dismissal?
- Is it possible to overhear telephone conversations in the reception area?
- Is there a part of the reception where a patient can speak in confidence without being overheard?

# Reviewing the practice

What's it like over at your place?

The only way to find out is to do a risk management audit. Sounds difficult? No, easy stuff. The idea is to spot what is likely to screw up and then do something about it. There are several approaches.

You could hire in an expensive herd of management guru types who would do it for you – and charge so much you'll never be able to afford to eat meat again.

You could ask for the help of your dental defence insurers. They like to know that you're running a tight ship. That way they expect to get less claims.

And, you could sort this out yourself. Here's how . . .

## Eight steps for implementing a risk management system

1 **Identify key risk areas**. The trick here, is to involve everyone. Use brainstorming techniques and interviews with staff to get their views on where the risks are. Take time to review past incidents, check previous claims and complaint histories and talk with patients.
2 **Identify key trigger events**. Look for trends. History is the great foreteller of the future. If it's happened before, what's to stop it happening again? Keep an eye out for national incidents – could it happen to you?
3 **Implement an incident reporting system**. There is no great sin in getting something wrong. The best of well run organisations make a mess of it at some stage or other. The sin is not knowing something has gone wrong, or having the incident covered up. Much has been said and written about the so-called 'whistle-blowing' policies in the NHS. It's daft to call something as important as this 'whistle-blowing'. Who wants to blow the whistle? Makes you sound like a referee at the big match. Encourage the kind of atmosphere in the practice that, if someone does make a mistake, they feel OK about letting people know. British Airways are very good at this. They have a senior captain (nick-named The Pope), who staff can confess foul-ups, glitches and mistakes to without the fear of being bawled out, or given the sack. Encourage a no blame culture. Be sure to cultivate an atmosphere where staff feel able to talk about a 'near-

miss'. It is good to learn from our mistakes but even better to learn from other people's. However, to learn we must know about them.

4 **Investigate high risk events**. When something does go wrong, investigate it immediately, even if all the facts are not immediately to hand. Look into what happened, get a feel for the likely causes and make sure you act quickly to avoid a recurrence, even if it means you put temporary restrictions and policies in place. Better to move first and change back later than have something bad go wrong, again. Take care when obtaining statements from staff. They may be nervous, cautious and feel under threat. Create an atmosphere where they feel relaxed about being frank. Consider support networks for staff and those involved.
5 **Monitor and analyse reports for trends**. Buy an anorak and be a trend-spotter. Risk management is all about trying to predict what might go wrong and the best indicators are likely to be trends. Track complaints, minor injuries, accidents – regularly. They will give you a clue to the bigger picture. Be honest about events and don't be tempted to fudge unpleasant truths. And, don't rush to judgement! If you can do all that, forget the anorak, just wear your underpants over your trousers and jump tall buildings in a single stride!
6 **Implement changes in practice as necessary**. No point having all this trend analysis stuff if you're not going to make use of it. Beware, even where obvious change is called for, it will still have to be 'managed into the practice'. This is true of both clinical practice and managerial practice. Start by ensuring everyone understands the reason for change. Even if they don't agree, make sure they understand the motives behind it.
7 **Education and feedback**. Folk generally don't come to work intent on fouling up. They often do it out of ignorance. Be sure there are regular feedback opportunities and, where necessary, staff training and education initiated so that risks in the future can be avoided.
8 **Consider an outside company with expertise in risk management**. You cannot expect to have all the answers, but you can be expected to know where to go to find them. Start by networking with other practices. Have they had the same problems? Compare your problems and share your solutions. Use a guru, but watch the costs.

Other sources of help may include:

- the health authority
- the Local Dental Committee
- the Primary Care Group (or LHCC in Scotland)

- commercial organisations such as pharmaceutical and insurance companies
- the Faculty of General Dental Practitioners, the Royal College of Surgeons.

Try this simple ranking system to get a feel for the size of the problem:

| | Likelihood of Hazard | | Severity of Consequences |
|---|---|---|---|
| Risk = | Likelihood of Hazard | × | Severity of Consequences |

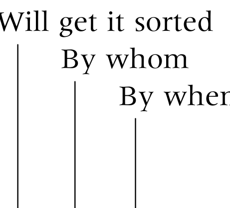
Risk factor = Numerical Representation of Risk

Where one is low and five is high, take a number between one and five to express the likelihood of the hazard and the same for the severity of the consequences. Multiply them together and use that as a numerical expression of relative risk.

