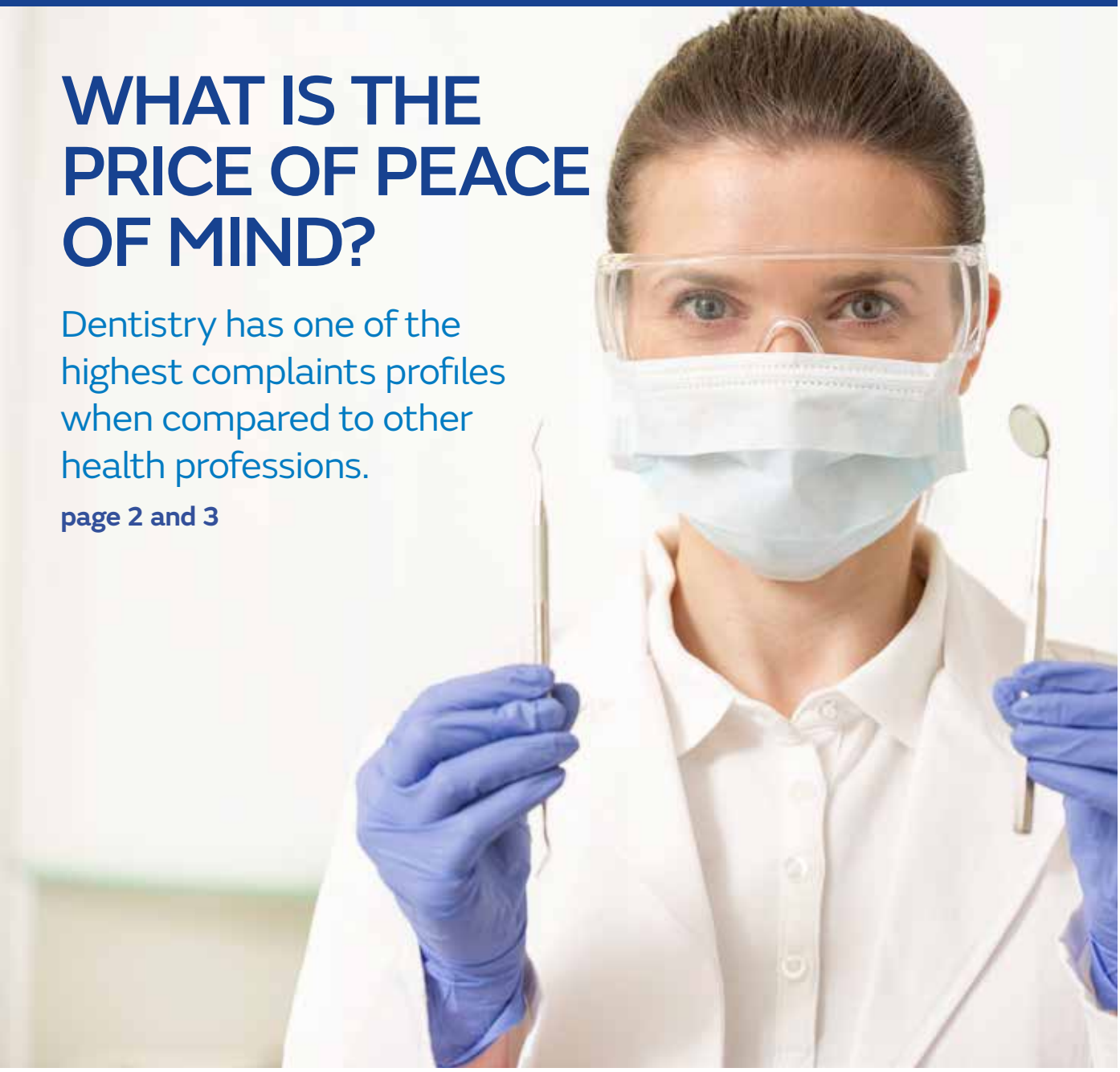
AUSTRALIA

Risk management from Dental Protection
for hygienists, dental therapists and oral health therapists

Dental Protection

# TEAMWISE

ISSUE 21 | **JUNE 2019**



## WHAT IS THE PRICE OF PEACE OF MIND?

Dentistry has one of the highest complaints profiles when compared to other health professions.

**page 2 and 3**

### CELEBRATING EXCELLENCE
Oral practitioner of the year awards

### IATROGENIC INJURIES
What can be done to avoid them

### TIRED AND TEARFUL
There are some classic symptoms of burnout

# CONTENTS




**Editor**
Anna Francis

**Production & design**
Ben Cole

**Print**
Panther Print, Brisbane

**Contributors**
Dr Mike Rutherford, Dr Simrit Ryatt, Dr Annalene Weston and Dr Chris Barker




# EDITORIAL

## What is the price of peace of mind?

It's no big secret that dentistry has one of the highest complaints profiles when compared to other health professions. This year the Australian Health Practitioner Regulation Agency (AHPRA) received their highest number of notifications in a single financial year – 5.5% more than received in 2016/17 and 20.1% more than in 2015/16.[1]

Over 90% of practitioners who provided feedback from the recent AHPRA survey rated the experience of the notification process as "very stressful" and said they would appreciate a more personal approach.[2]

This is why you need to have Dental Protection in your corner – we can walk through that journey with you. From the very beginning, when you receive that first phone call telling you something has not gone according to plan, or when you inform us that you have received a letter of complaint from a patient, regulatory body or lawyer, our experts are there to help.

We can support you with managing patients' complaints, provide assistance with a written response to the varying regulatory bodies, or be by your side and prepare you if necessary for the often-daunting experience of a formal enquiry/investigation. As fellow practitioners with specific clinical knowledge, understanding and empathy of clinical stresses, our experts understand what you're going through.

### ADDITIONAL SUPPORT

Many practitioners may not be aware of the additional benefits membership with Dental Protection provides, including access to a FREE confidential and professional counselling service if you are feeling overwhelmed or traumatised by an adverse event. A benefit that can safeguard your professional reputation, your career, but also you personally!

We appreciate and understand the demands and stress on a dental practitioner's everyday life and how the last thing you want is the additional pressure and anguish of an allegation or formal complaint. Fully trained, qualified and registered psychologists provide the counselling service entirely independently and confidentially. Accessing the service is easy: you can have immediate access to support 24 hours a day, 7 days a week, and face-to-face counselling sessions at a time that is convenient to you.

As pressure does not discriminate, we recently held a national roadshow tour called "Under Pressure". Dentolegal adviser Dr Annalene Weston and medicolegal adviser Dr Samantha King presented on the internal and external pressures of being a dental practitioner and highlighted how to recognise and manage those stresses. If you missed this event at one of the locations, the presentation will be available on our website shortly.

## PROFESSION-SPECIFIC ADVICE

There are many indemnity providers emerging in the current competitive market, all bidding for your hard-earned money and offering protection. Understandably, with the cost of living rising and budgets tightening, the cheapest one may be tempting. However, there is no such thing as "a top quality cheap deal" in professional protection, quite simply because providers cannot charge 'bargain basement' rates whilst also maintaining a high level of service.

Rather, you need an organisation you can trust to have the experience and expertise to help you when new challenges or issues arise.

Complaints or issues are not always determined by your skill or level of professionalism. This is certainly one thing I have learnt in my time as an adviser and case consultant at Dental Protection.

As an oral health therapist who has worked in private practice, government fixed and mobile facilities, and who has had my own business, I can appreciate the differing work environments and individual challenges our group of practitioners can face daily. We all work in varying fields and our environments can be unique to that of dentists. At times, the complexity and dynamic work environments we find ourselves in can place us at increased risk compared to our fellow dental colleagues. Our profession has evolved dramatically over the years and we are constantly faced with change and new challenges.

I greatly commend the respect Dental Protection has given our group of practitioners by recognising our need for a specific adviser. Frequently our matters or areas of complaints can be unique to our group and/or can be complicated by our individual scope of practice and structured professional relationship with dentists.

Often, in the circle of healthcare professional indemnity policies, we are categorised as 'other', illustrating the lack of understanding around how far our profession has come over the years. Dental Protection ensures it keeps its members up to date with information and material specific to each professional category. The Sliding Doors road seminar series was designed specifically for our group of practitioners, based on common real-life situations reported by hygienists, therapists and OHTs, providing our group of practitioners with skills and understanding to manage and lower risk around similar problems they may face in their own clinical practice.

## KEEPING YOU INFORMED

Dental Protection is also committed to providing our group of dental practitioners with up to date profession-specific news and material. As mentioned in our last edition of Teamwise, this includes information on the Scope of Practice Registration standard, which is currently under review.