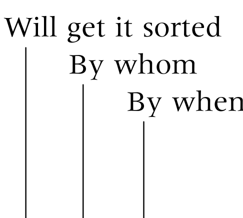
## Who's the risky person?

Appoint someone in the practice to be the risk management lead. Here's a basic outline of what you can expect them to deliver.

For each part of the practice:



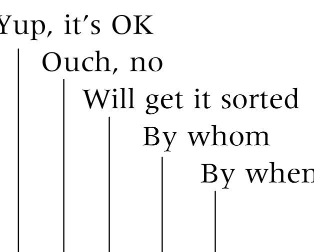

- define the hazard – use brainstorming, analysis of any data, information from service users
- define the potential risk sufferer – the clinician, the practice, the staff or the patient, carer or family
- identify existing controls
- identify requirements to achieve improvement




- identify who in the practice can take the responsibility for achieving the change – can it be a part of the normal day, do they have the skills, do they need training, what are the financial implications?
- set realistic targets for improvement
- record progress
- measure outcomes by audit and peer review.

## Practice review checklist

Do this and you are on your way . . .



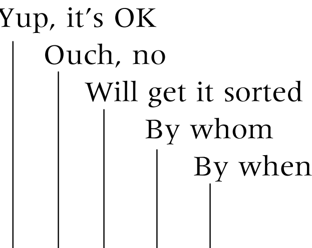

- Are there arrangements in place for the practice team to develop their own checklist for reviewing the practice?
- Is there a system in place for reviewing the practice for risk?
- Is there a mechanism for staff to report 'near misses'?
- Is there a mechanism for patients to pass suggestions to the practice (e.g. through a suggestion box)?
- Is there a staff member to identify, implement and co-ordinate any risk reduction procedures in the practice?

# The environment

No, not the hole in the ozone layer just above the surgery. This is about the surgery. It's cost a lot of money to build and maintain and it's worth looking after even if only for the sake of making sure it continues to make a substantial investment in someone's pension fund. More importantly, the public are in and out of the place and staff work there. Consequently, it must be safe for the public and meet all the requirements of health and safety. *(There's more on Health and Safety later in the Tool Kit).*

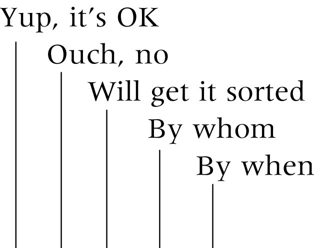
The surgery should be thoroughly inspected by a team of staff, including one or more of the dentists, the practice manager, a dental nurse and one or more senior receptionists. The assessment should be done from the perspective of the patient, both adult and child. Each area should be examined in turn and any risks identified, analysed and solutions sought.

Here's a list of the type of things they should be looking for:




The Reception/Waiting Area:

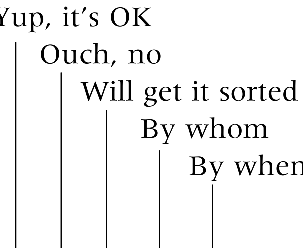
- Is the entrance door easy for a patient to open?
- Is there a disabled access?
- Is the reception on one level?
- If doors are fully glazed are there markings to indicate the presence of glass for a partially sighted patient?
- Is glass in doors toughened or laminated?
- Is there a part of the reception desk at a suitable height for patients in wheelchairs?




- Is there a hearing loop for deaf patients?
- Is there an area where a patient can speak in confidence to a receptionist?
- Is the telephone situated such that patients waiting in reception cannot hear conversations with patients?
- Is the telephone system adequate for the number of calls received?
- Are there sufficient chairs?
- Are patients kept informed of delays in being seen?
- Are there adequate instructions about what to do if not called within an agreed time?
- Are all parts of the waiting area visible to staff?
- Is the area adequately heated and ventilated?
- Are carpets of good quality (not frayed) and suitably fitted to minimise the risk of a patient tripping?
- Are floors safe and not slippery?
- Is there a notification about complaints, concerns and compliments?

Toilets:

- Do they meet requirements for disabled patients?
- Is there an alarm for a patient unwell in the toilet?
- Can the door to the toilet be opened by a staff member from the outside?




Consulting/Treatment Rooms:

- Is the dental surgery of adequate size, heated, lit and ventilated?
- Is the dental chair appropriately located and is the dental light in the correct position for maximum illumination?
- Is the sharps box inaccessible to small children?
- Are instruments, syringes, etc. kept securely?
- Are prescription pads and other documents kept secure?
- Is the room equipped with a panic alarm?
- Are there secure facilities for infected and other hazardous waste?
- Is the floor safe?

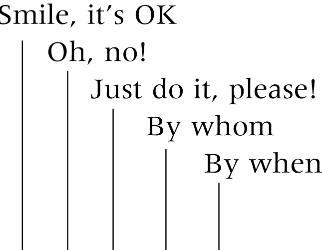
General:

- Is the lighting adequate?
- Is the décor of suitable colours for partially sighted patients?
- Do doors open safely?

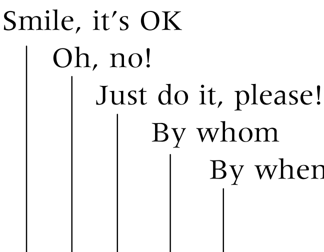
The standards expected of surgeries are rising. It is a good idea to inspect the whole building on a regular basis to ensure that standards are met.

## Practice environment checklist

Just when you thought you'd done it all – just to be sure . . .




- Does the practice have a disabled access?
- Does the practice have a part of the reception area accessible to patients in wheelchairs?
- Does the practice have a hearing loop?
- Can a patient speak privately to a receptionist in the reception area?
- Can the patients read any information about other patients recorded in appointment books, message books or dental records?
- Are any VDU screens in the reception area that may show patient information visible to other patients in the reception area?
- Can patients overhear information about other patients?
- Are there disabled toilet facilities?
- Are there adequate toilets for male and female patients and staff?
- Is there an effective appointment system which has the flexibility to meet the needs of patients with emergencies.
- Can a patient obtain an urgent appointment quickly?
- Are patients notified if the dentist is running late?
- If a dentist is running late can the patient be offered an appointment with an alternative dentist if appropriate?




- Does the practice display any appointment targets, e.g. maximum waiting time to obtain an appointment?
- Are the practice telephone numbers clearly displayed in the practice leaflet and in the waiting area?
- Are the receptionists given clear instructions about how to manage an urgent call received at reception?
- Is the reception notice board regularly inspected and obsolete notices removed?
- Are there adequate telephone lines for the practice?
- Are the receptionists trained in interpersonal skills?
- Is communication good between staff members?
- Does the practice comply with the Patient's Charter requirements?
- Is the practice developing protocols for use by receptionists?

## Dental records

What's your favourite record? Paul Lambden likes anything by Des O'Connor. Roy Lilley prefers Max Bygraves!

We all know the jokes about doctors' handwriting. No doubt the same is true of dentists! True or not, times are changing and a higher standard of record keeping is becoming par for the course.

Here are just a few of the changes that can impact on record keeping.

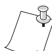
- The greater involvement of patients in making choices about their own dental care.

- Patients' access to their own records.
- The increasing use of computers.
- Clinical audit and governance.

What constitutes 'records'. Well, the rules say records should contain the famous five:

- Identify the patient.
- Support the diagnosis.
- Justify the treatment.
- Document the course and results.
- Promote the continuity of care among healthcare providers.

Clinical records do not have to show that the patient went home with a beautiful smile. They just have to show that the dentist acted reasonably, according to accepted standards, regardless of the outcome . . .



**Make a Note**

The Data Protection Act came into force in March 2000. It replaced the provisions of the Access to Health Records Act 1990 and gives access to the patient to all dental records including all electronic records. The legislation is in force in all parts of the United Kingdom.

By the way, records are supposed to be complete, legible and accurate. The complete and accurate bit doesn't seem to be a problem, it's the legible bit we seem to have most trouble with! *(More later!)*

What else about records? Well, here are five more things they are supposed to do.

- Meet legal and service requirements.
- Provide information and communication between practitioners.
- Document the care as a basis for planning care and treatment.
- Allow for the evaluation and progress of the patient.
- Change therapies where effectiveness has not been demonstrated.

Let's get risky.

Now we know the rules, what are some of the potential risks that we need to manage? Here are a few ideas, to get the juices flowing:

| *Problem* | *Solution* |
|---|---|
| Identify the patient without risk of error – look out for two patients with identical or very similar names. | Make sure the notes have a ***name hazard*** sticker on them. |
| Ensure the continuity of care. | Accurate and contemporary notes, comprehensive. |
| Enable communication between practitioners. | Clear data on what has been prescribed and done, the responses to treatment and a demonstration as to how clinical decisions have been arrived at. |
| Allow for concurrent or retrospective review. | Chronological records of a sequence of events, the factors observed and the response to treatment. |
| Allow for the collection of data for research/educational purposes. | Clarity of all elements. |
| Sufficient information to protect the dentist and the patient. | Allow for patients to examine their own records and be involved in their care through informed consent. Research shows where patients have made a complaint and been shown their records, they are less likely to pursue a complaint if the records are complete and clear. Where they are scant and indecipherable the patient is more likely to become suspicious and pursue the complaint. |

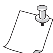
Nothing else could go wrong with documentation, could it?