The Chair of the Board and the CEO of the AHPRA briefed health ministers on the Dental Board of Australia's proposed revision of the Scope of Practice Registration Standard at the ministers' meeting on 8 March 2019.

At that meeting, health ministers agreed to refer the proposed revised standard to the Australian Commission on Safety and Quality in Health Care (the Commission) to independently assess the patient quality, patient safety implications and the consumer benefit of the revised standard, and to report to health ministers at their next meeting in July 2019. Once we have further information, we will inform members as soon as possible. During this period, you must ensure that you meet the current registration standards and guidelines and only practise within a structured professional relationship with a dentist.

Additionally, in 2017, The Dental Board of Australia announced that it had agreed to phase out approval of programs to extend scope. I discuss what this means in further detail and how you can safeguard yourself in your selection of CPD courses and programs on pages 18 and 19.

## EDUCATION AND CONTINUED PROFESSIONAL DEVELOPMENT

We have listened to members who indicated that with today's busy and demanding lifestyle, practitioners often find it difficult to attend presentations (particularly members in rural/remote areas). So we decided to bring the events to you.

Periodontist Dr Chris Barker recently conducted two webinars for us: Periodontics – where are we now? and Periodontics 2 – classification and active therapy. Dr Barker has followed up these webinars with an article on pages 12 and 13. Again, do not worry if you missed the webinars, as you can find them under Events & E-learning on our website.

With the current CPD cycle coming to an end in November this year, Dental Protection members have, in addition to our workshops, webinars and profession-specific presentations, FREE access to more than 40 hours of verifiable CPD online modules and courses. The courses use interactive videos that can be undertaken at a time convenient to you. All completed courses will be saved in your personal profile with certificates to print for your CPD record. Simply log into your Prism account and go. (Further details can be found on pages 18 and 19.

With renewals just around the corner, I wanted to ensure members are aware of the additional protection and support you will receive with Dental Protection.

Remember – choosing the right indemnity partner is not just about a one off policy. The value of having a good partner to protect you before and after an adverse event – one that will be with you every step of the way – is priceless!

I hope you enjoy this edition of *Teamwise*.

**Shireen Smith**
Oral Health Therapist, Hygienist, Therapist Adviser, Australia


REFERENCES

1. Australian Health Practitioner Regulation Agency Annual Report 2017/18
2. Dental Board of Australia March 2019 communiqué

# CELEBRATING EXCELLENCE: ORAL PRACTITIONER OF THE YEAR AWARDS

**Recently, the Australian Dental and Oral Health Therapist Association (ADOHTA) recognised outstanding oral health practitioners who exemplify their commitment to oral healthcare and drive the profession towards excellence. Shireen Smith introduces us to some of the winners**

The winners were announced at the Modern Practitioner Conference gala dinner on 29 March 2019 in Brisbane, Queensland.

We would like to congratulate all dental practitioners who were nominated for the ADOHTA Oral Health Practitioner of the Year Awards – it is lovely to be recognised for the dedication and commitment you have contributed to the profession. We were pleasantly surprised to learn that ALL winners were also Dental Protection members, and they have given us permission to share this news with you.

Congratulations to the winners below! We celebrate with you on your outstanding achievements in your nominated fields.

## ORAL HEALTH PRACTITIONER OF THE YEAR AWARD 2019: DENISE HIGGINS (NSW)

Denise is the epitome of everything that is needed to be the deserving recipient of this award.

She is awe-inspiring in her role as a lecturer and innovator and an avid advocate of the profession and the ADOHTA. Denise works with the ethos of "strive harder, work smarter and achieve more at all times".

Congratulations to Denise on being the inaugural ADOHTA Oral Health Practitioner of the Year.

## VOLUNTEER OF THE YEAR 2019: SHAUNA MCNAUGHTON (NSW)

Shauna regularly volunteers with the Remote Area Health Corps to provide much needed oral health care in remote indigenous communities in the Northern Territory, as part of the Close the Gap initiative. It is through this work that Shauna has been recognised as the ADOHTA Volunteer of the Year for 2019.

## HEALTH PROMOTER OF THE YEAR 2019: JULIE BARKER (QLD)

Julie has a long history of involvement in oral health promotion. Recently she has been involved in, and currently chairs, a global group called the Alliance for a Cavity Free Future. Julie is continually committed to the prevention of oral diseases and a proud oral health promoter.

## EDUCATOR/RESEARCHER OF THE YEAR 2019: DENISE HIGGINS (NSW)

Denise is a world leader in simulation teaching, an innovative oral health inventor and an ambassador for change in oral health education. Denise is the futuristic face of oral health simulation teaching, an inspiring academic and 'change maker'. Her excellence and oral health reputation has been deservedly recognised with this award.

## PROFESSIONAL ADVOCATE LEADER OF THE YEAR 2019: JUDITH OTTAWAY (WA)

Jude is seen as a leader within the Western Australian dental community, delivering continuing education seminars and events. Jude is often asked to mentor others, provide professional and clinical guidance and give advice on employment and advocacy.

## CLINICAL LEADER OF THE YEAR 2019: DENISE HIGGINS (NSW)

The ground-breaking virtual reality environment that Denise has developed for students to practise within before treating patients has put Denise at the forefront, globally, of teaching excellence and clinical leadership. At the same time, it has increased the awareness of our profession outside the dental world. The media reports on this innovation alone reached 3.3 million people globally.

Note: Photos and information courtesy of ADOHTA

# IATROGENIC INJURIES AND WHAT CAN BE DONE TO AVOID THEM

**Wherever you are in the world, there is generally a legal obligation in place that sets out the duties of employers to ensure appropriate standards of quality and safety in a dental practice. Dr Simrit Ryatt, dentolegal consultant at Dental Protection, looks into some iatrogenic injuries and what can be done to avoid them**

This legal obligation can include a delegable duty to team members to make sure equipment used in treatment is safe and maintained to be in good working condition in accordance with the manufacturers' instructions. It is, nevertheless, important to emphasise that it remains the responsibility of the clinician who is handling a piece of equipment to ensure a patient is not inadvertently harmed, either by operator carelessness or equipment malfunction.

Experience is generally a good thing, as you become more comfortable with dealing with challenging situations throughout your day. It is also worth bearing in mind that an experienced clinician may subconsciously become complacent about the risk attached to hazards in a dental surgery – particularly where the risk has been identified but not corrected for a while.

No matter how proficient you are, there are some scenarios that are impossible to predict and are not under your direct control, such as sudden movements or the behaviour of a patient. In light of this, it is important that we manage risk by focussing on the variables that we can control and ensuring that a regular risk assessment of the surgery equipment and operative procedures is carried out.

A good example of how this may be put into practice is to plan procedures in advance and adopt a checklist approach to ensure that the required materials and equipment are readily available and on-hand.

It goes without saying that personal protective equipment at work protects both the members of the dental team and the patients. All members of the dental team play a part in identifying hazards and risks, and reporting them before they cause injury. Risk assessment and reporting should be discussed at team meetings and follow-up actions should be notified to all team members. It is also important to keep a record of these discussions for future reference.

To help your understanding of how incidents can occur, we have looked at some examples from our case library. We have also highlighted the learning opportunities each incident provides.

## CASE STUDY: A LACERATION FOLLOWING AN ULTRASONIC SCALE

A professional opera singer attended his hygienist for his regular periodontal treatment. He preferred to have local anaesthetic administered when he was receiving deep root debridement and always struggled with treatment when the lingual surfaces of his lower molars were cleaned. He found this particular area difficult to tolerate as he found it difficult to breathe and it triggered his gag reflex. Midway through the appointment the dental hygienist was debriding the lower lingual area and the patient experienced an exaggerated gag reflex. As a result the patient drastically moved so the hygienist immediately stopped. It became evident there was an intraoral laceration at the floor of the mouth that was profusely bleeding.

## HOW WAS THIS MANAGED?

The hygienist explained what had happened to the patient and applied pressure with a gauze; however, the laceration was freely bleeding even after ten minutes. The patient was beginning to panic, so a dentist colleague was called upon to provide a second opinion and a decision was made to suture the area. A review appointment was arranged and the patient was contacted by telephone later in the evening, when he advised he was experiencing swelling of the floor of the mouth, along with some discomfort.

## AT THE REVIEW APPOINTMENT

At the review appointment the wound was assessed and the sutures removed. The injury was iatrogenic, caused by an error in the technique and, as such, the risk of this type of injury had not been discussed.

The patient subsequently had to take a week off from work and had to cancel a number of performances. Although he had a good relationship with the clinician, he advised the hygienist of his intention to claim for compensation for pain, suffering and loss of earnings.