You wanna bet! Take a look at this lot!

## Legibility

It's not too much to ask, is it? Why can't practitioners write nicely? They say docs write badly so they can get off the hook – they write a squiggle and pretend it means anything. The trouble is, it might mean 'anything' to a fellow dentist seeing the same patient and trying to work off the notes.

The patient has a perfect right to see his or her dental record and also has an entitlement to understand it. The dentist may be called upon to explain the meaning of notes made. Misinterpreting a set of notes can be disastrous. Hypertension can easily be muddled up with hypotension. See what I mean?



### Make a Note

A great trick some barristers play is to ask a dentist to read an entry he or she wrote, perhaps years earlier. If it cannot be read, the dentist looks really stupid – and dangerous. Ouch!

## Exercise

Describe how you would arrange to sample dental records for legibility. Consider issues such as patient confidentiality.

Also, how would you approach a colleague suffering from *chronic-handwriting-unreadability-itis?*

## Blank spaces

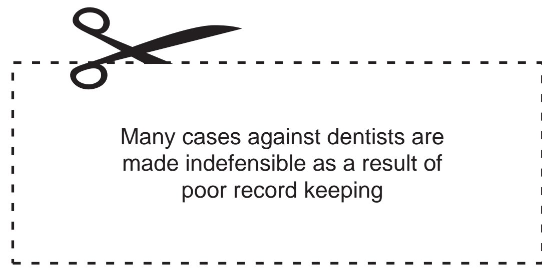
This is a great trick. A few well chosen spaces can be left and filled in at a later date. It has been known to work quite well. The problem is, these days, ink can be forensically dated. Mmmm, embarrassing if a word or sentence in the middle of the notes can be shown to be three years younger than its parent paragraph! Do you like porridge? I think they still serve it in prison, don't they?

## Alterations to the record

Never destroy, or rewrite a previous record, tempting though it may be. In the past it might have been possible to get away with it. The problem is, these days patients have access to their records. If they turn up in court with a copy of their records, which look nothing like the copy you have brought along from the practice – well, it's back to the porridge for someone!

## Are we labouring the point about good records?

Yes, without an apology. Here's a repeat of the reason. Cut it out and stick it on the surgery fridge with one of those magnet thingys, or tape it to your forehead:



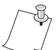

**Here's the gold standard**. The dentist should ensure:

- consistency of reporting and recording
- consistency of record organisation

- consistency of management of the records in respect of completing FP17s (GP17s in Scotland) and organising recall systems
- confidentiality
- quality assurance
- access to information through appropriate recording, clear handwriting and avoidance of the use of unfamiliar abbreviations
- that records are made contemporaneously or as nearly contemporaneously as possible. Writing up records once a significant time has elapsed, brings with it the risk that important facts may be omitted. This could have serious consequences.
- that care is taken that there is no risk of confusing two patients with the same or similar names. If a patient has a common name, e.g. Smith, the notes should carry with them a warning to check the address or date of birth of the patient at the time of the consultation to ensure that the correct notes have been selected. It is also helpful to spell out complex names phonetically to ensure that they can be pronounced correctly during any patient encounter. To mispronounce a patient's name may often set a consultation off on the wrong foot and may be offensive.
- that record entries are made only by those people who are authorised to do so. In general, this will be the dentist, the dental surgery assistants, hygienist and nurse practitioners. Anyone entering information on the record should have a consistent style.

## Isn't all this a bit of a fag?

Many dentists feel that to record all relevant information places a large burden upon them in terms of the time required. It is important to understand that notes are comprehensive if they include all *relevant* data and it may not be necessary to write large volumes. War and peace is not required. However, dentists should certainly be sensitive to any possibility of a treatment or condition where there is a chance that a patient may end up dissatisfied or frustrated at the end of treatment. In such cases, it is particularly important to record the events surrounding the consultation.



## Make a Note

Here's a neat trick

An easy shorthand for managing emergency consultations is to use the SOAP formula. No, not Coronation Street, although it's been around just as long, if not longer! It is used to group the examination and management under four main headings:

- **Subjective**: the patient's own complaints
- **Objective**: the dentist's assessment of the problem
- **Assessment**: the differential diagnosis of the symptoms
- **Plan**: for management and this should be followed by the treatment actually provided.

In assessing what is relevant in the dental record, it is useful to follow a simple rule of thumb. So, in a patient who had not been seen for many years and about whom the dentist had forgotten, from the information in the record it should be possible to:

- establish the clinical state, treatment required and what treatment was provided, when and why
- perform whatever treatment is due for the patient and know why that treatment is necessary.

## Hazard Warning

The dentist is responsible for the acts and omissions of his staff including information documented in the dental record. It is therefore important that the dentist makes explicit what information he does and does not require to be noted down for the avoidance of any confusion.

All records should be legible and signed by the person who made them.

The dentist should regularly check entries made by other staff members to ensure their quality and accuracy. In the event of a complaint or claim arising weeks or months after the event, it will probably be impossible to establish if information written contemporaneously was incomplete or inaccurate.

The record should also include details of any failed appointments.

**Hazard Warning**

One of the biggest problems with dental records occurs when litigation arises and it is not possible to substantiate diagnosis, treatment plan, treatment provided or referral details if they are not supported by appropriate note entries. It is a fundamental requirement that all notes are adequately maintained and therefore a dentist's credibility is seriously diminished if he or she cannot provide documentation to support what has been done.

The measure of the quality of dentist's notes is the good old Bolam test *(see previous references)*. The court will ask what records a reasonable dentist would have kept.

Not only should all routine visits be recorded but every unscheduled or emergency attendance should be noted. It may be particularly important to detail emergency treatment provided because it may be that it is the first sign of a complication or failed treatment and evidence that it was promptly and appropriately managed may be vital in defending the dentist's position.

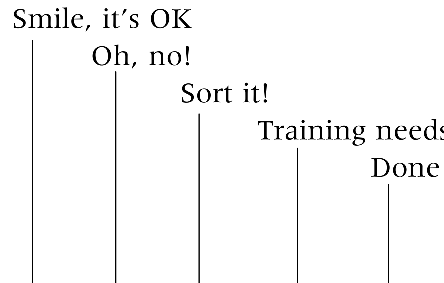
## Record quality assurance

With the development of clinical governance for all doctors and dentists, it is becoming increasingly important that the dentist ensures that his dental records meet quality assurance parameters.

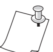
How do you do that? Here's a neat trick . . .

Pick out, at random, (say) 20 records per month and inspect them to check that the information documented is accurate and appropriate and reflects the care actually provided for the patient. This is a very good way to pick up trends in mistakes and that is a good pointer to finding out what needs to be changed and often helps to identify the training needs of staff and colleagues. Be sure to keep a record of the checks as they will form part of the evidence of personal and professional development and maintaining standards.

What to look out for when checking the records?




- Is the record appropriately stored, clean and dry?
- Does the record contain adequate information about the patient's medical history and any medication?
- Does the record contain adequate information about the patient's dental status and any significant diagnostic information?
- Does the record contain information about treatment undertaken and materials employed? Is the dosage and type of local anaesthetic recorded?
- Does the record contain information about any referrals made, to whom they were made and the reasons for making such referrals?
- In the case of private patients and in those patients with insurance plans, does the record contain adequate financial information to enable an assessment of probity if required?
- Are entries legible, signed and dated?
- If abbreviations are used, are they clearly understandable? No jokes or pejorative terms?



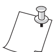
**Make a Note**

Never alter contemporaneous records at a later date. If you need to clarify something, or add a detail, do this:

- add an additional card
- date it with the current date
- explain why the additional record is being added, i.e. for clarification, etc.
- write the additional note and file
- do not write notes in pencil

**Hazard Warning**

In the event of a claim or a criticism, notes can help you swim, or can sink you. If notes are not clear you'll be in trouble if you need to fish them out and refer to them five years from now. Yes, it does happen. If you can't read your notes, the judge will have a go, prosecuting council will have a go and the press will have a field day.



**Make a Note**

For private records it is advisable to retain, store or destroy them using the same criteria as for NHS records.

Here's how:

General Dental Council guidance requires that dental records are stored 'carefully'. There's no definition of 'carefully' but there are some guidelines. The responsibility of the dentist extends to storage, disposal, transfer and destruction of records.