The hygienist contacted Dental Protection and our team was able to negotiate an early and appropriate settlement, protecting the member's position and avoiding any risk of escalation.

### LEARNING POINT

- Although the hygienist was very experienced, the error was attributed to a lapse of concentration, which had unfortunate consequences. His reflection and subsequent analysis was recorded and shared with the rest of the team in the expectation that a similar situation may be prevented in the future.

## CASE STUDY: A CHEMICAL BURN

Miss C attended a surgery complaining of discomfort at tooth 27 following a dislodged restoration. A radiograph was taken that showed distal-occlusal caries and the patient was made aware of the radiographic and clinical findings. The patient opted to have a composite filling and an appointment was arranged with the practice dental therapist.

The dental therapist set about administering local anaesthetic and then provided the composite filling. At the end of the appointment the patient sat up in the chair and advised she was experiencing a burning sensation from her lip. The therapist viewed the area and could see what appeared to be some remnants of 30% phosphoric acid (acid etch) around the area of her lip. The sore and erythematous area was immediately rinsed with a copious amount of water.

It was thought that during the application of the acid etch, the syringe tip had loosened from the body of the syringe and a small volume of acid etch had leaked over the patient's face. Another theory was that some of the solution may have escaped on the dental therapist's gloved hand and this had been in contact with the patient's lip during the appointment.

At the review appointment the next day the patient reported some soreness in the area that had been in prolonged contact with the 30% phosphoric acid and the dental therapist could see the area had crusted over and had left an unsightly scar. The patient complained, requested compensation for the adverse incident and threatened to escalate her concerns to the AHPRA.

After seeking advice from Dental Protection, it was agreed that the treatment fees should be waived and a contribution was made by Dental Protection towards the cost of treatment provided by a specialist dermatologist.

### LEARNING POINTS

- Reflecting upon the treatment, and with the benefit of hindsight, the dental therapist acknowledged a rubber dam should have been used.
- Always ensure that the acid etch needle is fully engaged on the body of the syringe and avoid excessive force during the application or alternatively;
- The solution should be dispensed on to a Dappen dish before application to the tooth.

## CASE STUDY: A BURN INJURY TO THE LIP DURING TOOTH SCALING

A dental hygienist working in a busy clinic had been moved into another room as the equipment in her usual room had broken. This had only been realised at the start of the day and the hygienist had to swiftly set up in a room she was unaccustomed to. She was conscious she had a full list of patients and was already running late with three patients waiting.

The first patient wanted a routine teeth-clean that day as she was due to get married the next week and wanted clean teeth for her special day. The hygienist brought the patient in and started the treatment. She could see that only a small volume of water seemed to be flowing from the scaler tip. She attempted to adjust the water setting and the scaling continued; however, the patient screamed loudly causing the hygienist to immediately stop. The water volume had inadvertently been further reduced and a small burn mark at the corner of the mouth could be seen.

### HOW WAS THE SITUATION MANAGED?

The hygienist apologised and a cold pack was placed on the area. The fiancé of the patient joined her in the surgery and although they accepted the explanation at the time, they called later that evening to complain.

A couple of weeks later, the wound had healed fairly well, but there was a faint scar that could be seen in some of wedding photos and the patient had said the scar had ruined her perfect wedding day. The hygienist and her clinic agreed to arrange treatment for her with a plastic surgeon and they were informed there was a good chance the wound would heal completely with minor surgery.

The patient went on to claim for compensation. Although the hygienist had expressed her regret at what had happened and arranged for further specialist care, there was still an expectation that the exercise of a reasonable standard of care would have meant that such an injury would not have occurred.

### LEARNING POINT

- A team meeting was held following the incident and everyone acknowledged how potentially easy it was to cause such an injury, especially when working in an unfamiliar room. The team realised that special training needed to be provided for the team clinicians as each room had different equipment. In recognising the risk the team were in a position to avoid future occurrences.

## CASE STUDY: CRUSH INJURY

A nine-year-old patient was booked in for a routine extraction of a deciduous lower left second molar tooth, which had been causing discomfort and was unrestorable. The young boy was naturally anxious, as this was his first extraction, but he was communicative and co-operative.

The oral health therapist set about extracting the tooth but the procedure took longer than expected. Eventually the tooth was removed in one piece and the oral health therapist was relieved the patient had coped without becoming distressed. During the extraction the patient had been extremely brave and tightly held on to his mother's hand.

Following the extraction, the oral health therapist noticed the patient had developed some bruising around the lower lip that had been caused by the forceps trapping the soft tissue. The oral health therapist had not noticed this at the time, presumably because of his focus on the challenge of the extraction itself, and because he was under some stress knowing that the patient was nervous; a number of other patients were waiting to see him and he was now running very late.

### HOW WAS THE SITUATION MANAGED?

The oral health therapist immediately apologised and also contacted the patient's mother later on that day. As the patient's mother was happy to have her son's problematic tooth extracted, she did not take the matter further and accepted the apology.

### LEARNING POINTS

- The oral health therapist acknowledged that he had been so focussed on the extraction that he had forgotten that he may be applying too much pressure to the adjacent soft tissues. As they were understaffed, he had been sharing a nurse with another clinician and usually his nurse would be on-hand to notice an event such as this. At the next practice meeting this incident was discussed and it was agreed the oral health therapist should always be supported by a dental assistant when carrying out extractions and to be mindful that soft tissue injuries of anaesthetised areas are at risk of compression injury without feedback from the patient.
- Complications always seem to occur when there is time pressure. There should be protocols in place for managing such situations. In this case, a collective team-lead decision was made that should a clinician run particularly late, patients would be advised of the delay and given the option to rearrange their appointments or be seen by another dentist if possible.

## CASE STUDY: MECHANICAL INJURIES

A newly qualified dental therapist mentioned to her principal that the fixation plate that attached the x-ray machine to the wall was not stable and when the arm was fully extended, the pressure on the plate caused some movement. The machine was wall-mounted to the left of the patient chair. It had to be extended fully when taking radiographs on the right hand side. The arm was not stable at its full extension and would often drop after it had been aligned to expose the film. As a result, the final images were of limited diagnostic value as they did not capture the teeth and surrounding areas.

The dental therapist asked for the fixation mechanism to be repaired or replaced. The principal resisted this and believed the dental therapist was over-reacting. He suggested an 'alternative technique', which he thought would remedy the problem. His solution was to forcibly wedge the collimator so it would sit uncomfortably next to the patient and the x-ray arm would not slip down.

The dental therapist contacted Dental Protection and a dentolegal consultant suggested the member put her concerns in writing to the principal. It was suggested her concerns could be justified by carrying out a risk assessment of the situation, hypothesising what could go wrong and what harm could flow from a potential incident. It was also highlighted that should the dental therapist believe the working environment was hazardous, as she was controlling the handling of the equipment, it would be her responsibility to ensure it was safe.

Before the dental therapist could consider the advice further, she realised her next patient was due and required a radiograph. Unfortunately, the x-ray machine fell off the wall and took the surgery chair-light down with it, striking the patient on the head.

### HOW WAS THE SITUATION MANAGED?

The patient was able to have the x-ray in the next room and the principal immediately set about arranging for the x-ray machine and surgery chair-light to be repaired.

### LEARNING POINT

- The principal recognised he should have immediately addressed the situation. The patient was not injured but was unsettled, and the practice called later on that day to ensure they were alright.

## SUMMARY

These case studies highlight the importance of teamwork, learning from mistakes and how risk awareness can reduce the number of injuries that are often avoidable.

Where risks can be avoided, such as the placement of a well-fitting rubber dam for all composite fillings, it is surprising why anyone would risk not doing so. Similarly, when equipment is well maintained this reduces the risk to staff and patients.

These examples demonstrate the value of a sincere and sympathetic apology and the importance of professional support. Although some patient safety incidents may require additional help in order to resolve the situation to the patient's satisfaction, a telephone call following an accident can go a long way to convey care and indicate genuine concern, and can help reduce the chance of a patient taking matters further.

Whether it is in the form of professional advice, help with writing a response to a patient or assistance with arranging formal compensation, Dental Protection is here to protect the careers and reputations of members.

# KEEPING UP-TO-DATE WITH CONSCIOUS SEDATION AND RELATIVE ANALGESIA

At times, as an oral health therapist or dental hygienist/therapist, the everyday pressures of practice can make it difficult to stay within individual scope and regulations

## RELATIVE ANALGESIA (RA) NITROUS OXIDE

It is important to recognise the variability of effects that may occur with sedative drugs, however administered, and that with over-sedation airway obstruction or cardiovascular complications may occur at any time.