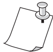
- Current records must be stored on the surgery premises.
- They must be protected from fire, flood and damp.
- Records for patients no longer receiving treatment by the practice must be securely retained.

**Hazard Warning**

Any record documents to be destroyed should be incinerated or shredded with appropriate safeguards for confidentiality during the procedure. So, make sure that the *Friend of the Stars*, Benny the Bin-man, can't rummage through your dustbin. This is particularly important for dentists who have well known personalities as patients.

Thinking about up-dating your computer or sending one off for repair? Read this next bit with care.

> Dentists wishing to dispose of computer hardware should ensure that there is no information on the hard disk that can be retrieved. This is particularly important when computers are being sold or when they are being repaired at other premises. The dentist should be sure, either that the hard disk is fully erased. Alternatively they must ensure that the computer and its hard disk have been destroyed before allowing them to be removed to a refuse tip or for other disposal. In the case of repair, the dentist should take steps to prevent the information on the hard disk becoming available to maintenance staff.



**Make a Note**

So, now you know – looks like time you found out about back-up onto tape, Zip-files or writeable CDs. In the dark? Try your average 15-year-old!

## Patient access to dental records

Oops, this is getting a bit tricky. Now you can see why those naughty little *aide-mémoires* about patients could catch you out.

The Data Protection Act 1998 came into force in March 2000. The Act now covers all health records including all electronic records and permits access to all health records whenever they were made. The Act is in force in all parts of the United Kingdom.

Read this bit again:

The Data Protection Act 1998 came into force in March 2000. **The Act now includes all health records** including all electronic records **and permits**

**access to all health records whenever they were made.** The Act is in force **in all parts of the United Kingdom.**

Get the picture? Old records made 20 years ago on the Isle of Skye still count!

What's a health record? Here's the official version:

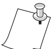
> A health record is defined as any record relating to the physical or mental health or condition of an individual and which has been made by a health professional. This may include electronic data, manual data, sound recordings and video recordings.

What happens when a patient asks for a copy of their records? Section 7 of the Data Protection Act says:

- a request must be received in writing and with the appropriate fee
- access should be provided within 40 days and the patient is entitled to receive a copy of the record
- the standard fee payable is £10 for electronic records and a maximum fee of up to £50 for paper records (this may be about to change restricting the maximum fee to £10 for all records).

A patient may request that inaccurate information in the dental record may be corrected. If dissatisfied he or she may complain to the Data Protection Commissioner or apply to the courts for a certificate of compliance.

The court may order a dentist to rectify, erase or destroy inaccurate data or require that the records are supplemented with a statement setting out the true facts.



### Make a Note

All records are now *disclosable* and the previous deadline of 1 November 1991 under the Access to Health Records Act 1990 no longer applies except in respect of deceased patients.

Information that breaches confidentiality of, or relates to, a third party (who is not a health professional) who has not consented to disclosure, may be withheld.

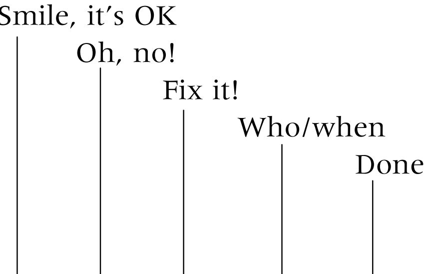
Disclosure may also be withheld if it would be likely to cause serious harm to the physical or mental health or condition of the data subject (patient) or any other person.

Just to cheer you up . . . Data subjects (patients) now have a right to claim compensation for damage or distress caused by a breach of the Act.

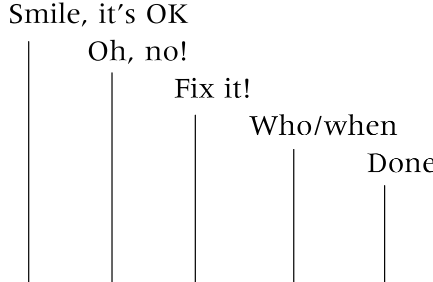
Time for a brew – or something stronger! Whilst you check the check-list . . .

## Dental records checklist

Here we go . . .