Anxiolysis includes minimal sedation through single low dose oral or inhalation-type medications for treating anxious patients, but not inducing a state of conscious sedation.

Dental hygienists/therapists and oral health therapists do not have the prescribing authority required under state and territory drugs and poisons legislation to administer nitrous oxide, even if they have been trained to do so.

The dentist is the practitioner with the prescribing authority to administer the nitrous oxide, so the dentist is accountable for the effects of the scheduled medicine on the patient. As a dental hygienist/therapist or oral health therapist, you have a duty of care to your patients just as dentists do. Therefore, as the treatment provider to a patient under RA, it would be your dual responsibility to ensure the dentist is adequately monitoring the patient throughout their treatment.

Although the Dental Board of Australia does not give specific advice on how workplaces structure the delivery of their dental services, it would be hard to demonstrate the dentist's adequate accountability for a patient's safe monitoring if they aren't even in the same room.

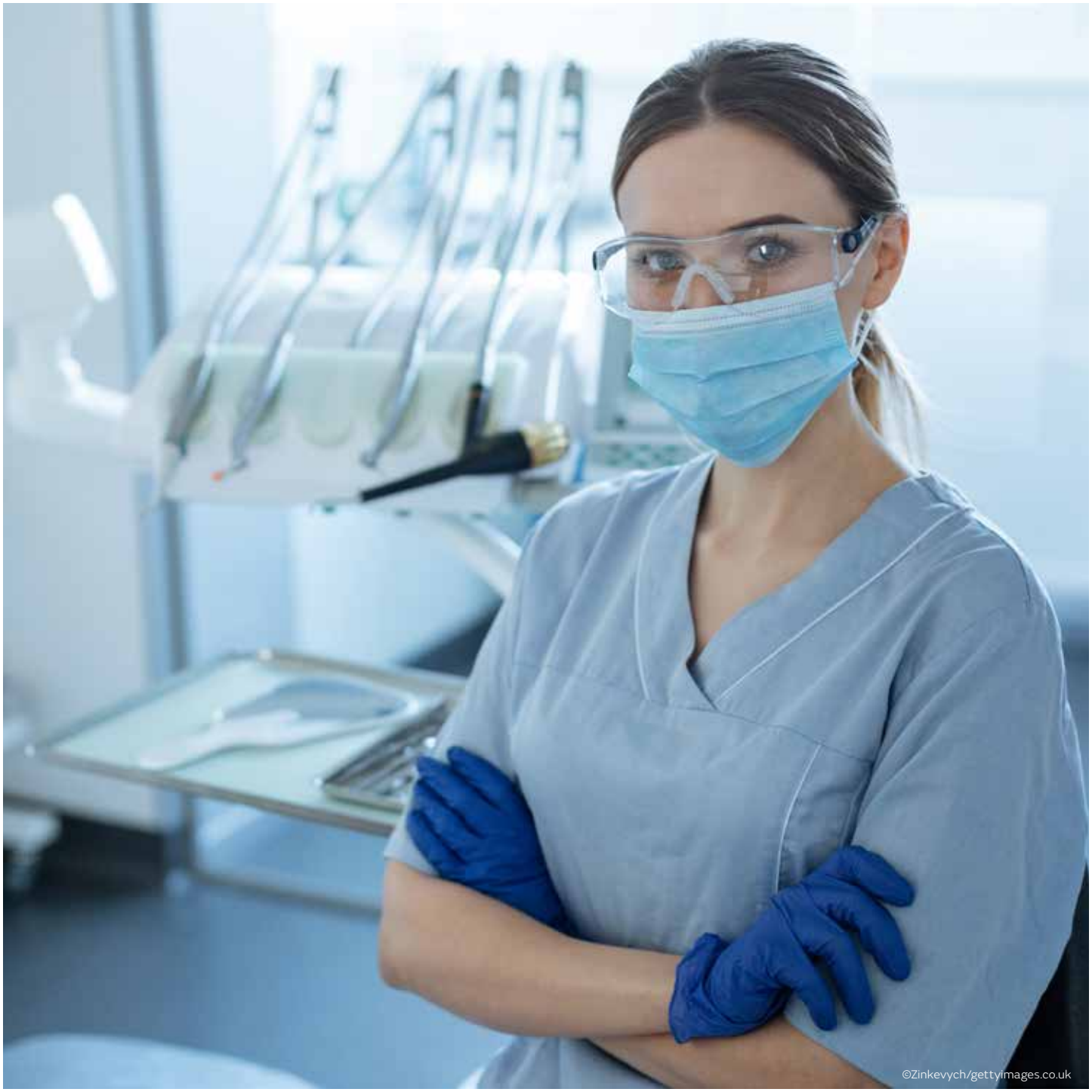
All dental practitioners exercise autonomous decision making within their particular areas of education, training and competence, and need to ensure they provide the best possible care for their patients.

If something went wrong and the dentist was found to not have adequately monitored the patient, it would leave you – the treatment provider – in a vulnerable position. Potentially, it may be deemed that you have breached your duty of care to your patient for not ensuring a safe environment, because the administrating dentist has not personally maintained adequate monitoring.

Dentists using RA should follow the ADA guidelines for the *Administration of Nitrous Oxide Inhalation Sedation in Dentistry*.[1]

As dental hygienists/therapists or oral health therapists, we can only practise within a structured professional relationship with a dentist, not as independent practitioners.

Therefore, the structured professional relationship provides the framework for appropriate referral and management to the dentist when the care required falls outside the scope of practice of the dental hygienist/therapist or oral health therapist.




## CONSCIOUS SEDATION

Conscious sedation is a combination of medicines to help a patient to relax (a sedative) and to block pain (an anaesthetic) during a medical or dental procedure. Interventions to maintain a patient's airway, spontaneous ventilation or cardiovascular function may be required in exceptional circumstances.

The Dental Board of Australia has adopted a registration standard for conscious sedation for dentist and dental specialists. There are entry-level competencies expected of dentist and dental specialists before they can practise in the area of conscious sedation.

Currently, oral health therapists and dental hygienists/therapists are unable to apply to become endorsed dental practitioners in the area of conscious sedation. You would be in breach of the Dental Board of Australia if found providing treatment in this area.

### THE DENTAL BOARD OF AUSTRALIA ADVISES:

"A dental practitioner MUST NOT direct any persons whether a registered dental practitioner or not to undertake dental treatment or give advice outside that person's education or competence."

REFERENCES

1. Australian Dental Association, The Administration Of Nitrous Oxide Inhalation Sedation In Dentistry


# TIRED AND TEARFUL

Is practice getting you down? Do you feel like you can't face another day? These are some of the classic symptoms of burnout, and you are not alone, with one in two dental practitioners in Australia suffering from burnout.[1] Dr Annalene Weston, Dental Protection dentolegal adviser, shares some advice on how best to recognise and manage burnout

As many of you will be aware, my colleague Dr Sam King and I have recently presented the national lecture tour called 'Under Pressure', as we wanted to start the conversation on burnout.

We want to thank each and every one of you who attended to support the profession, as we cast the spotlight on our mental and emotional wellbeing, and take positive steps to help and protect ourselves and our colleagues.

The response has been overwhelming. It is one thing to be told that every other dental practitioner in Australia is burned out and quite another to have them come up to you in tears, take your hand and thank you for giving them permission to admit how they feel and to talk about it freely.

## WHAT IS BURNOUT?

"Burnout occurs when passionate, committed people become deeply disillusioned with a job or career from which they have previously derived much of their identity and meaning. It comes as the things that inspire passion and enthusiasm are stripped away, and tedious or unpleasant things crowd in."[2]

Burnout is a measurable analysis of 'stress', with the most commonly used measure being The Maslach Burnout Inventory Triad:[3]

- emotional exhaustion
- low sense of personal accomplishment
- depersonalisation (an increase in cynicism or distancing ourselves from others).

When you consider these in the context of dental practice:

"Burnout is a condition born out of good intentions. Dentists [sic] who fall prey to it are for the most part unselfish individuals who have painstakingly striven to reach perfection in their careers, pushing themselves too hard for too long, failing to acknowledge their limitations for fear of ridicule or failure."[4]

Finally, dental practitioners suffering from burnout are far more likely to experience an adverse outcome or receive a complaint, as burnout affects all of our body's systems:

**Emotional**
Feelings of failure, guilt, negativity, anger, resentment, loss of sense of humour.

**Cognitive**
Poor concentration, distancing, ruminating, cynicism.

**Behavioural**
Work avoidance, habitual lateness, addiction.

**Physical**
Tiredness, lethargy, poor sleep, increased minor illnesses, anxiety.

It is self-evident then that we need to recognise when we are burning out, not only for ourselves, but also for our patients' safety, and take appropriate steps to manage it.