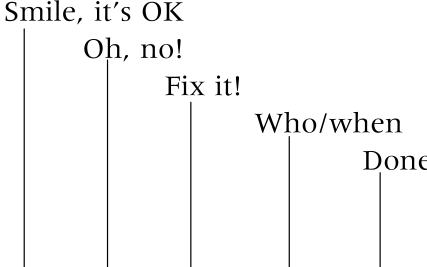



- Are the dental records kept securely?
- Is a system in place for the collection, maintenance, storage, retrieval and distribution of dental records?
- Is a member or members of staff responsible for the confidentiality, security and physical safety of dental records?
- Are dental records maintained in a specific order for easy retrieval of information?
- Is each dental record labelled with the patient's name, NHS number, date of birth, address and registered doctor?
- Is access to dental records appropriate?

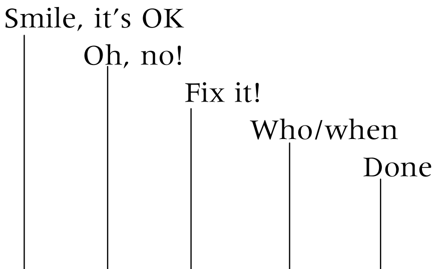



- Do the reception staff understand the *Data Protection Act 1998*?
- Are dental records suitably marked with hazard stickers for patients with similar names?
- Do the notes indicate a patient who may be medically compromised, e.g. taking the drug Warfarin?
- Is there a tracking system for knowing when a dental record is with an individual dentist?
- Is the writing in the record legible?
- Is there a system for arranging the release of patient information? Does this include a written authorisation signed by the parent or guardian where appropriate?
- Is there a procedure for information requiring special release (e.g. HIV, psychiatric detail, alcohol/drugs)?
- Is there a policy for the release of information to a third party?
- Is there a policy for making any charges for the reproduction of dental records?
- Is the dental surgery assistant adequately tutored in dental charting when assisting the dentist?
- Is there a system in place for arranging the removal and storage (if appropriate) of inactive records?
- Are the notes in chronological order?

There's more . . .




- Are dental records of a suitable quality and sufficiently detailed to be understood at a later date?
- Are notes made contemporaneously?
- Do the dentists avoid the use of abbreviations that are not approved?
- Do the dentists avoid the use of disparaging or pejorative terms in the records?
- Does everyone understand that dental records should never be altered at any time after the consultation?
- Are new patient medical history details entered in the dental record when the patient is first seen?
- Do healthcare professionals other than the dentist enter their own notes in the medical record?
- Are errors in dental records deleted by drawing a single line through the note?
- Are corrections clearly recorded, dated and signed by the author?
- When a patient is referred for a further opinion is there a maximum time agreed for the referral letter to be completed and sent?
- Are computer records kept securely and backed up?
- Is the computer kept securely to minimise the risk of theft or damage?



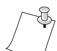

- Is the computer registration with the Data Protection Registry correct and up to date?
- Are arrangements in place to manage requests from patients to amend or erase information in the dental record?
- Is there an effective system to ensure that dentists review all communications and reports before filing?
- Does the dentist initial and date stamp every communication before filing?

How did you make out? Time for something stronger?

## Domiciliary visiting

To go, or not to go? That is the question.
Here are the rules:

> An NHS dentist under his Terms of Service shall visit and treat a patient, whose condition so requires, at the place at which the patient normally resides or is temporarily resident, provided it is not more than twenty miles from the practice premises.

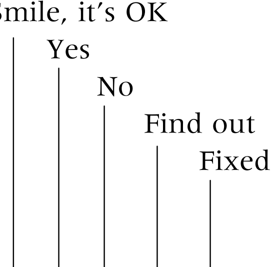


**Make a Note**

A dentist who provides services privately may make whatever visiting arrangements he or she wishes with any patient who cannot attend the surgery.

Private or not, the same standards of care and treatment are expected whether they are provided in the practice or in a domiciliary visit.

### Visit checklist




- Does the dentist provide a domiciliary visiting service?
- Does the dentist, if working under the terms and conditions of the NHS, understand the rules concerning mileage incurred when multiple visits are undertaken?
- Does the dentist understand that a lower standard is not acceptable because the patient is not seen in the surgery?
- Does the dentist make arrangements to have a chaperone present whenever appropriate?

## Message taking

Message taking? What's that got to do with risk management?

Well, strictly speaking, nothing, something, everything, zilcho and a hell of a lot. Look at it this way. The receptionist is the front-of-house, shop window, first port of call, scene setter and fixer. If the receptionist is pleasant, efficient and on top of the job, a lot of potential problems fly out of the window. If they are rude, flustered, badly trained then

appointments get screwed up, messages muddled up and the whole thing becomes a foul-up. A busy practice may receive thirty or more calls an hour and it is essential that any information received for onward transmission to a dentist is taken accurately and reliably and appropriately recorded. Here are a few simple rules and training tips to make a patient's first contact with the surgery a delight. It then allows just the dentist to make a mess of things!