One important point to make is that burnout is not a sign of weakness, nor evidence that you are any 'less than others'. Anyone and everyone will eventually burn out if they carry too much pressure for too long. As pressure does not discriminate, any one of us could be affected at any given time.

## WHAT CAN WE DO ABOUT IT?

The more you read about burnout, the more you will learn, and the more solutions will present themselves. This list, however, nicely summarises the steps a dental practitioner can take to address burnout:[5]

1. **Avoid isolation and share problems with fellow practitioners**

Not only is 'a problem shared a problem halved', but there is strong evidence to indicate that increasing your social interactions increases your ability to handle stress and pressure, therefore decreasing your risk of burnout. The evidence base also demonstrates that getting involved in organised dentistry groups can lead to feeling more content and less isolated.

2. **Work sensible hours and take time each day for a leisurely break**

While we have explored the risks of working Hungry Angry Late and Tired (HALT) many times in our presentations and publications, to summarise: be your best self to give the best care to your patients.

3. **Take time off whenever the pressures of practice start to build**

Burnout can mimic depression, so how do you know if you are burned out or if you are depressed? Broadly, burnout will improve with a break or time away from the workplace. Depression does not, so perhaps a good first step is to take a break! Not only will this give perspective about your workplace, and perhaps identify some changes you may wish to take place, it will also help identify whether you need to seek medical help for an underlying condition.

4. **Learn how to better handle patient anxiety and hostility and attend courses on stress management and communication skills**

With a CPD requirement of only 60 hours every three year cycle, we would suggest that you consider investing in your soft skills too. Communication can be practised and learnt, and the evidence strongly points to improved communication capabilities decreasing the likelihood of ever receiving a complaint.

5. **Adopt a programme of regular physical exercise**

Exercise not only serves to release endorphins, but it's also an outlet for the built-up tension you carry. Developing the positive habit of regular exercise can benefit you, both body and mind, with the benefits of exercise shown to be greater, and longer acting, than taking antidepressants for those suffering mild to moderate clinical depression.[6]

6. **Be kind to yourself and less critical and demanding of your efforts**

Judging your day-to-day efforts through a clouded filter of negativity will create great distress. Be kind to yourself. You help patients. Every day. Without exception. This is something to be proud of.

## BRINGING IT ALL TOGETHER

Burnout is real and impacts dental practitioners at a higher rate than it impacts the general populace. Not only do we need to recognise it, both in ourselves and others, but we also need to take active steps to manage it once realised.

"Under Pressure" is available to view on Prism, accessible via the Dental Protection website. If you feel you may be suffering from burnout then get in touch with the experts here at Dental Protection to get the support you need.



REFERENCES

1. Stress, Strain &Burnout among NSW & ACT Dentists: April 2014: Dr Robyn Johns, University of Technology, Sydney and Dr Denise Jepsen, Macquarie University
2. Mindtools.com
3. Christina Maslach, Maslach Burnout Inventory Triad, 1981
4. Dentistry on the couch: Hugh Joffe; ADJ 1996; 41 (3) 206-10
5. Stress Management in Dentistry: Mark Grossman, Alpha Omegan. Fall 2014. Pg18-21
6. Exercise treatment for major depression, maintenance of therapeutic benefit at 10 months. :Babyak et al. Psychosom Med 2000 Sep-Oct; 62(5): pg633-8

# PERIODONTITIS - WHERE ARE WE NOW?

Recently, a new classification system of periodontal diseases was released. Specialist periodontist Dr Chris Barker explains how a classification system is primarily used for communication between clinicians and in research

The primary aim of the classification system should be the diagnosis of a patient and identification of risk factors that have contributed to the patient requiring periodontal therapy in the first place.

The 2017 world workshop classification system for periodontal and peri-implant conditions integrates with established pathways and parameters, such as the basic periodontal examination.

The classification system for periodontology has been updated a number of times in the history of the specialty. Apart from refining pre-existing categories, the addition of definitions of periodontal health and various conditions associated with implants is a key feature. All while remaining easily applicable to the everyday practice of the general dentist.

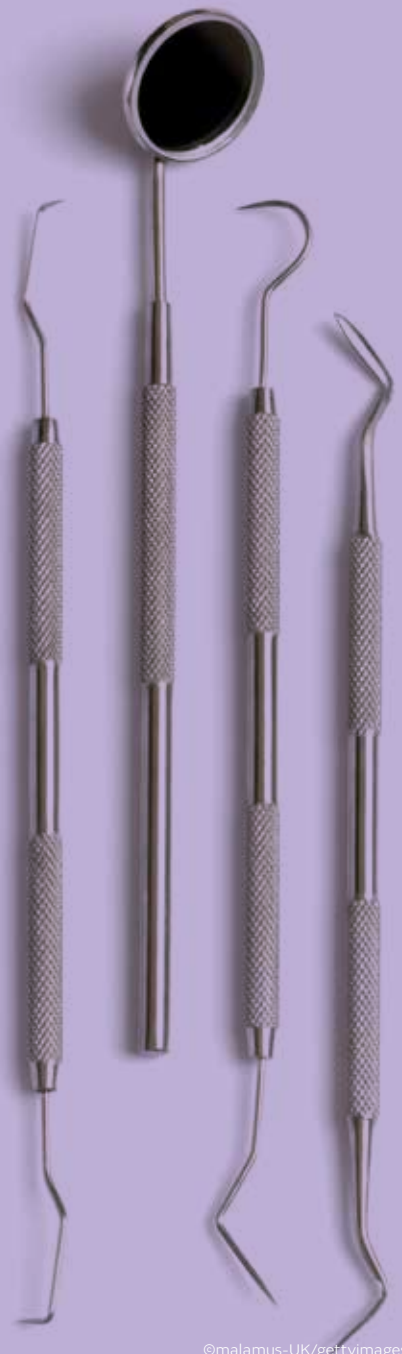
Other aims were to distinguish the extent of clinical attachment loss (CAL) versus an actual patient's susceptibility to this process (typically reflected in the patient's progression of disease or lack of response to therapy) and to develop a forward thinking and easily adaptable model to incorporate research advances.

## REQUIRED EXAMINATIONS/ RESOURCES

This classification system has been designed to incorporate all the critical elements of a basic periodontal examination. This exam includes full medical histories, full dental histories and a relevant social history. Clinically, a charting of all teeth with a full assessment involving six points per tooth would include:

- recession (Rec)
- periodontal probing depths (PPD)
- bleeding on probing (BOP)
- furcation involvement (Fur)
- plaque indices
- mobility.

A useful online source is "Perio Tools" from Bern university[1] and supporting this would be the essential radiography – a panoramic radiograph is initially sufficient, with supplemental periapical radiographs as appropriate.



## CLASSIFICATION SYSTEM

The classification system is broken into four groups:

**Group 1 - Periodontal health, gingival diseases and conditions**

A key feature from this group is the definition of clinical gingival health on reduced periodontal in a stable periodontitis patient versus a non-periodontitis patient. A proposed simplified classification of gingival conditions includes:

- a description of the extent of the number of teeth involved: generalised (>30%), localised (<30%), introduction of the term *"incipient gingivitis"*
- a description of the ***extent*** and ***severity*** of gingival ***inflammation***
- a description of the ***extent*** and ***severity*** of gingival ***enlargement***
- a reduction of categories in the dental plaque-induced gingival disease taxonomy
- differentiating between bio-film induced and non-dental bio-film induced gingival pathologies.

Potential diagnosis could be: gingivitis, bio-film induced, generalised, mild inflammation, moderate enlargement.

**Group 2 - Periodontitis**

Group 2 is focused on specific forms of periodontitis. The three main categories are: necrotising periodontal diseases, periodontitis as a manifestation of systemic diseases, and periodontitis.

In the commentaries about the classification system, it is specifically noted that the vast majority of clinical cases of periodontitis do not have the local characteristics of necrotising periodontitis or the signs and symptoms of the rare immune disorders that have a secondary manifestation of periodontitis.

However, the most significant change by far has been a migration to the staging and grading system of periodontitis.[2]

The nomenclature of the periodontitis diseases is:

- stage (I, II, III, IV): which relates to the amount of clinical attachment loss (CAL) already observed and the prognosis of losing teeth in the future
- extent and distribution (localised (<30%), generalised >305) and the introduction molar/incisor pattern that was characteristic of the previously-termed aggressive periodontal disease
- grade (A, B, C), that relates to the predicted progression of the disease or patients' susceptibility to further loss
- potential addition of descriptors (risk factors or issues identified, which may contribute to the management of the disease).

Critically, this classification system makes allowances for identification of specific risk factors and other complexities that are associated with the progression of, and difficulty in, treatment of periodontal disease. These could include such issues as PPD, type of bone loss (vertical and/or horizontal), furcation status depths, tooth mobility and bite collapse. For ease of clinical reference, using the guides outlined previously will significantly help the clinician incorporate this in their day to day practice.

A potential diagnosis could be: periodontitis stage II, generalised, grade B. Risk factors: DM, former smoker.

**Group 3 – Periodontal manifestations of systemic disease and developmental and acquired conditions**

Group 3 is detailed as the manifestations of systemic diseases and conditions that affect the periodontal attachment apparatus. Specifically, the first element discusses systemic disease conditions affecting the periodontal supporting tissues.[3] This includes such elements as smoking, diabetes mellitus and obesity. The idea is that if evidence becomes available, these current risk factors could in fact be their own forms of periodontal disease.

Other elements of this group include periodontal conditions, muco-gingival deformities and traumatic occlusal forces. Periodontal conditions relate to periodontal abscesses and periodontal-endodontic lesions. These are distinctly different clinical presentations and each require their own special management. Muco-gingival deformities and conditions around teeth include various deficiencies in either tissue composition, volume or potential recession of tissues. Traumatic occlusal forces mentioned in this group include primary traumatic, secondary traumatic and orthodontic forces. This category also includes prosthesis in tooth related factors that modify risk of, or predispose to, plaque-induced gingival conditions; it also takes into account the localised tooth related factors and/or dental prosthesis related factors, overhangs for example.[4]

The specific descriptions frequently match a particular therapy, ie endo-perio lesions requires both endodontic and periodontic concurrent therapy.

**Group 4 – Peri-implant diseases and conditions**

Group 4 relates to peri-implant diseases and conditions with definitions for health, mucositis, peri-implantitis, and a narrative description of peri-implant soft and hard tissue deficiencies.[5] This would require its own narrative as this area rapidly develops with new research.

## THE NEXT STEPS FOR A CLINICIAN

The recommendation for clinicians would be to focus on diagnosing how a patient developed the need for periodontal therapy and what treatment is indicated. If there is any doubt, then reassessing if you are going to treat the patient or refer to a specialist may be appropriate. This approach, in conjunction with the guides previously mentioned, will allow the appropriate classification to be made.

The full compilation of articles and other useful short summaries are available for free from the American Academy of Periodontology.[6] The general summary of differences between this system and previous classification were outlined by Caton et al in the *Journal of Periodontology*. Other authors have also written guides for practical integration in general practice, one of the most useful being the review written by Dietrech et al.[7]

If you missed either of Dr Chris Barker's periodontal webinars they are available to watch on Prism now.


REFERENCES

1. Perio-Tools - Department Of Periodontology - School Of Dental Medicine - University Of Bern - Switzerland. Perio-tools.com. 2019.http://www.perio-tools.com/en/index.asp
2. Tonetti M, Greenwell H, Kornman K. Staging and grading of periodontitis: Framework and proposal of a new classification and case definition. *Journal of Periodontology* 2018;89:S159-S172. doi:10.1002/jper.18-0006
3. Albandar J, Susin C, Hughes F. Manifestations of systemic diseases and conditions that affect the periodontal attachment apparatus: Case definitions and diagnostic considerations. *Journal of Clinical Periodontology* 2018;45:S171-S189. doi:10.1111/jcpe.12947
4. Ercoli C, Caton J. Dental prostheses and tooth-related factors. *Journal of Periodontology* 2018;89:S223-S236. doi:10.1002/jper.16-0569
5. Berglundh T, Armitage G, Araujo M et al. Peri-implant diseases and conditions: Consensus report of workgroup 4 of the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions. *Journal of Periodontology* 2018;89:S313-S318. doi:10.1002/jper.17-0739
6. Periodontology A. Proceedings from the 2017 World Workshop on the Classification of Periodontal and Peri-implant Diseases and Conditions | Perio.org
7. Dietrich T, Ower P, Tank M et al. Periodontal diagnosis in the context of the 2017 classification system of periodontal diseases and conditions – implementation in clinical practice. *BDJ* 2019;226:16-22. doi:10.1038/sj.bdj.2019.3

# HANDLING DISSATISFIED PATIENTS AND THEIR COMPLAINTS

There can be no doubt that dealing with patient dissatisfaction and receiving complaints are among the most challenging experiences a dental practitioner can face. Dr Mike Rutherford, senior dentolegal adviser at Dental Protection, explores these issues


A patient tells you they are unhappy with you and the treatment you provided. It is a heart-sinking moment, creating all manner of emotions, including frustration, resentment, a fear of being overwhelmed, a feeling of being 'deprofessionalised', anger, helplessness, hopelessness and powerlessness. These feelings, while understandable, are also unhelpful in formulating your response to this dissatisfaction, as you may 'react' to the situation rather than 'respond' in a professional manner. They are also unhelpful to you, as they may lead to long-term stress and the consequences of this for your physical health and emotional wellbeing are well documented.

When we consider how to handle patient dissatisfaction or a complaint our approach should be threefold:

1. resolve the patient's concerns
2. care for ourselves throughout the process, and beyond
3. audit to safeguard against future complaints of this nature.

## THE FIRST STEPS

A patient complaint needs to be acknowledged in a timely fashion. But what is considered timely? Unlike some other countries, Australia does not have any regulated guidance on how quickly a practitioner needs to respond to a complaint. A sensible rule of thumb may be within two business days of receiving the complaint.

Acknowledging a complaint when it is being expressed to you directly is simple, although you should take care to respond appropriately and not 'react' to this potentially stressful situation. Many practitioners, however, forget to acknowledge a written or emailed complaint. At the initial stage of having received a complaint, it is not necessary that a full reasoned response be provided within two business days, but rather an acknowledgement to your patient that their complaint has been received and that you intend to reply comprehensively. As part of this acknowledgement the patient's expectations regarding 'what happens next' need to be set:

1. Does the patient need to provide any additional information? For example the records of, or a report from, their new treating dental practitioner.

2. How long will it take you to assess this matter – when should they expect to hear back from you?

This should get you through the acute phase of receiving a complaint. It is important that every staff member who deals directly with the public has the ability and training to be the 'first responder' to a complaint, as not only will this give them greater confidence when these situations arrive, but better early management will render the complaint far less likely to escalate to a third party (such as the Dental Board or a lawyer). Staff can become defensive too and react when they believe that a complaint is being unfairly directed at them; or a patient is demanding an immediate response. A little training and a practice policy detailing steps to be taken can help both the patient and the staff member in these situations. Patients who complain and then feel that they have been ignored or, worse still, rebuffed, are more likely to escalate their complaint.

It can also be helpful to have a nominated 'complaints officer' at the practice. Preferably someone calm by nature, this person could have additional training in complaints management and should be a good communicator, to enable them to establish rapport with the patient. All future communications regarding the complaint can then go through them.

## WORK THROUGH THE PATIENT'S CONCERNS TO REACH A RESOLUTION

The mechanism for doing this will vary from case to case and will depend on the nature of the complaint, the severity of the complained adverse outcome (if there is one) and its consequences for the health or wellbeing of the patient and, above all else, the willingness of both parties to engage in reasoned conciliation.

Regardless of the nature of the complaint, if you have any doubts about the approach to take or your ability to resolve it amicably, you should contact Dental Protection for advice. Our advisers are experienced in resolving patient concerns and, just as importantly, can be a sounding board for your thoughts and concerns. Information you provide us with and advice that we give remains confidential – except in some criminal events. We can provide an objective and expert (in the experienced dental practitioner sense) opinion on whether the complaint is reasonable, and tailor your response to suit the individual circumstances in a collegiate non-judgemental manner.


## TAKE TIME FOR A DEBRIEF, AND CARE FOR YOURSELF

Feeling professionally challenged can be a terrifying and isolating experience. We may fear ridicule or a critical judgement from our peers as a consequence of the patient dissatisfaction, particularly if the patient had a genuine and legitimate reason to feel that way. We may feel that our reputation will be besmirched by a complaint and wish to keep the complaint or patient dissatisfaction to ourself.

While all of these reactions are understandable, they will not be helpful to you in the long term. Sometimes, as in this case, the old clichés are the best, and a 'problem shared is a problem halved'. Talking through our complaints, concerns and distress with others can enhance personal growth and understanding. Furthermore, discussing our difficulties with others can help them recognise similar issues before they arise, and help them to better manage patient dissatisfaction in their own practice.