Receptionists, please, when speaking to a patient on the telephone:

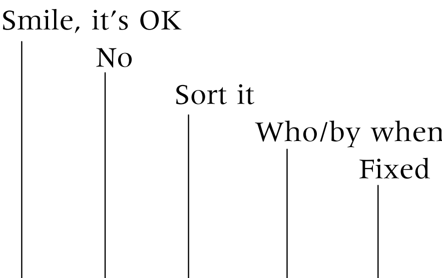
*Check!*

- identify yourself
- make notes of date and time of call and all relevant information in the message book
- make sure that the call recipient signs each entry
- if the message is taken by the receptionist ensure that the message is passed to the dentist, either immediately if it is urgent or at the first possible opportunity
- ensure that the dentist confirms receipt of the message by signature in the message book.

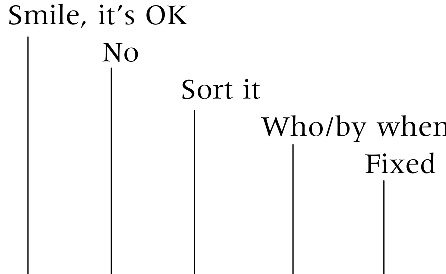
Thank you!

## Message taking checklist

Get this right and you should be OK. Get the message?




- Does the practice have a message book?
- Do the receptionists enter messages according to a protocol, i.e. name, address, telephone number and message synopsis?
- Does the dentist sign the message book when a message is collected?




- Do receptionists have authority to give patients information about themselves over the telephone?
- Is there a policy and do receptionists understand that information should only be given out to the patient to whom it relates and not to a third party or left on an answering machine?
- Are all staff aware that an acknowledgement or recognition to a third party that a person is a patient is a breach of confidentiality?

## Chaperones

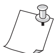
Do we have to spell it out?

Some dentists have been accused of some 'embarrassing' behaviour. The dentist works in close proximity to the patient and there is opportunity for actions by either party to be misinterpreted by the other during examination or treatment. Usually the nurse works in the consulting room but, with a risky patient, what happens if the nurse goes out to develop the X-rays?

Be sure to get this right.

- Ensure a chaperone is present during treatment.
- The chaperone may be a member of staff or a relative but, in the latter case, make sure that the relative is present with the patient's consent.
- The dentist should never make suggestive comments to a patient during treatment.
- Some sedative agents have hallucinogenic properties and may generate sexual fantasies. It is vital that a member of the practice staff is present

during the whole of treatment under sedation of any sort to act as witness and chaperone.
- The dentist should never rest or leave instruments on the chest of a patient during treatment.
- Risks are greater out-of-hours when treatment is provided by a dentist for a patient with an emergency. The dentist should take steps to ensure that they are not alone with the patient.



**Make a Note**

When seeking to examine any patient at any time, ensure you have permission. It is good practice to ask if you can proceed.

**Hazard Warning**

Ensure that the practice has a strategy for managing any amorous advances by a patient. In a group practice arrange for the patient to be seen in future by a dentist of the opposite sex from the 'target' dentist.

The practice principal or practice owner should write to the patient (especially if not prepared to accept the change of dentist) explaining that attention to the dentist in question is neither appreciated nor reciprocated.

If problem persists, warn of refusal to treat further and de-registration from the list, explaining why and reaffirming the unwillingness of the dentist in question to reciprocate. A private patient should be told that no further treatment could be provided.

If a single-handed practice, the dentist should immediately write to the patient advising that advances are not appreciated or reciprocated and that the patient cannot continue to receive treatment at the practice. In the case of an NHS patient the health authority should be notified immediately. Be sure to write in confidence and describe the circumstances as a 'professional relational difficulty'. Don't go into detail or you may find yourself saddled with a defamation case – even if you are right!

## Chaperones and amorous patients

Don't argue/delay/vacillate – just sort it

- Is a chaperone available for any patient who requires one?
- Is the availability of a chaperone publicised in the waiting room or in the practice leaflet?
- Does the practice have a strategy for managing amorous patients?
- Does the practice nurse understand the significance of her role as a chaperone?
- Does the nurse ensure that the dentist is not left alone without the dentist's agreement?
- Does the dentist have any sort of signal to indicate to the nurse that he/she should not be left alone at any time with the patient?