## AUDIT

Finally, something that can be helpful, although it seems slightly counter-intuitive perhaps, is to keep a complaint file. This is kept separate to the clinical notes for each patient. While this complaint file may sit empty for many years or it may only have one complaint in it, it is important to take the time to review any complaints received to see if there is a pattern of issues. Is it timekeeping, fees or the way that the practice is making patients feel? If so, what steps can you take both personally and through the practice to safeguard against complaints of this nature in the future?

## CONCLUSION

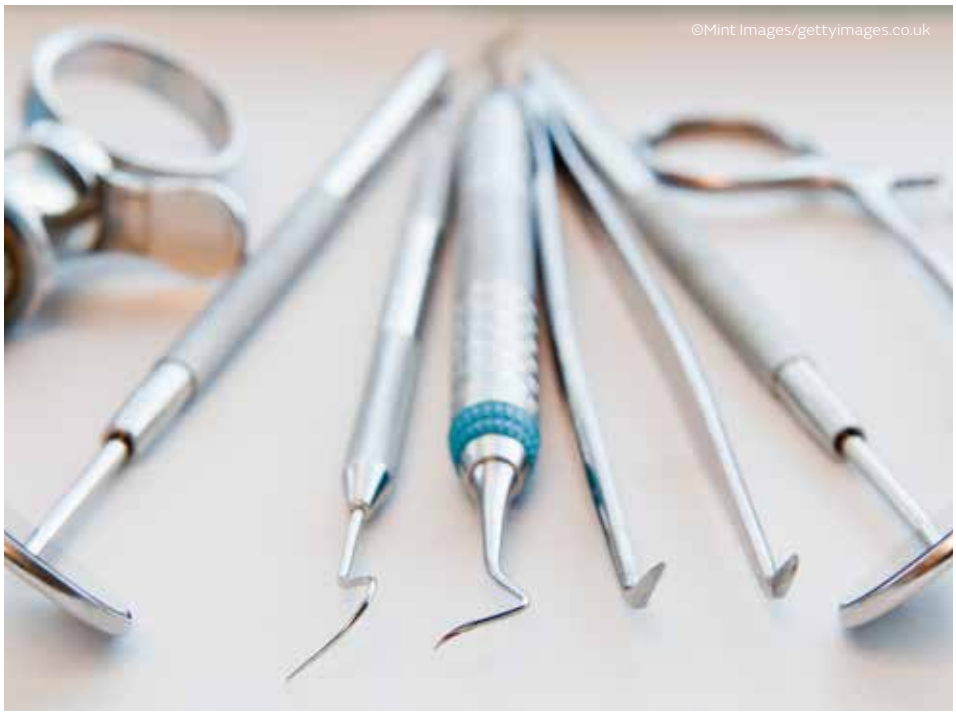
Dental Protection can offer you both support and advice during the often stressful process of complaint management. We can assist with appropriate wording and help make this, as trying as it is at the time, a learning exercise for the future. The essential elements are that a sympathetic, polite and objective reply needs to be forwarded in response to a complaint in a timely manner.


REFERENCES

1. Mathers et al 1995, Butler et al 1999, Elder et al 2006
2. Bodner 2008

# WHEN THE TIME IS RIGHT

A hygienist member contacted Dental Protection to report that the practice she worked in had received a strongly worded telephone complaint from a patient, concerning an initial calculus debridement she had provided




The patient, who had not had any oral hygiene treatments in eight years, had complained that the procedure was unnecessarily rough and prolonged, and had resulted in bleeding, puffy and infected gums, as well as severe cold sensitivity. The patient had attended his medical practitioner, who had diagnosed gingival infection and prescribed antibiotics. Unfortunately, the patient was convinced that the hygienist had either used non-sterile instruments that caused the infection or had failed to prescribe antibiotics for the gum infection, which he felt must have been visible at the time of treatment. The receptionist had recorded in writing the details of the complaint, and the practice, which was part of a large group of practices, had forwarded the complaint to the hygienist for a response.

The hygienist, who felt overwhelmed by the situation and also 'outranked' by the medical practitioner's diagnosis, had unfortunately dwelled on the complaint for a few days before contacting Dental Protection. We assisted in writing a suitable letter to the patient, demonstrating sympathy for his discomfort and offering a detailed explanation of the treatment and likely cause of the postoperative symptoms (including the effects of the patient's low dose aspirin medication).

The practice manager insisted on reviewing the letter before it was sent and had concerns about the sympathetic style of the letter and the use of the words "I am sorry that..." She was worried that this may be interpreted as admitting liability and decided that the letter would have to be seen by the practice owner – who was away for a few days - before it was sent. This delay left the patient believing that no reply was forthcoming and he formalised the complaint to the AHPRA.

The hygienist was eventually cleared of any wrongdoing, assisted by Dental Protection with a response that referred to instrument tracking and the Therapeutic Guidelines Oral and Dental for antibiotic usage protocols. This was a fortunate outcome, though the AHPRA investigation did note the member's initial lack of response to the complaint. Being the subject of any investigation by a regulator such as the AHPRA is understandably very worrying for a dental practitioner, with the process also being necessarily time consuming, both in responding to the complaint and waiting for a decision to be made.

## LEARNING POINTS

Whether this complaint would have been resolved simply by a timely response of sympathy and explanation is unknown, but we do know the patient's decision to escalate the complaint was based on the lack of a reply and the feeling that he was not being listened to and taken seriously.

The role and place of antibiotics in dentistry is unfortunately a poorly understood process by much of the general public, and often the subject of patient complaints. Dental Protection can guide you towards appropriate references to reflect protocols for non-usage of antibiotics.

The member was feeling overwhelmed and unsure of how to deal with the complaint. She also felt that the practice had left her isolated in demanding that she deal with the complaint personally, as she had little experience with complaints processes. Fortunately, the experts at Dental Protection deal with these situations on a daily basis and could provide advice on responding appropriately. When the complaint became an AHPRA investigation, Dental Protection could again guide the member through the process and provide collegiate support through the anxious wait for a decision.

After the complaint had been resolved, Dental Protection encouraged the member to discuss the delay in replying, caused by the practice wishing to review her response. While a practice owner's desire to review any reply involving their practice is understandable, it is the individual practitioner's responsibility to respond to a patient complaint. If a complaint is received by the AHPRA it will be directed at the practitioner personally and not the practice. These discussions resulted in a streamlined process for the practice to deal with any future complaints, recognising the need to support employed practitioners in the process and accept the role of dentolegal advisers in providing expert support to the member involved.

# LEAVING A SOUR TASTE IN THE MOUTH

Dental hygienists, dental therapists and oral health therapists leave their practices for a variety of reasons, and occasionally this can be due to a breakdown in communication and issues surrounding working relationships within the practice


©fizkes/gettyimages.co.uk

When a dental practitioner leaves a practice on bad terms it can be the catalyst for a number of unexpected patient complaints. This scenario can be difficult to manage if there is no agreement with the practice owner about how to manage post-treatment issues that would otherwise have been addressed by the practitioner had they remained at the practice.

It is common practice for an agreed sum of money to be withheld by the practice owner for an agreed period of time when a dental practitioner leaves a practice, to allow minor problems to be resolved.

## CASE STUDY:

The relationship between a practice owner and an oral health therapist (OHT) had deteriorated to such an extent that the OHT had left the practice.

The OHT was clinically very competent and experienced, and had completed a number of challenging anterior composite filling cases. One particular patient, Mr L, had been treated with composite build up restorations on numerous teeth to conservatively manage his tooth wear, and the finished result was satisfactory. Whilst the OHT's clinical records reflected the merits and limitations of composite resin versus porcelain restorations, there was no mention that further charges would apply for the maintenance and/or repair of these restorations. When Mr L required some fairly minimal general polishing of the composite restorations due to surface staining, he said he had not been informed that additional charges would apply and did not expect the owner of the practice to charge him for this treatment.

Mr L resented being asked to pay for polishing the composites and raised the issue with the practice owner, who passed the complaint to his former OHT. Although the OHT had moved over 70 kilometres away, he offered to review the patient and provide the necessary treatment at no cost, but the patient was understandably unwilling to travel to see him.

This scenario was not an isolated example; it was a recurring story involving a number of patients who required similar maintenance work. Rather than completing this work as a gesture of goodwill to maintain the reputation of the practice, the practice owner encouraged every minor concern to develop into a complaint that required a formal response from the OHT. The fact that the patients felt they were being charged an over-inflated cost for maintenance treatment by the practice owner only added to their dissatisfaction.

The OHT contacted Dental Protection, and with the benefit of hindsight, realised that he had not made it clear to Mr L – or to the other patients – that ongoing maintenance would be chargeable. He recognised that there had been no clarity regarding what aspects of the treatment were covered by the original fee and, as a result, patients had unilaterally made some assumptions.

Dental Protection advised the OHT to talk to the practice owner and try and come to an agreement, so as to avoid further incidents that could be harmful to both their reputations.

The OHT and practice owner reached an agreement between them to cover the reasonable cost of post-treatment maintenance/polish appointments.

## LEARNING POINTS

- This case study illustrates the importance of maintaining professional relationships and taking the time to agree how patient care can, and should, be handed over when a dental practitioner leaves a practice.
- There should be a signed agreement that includes a clause regarding the retention of fees for remedial work when a practitioner leaves a practice. This avoids disputes and disagreements that may arise after the departure of a practitioner.
- When planning treatment that requires ongoing maintenance, clear explanations should be given to the patient and documented in the record. This should include an explicit statement about what the initial fee includes and what charges may apply in the future. This should be set out clearly in writing for the patient and a copy retained in the records, so everyone knows what to expect.
- Financial disputes between the practice owner and a dental practitioner should be resolved between the two parties and not involve the patient.

# CPD CHECKLIST FOR COMPLIANCE

With the current continuing professional development (CPD) cycle concluding in November this year and recent changes being made to the extension of scope 'add on' courses, Shireen Smith gives us a timely reminder of your obligations for CPD

The CPD standard applies to all dentists, dental specialists, dental hygienists, dental therapists and oral health therapists – except those who have one of the following types of registration: non-practising registration, some categories of limited registration or student registration.

There are no specified mandatory CPD activities or set limits on the number of hours a dental practitioner can do. However, it would be advisable to undertake a variety of CPD activities, such as conferences, face-to-face, online courses, webinars and journal articles to demonstrate a robust and comprehensive compliance with the CPD standard. Additionally, completing a CPR course yearly, and a first aid course and infection control CPD course every couple of years, can help practitioners ensure they are meeting their obligations regarding patient safety.

## DENTAL PRACTITIONERS MUST COMPLETE A MINIMUM OF 60 HOURS OF CPD ACTIVITIES OVER A THREE-YEAR CPD CYCLE

Regardless of whether you practise one day a year or five days a week, practitioners need to complete 60 hours of CPD. If you are practising at all, patients are entitled to expect the same level of knowledge and skill whether you are full time or part time, and therefore CPD requirements are the same.

Practitioners registered as both a dental hygienist and dental therapist only need to complete 60 hours over the three years.

The only time CPD hours are adjusted is if you are registered for the first time part-way through a CPD cycle (eg graduating students). The number of CPD hours that a new registrant will need to complete will be calculated on a pro-rata basis using the formula published in the Dental Board of Australia's guidelines on continuing professional development.[1]

A minimum of 80% of the total of a practitioner's CPD activities must be clinically or scientifically-based. Clinically or scientifically-based activities relate to the scientific, clinical or technical aspects of oral healthcare. Scientific and clinical activities should reflect accepted dental practice or be based on critical appraisal of scientific literature. Therefore, the content must ideally be evidence-based, without exaggerated claims, and have scientific integrity (eg activities about infection control, cardiopulmonary resuscitation (CPR) or patient record keeping and a range of topics relating to oral health or particular dental procedures).

Non-scientific activities are activities that are indirectly related to, but supportive of, dental care, and include courses about practice management and dentolegal responsibilities.

As a registered dental practitioner, it is your responsibility to know your own scope of practice and ensure that you comply with the requirements of the Dental Board's registration standards and guidelines.[1] This is especially important when updating or refreshing your knowledge and skills in selecting courses for your continued professional development obligations. It is also essential before introducing new technologies, equipment and/or treatments/advice into your scope of practice.

**What should you consider when choosing your CPD?**

- evaluate the credibility/suitability of course providers
- assess the quality and amount of training provided, ie scientific evidence and written, practical and mentoring components
- check the subject matter aligns with your division of registration and definition of dentistry
- self-assess whether you have been provided with sufficient clinical knowledge and experience to incorporate this new technique into your clinical practice
- check if you have completed a variety of CPD formats
- undertake regular infection control, CPR or first aid CPD courses.

## PHASING OUT THE APPROVAL OF PROGRAMS TO EXTEND SCOPE

Previously, dental hygienists, dental therapists and oral health therapists could extend their scope of practice by completing an 'add on' program. The 'add on' programs, known as "programs to extend scope", were previously reviewed and approved by the Dental Board. The programs to extend scope covered a range of skills, which allowed dental practitioners to extend their education, training and competence in certain areas and within the division in which they are registered.

In 2017, the Dental Board announced that it had agreed to phase out approval of programs to extend scope. This means these programs will no longer be accredited by the Australian Dental Council, or approved by the Dental Board. The approval of these programs expired on 31 December 2018 and the list was removed from the Board's website.

The Board has not specified an approval process for courses or course providers who provide CPD. The Board's CPD guidelines, however, have detailed some requirements and expectations.

Additionally, dental practitioners should be mindful of other regulatory requirements, including drugs and poisons legislation, the radiation authority, and workplace agreements which can affect their ability to incorporate their new technique/treatment into their clinical practice. You should always practise in accordance with the Board's code of conduct.

Although the scope of practice registration standard is currently under review, dental practitioners wishing to "broaden their knowledge, expertise and competence" by completing either a program to extend scope and/or a CPD program may continue to do so during this transition period.

If you decide to complete a program to extend scope or undertake a CPD course that broadens your knowledge, expertise and competence (eg a CPD course to learn a new technique) and is relevant to your profession's scope, you will need to self-assess whether you have been provided with sufficient clinical experience to incorporate this new technique into your clinical practice.

You should consider contacting each individual university or training institute for written clarification and information to self-assess whether the intended course meets the Dental Board's requirements.

## How do I choose appropriate CPD activities?[1]

You should choose activities that demonstrate the following characteristics:

- open disclosure about monetary or special interest the course provider may have with any company whose products are discussed in the course
- the scientific basis of the activity is not distorted by commercial considerations. For example, be aware of embedded advertising and direct commercial links
- strong and clear learning objectives, independent learning activities and outcomes
- be referenced in articles from peer-reviewed journals and/or written by a suitably qualified and experienced individual
- addresses contemporary clinical and professional issues, reflecting accepted dental practice and/or based on critical appraisal of scientific literature
- the content is evidence-based
- offers the ability to enquire, discuss and raise queries to ensure that you have understood the information
- offers an assessment or feedback activity designed to go beyond the simple recall of facts, seeking to demonstrate learning with an emphasis on integration and use of knowledge in professional practice
- offers the opportunity to provide feedback to the CPD provider on the quality of the CPD activity.

©glegorly/gettyimages.co.uk

## What can happen if I do not meet the CPD standards?

- the Board can impose a condition or conditions on your registration, or can refuse an application for registration or renewal of registration, if you do not meet a requirement in an approved registration standard for the profession (sections 82, 83 and 112 of the National Law)
- a failure to undertake the CPD required by this standard is not an offence but may be behaviour for which health, conduct or performance action may be taken by the Board (section 128 of the National Law)
- registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct for dental practitioners (section 41 of the National Law).

It is important that you keep a clear record of any program to extend scope or any CPD activity/course that you complete for a period of five years as your compliance with this standard may be audited. If this occurs, you must produce a logbook (electronic or hard copy) of your CPD activities. The logbook is to include details of the activities, the number of hours spent and whether the activity is clinically/scientifically based or not. The Board may ask for additional supporting evidence, such as certificates of attendance or academic transcripts.

At the time of this edition of Teamwise going to print the Dental Board of Australia released a newsletter which is available to read in full on the Dental Board of Australia's website. In summary the newsletter states:

- The proposed changes will not alter the scope of practice of any registered dental practitioner
- The proposed changes will not allow dental practitioners from the other four divisions – dental hygienists, dental prosthetists, dental therapists and oral health therapists – to become or practice as a dentist, through continuing professional development (CPD) courses.

Dental Protection will await further information before providing more definitive advice, however these statements can be interpreted to mean that for example an oral health therapist could not administer Nitrous Oxide or provide adult endodontic treatments on the basis of having undertaken additional training or CPD, as these dental services are outside of the scope of practice for an Oral Health Therapist.

REFERENCES

1. Dental Board of Australia, Registration Standard: Continuing Professional Development

# CONTACTS

## You can contact Dental Protection for assistance dentalprotection.org.au

### Membership Services
Telephone 1800 444 542

### Dentolegal advice
Telephone 1800 444 542



06/19