Dental Council
Te Kaunihera Tiaki Niho

Newsletter: December 2015

Dental Council - December 2015

Message from the Chair

Being Chair of the Dental Council has been an interesting capstone to my career, as not only is my term on the Council coming to an end I also intend to retire from all dentistry – we all have a use-by date. It is appropriate that I reflect on my term on a personal note, and my comments do not necessarily reflect the views of the Council. One does not aspire to the role of Chair of the Council in order to seek personal glory. Indeed, brickbats tend to outnumber the bouquets! Instead, it gives a quiet sense of professional satisfaction when dealing with the challenges, and there are many that come with the task.

As I look back over the past six years on the Council, I think that dentistry, in a regulatory sense, is in pretty good shape. The graduates coming onto the register are capable young practitioners from both Auckland University of Technology and the University of Otago, both of which run fine programmes. Otago University was credited with being the eighth best dental faculty in the world, despite the much needed new clinical block still being in its formative stages. It just shows that good staff and good students, not bricks and equipment, produce good graduates. Next year will see the introduction of new outcome-focused accreditation standards, a joint project with our Australian counterparts, which should enhance assurance that our graduates are up to the mark. Further assurance will come from the new examination process for overseas-trained dentists, as will the completion of the competencies and attributes framework for specialists, a joint project being undertaken with the Dental Board of Australia.

The 2016 year may, or may not, see the introduction of a new scope of practice, Oral Health Therapy. This is causing some controversy but the proposal for the scope is a reflection of the times. Whatever the outcome, the public will be assured that practitioners are competent and safe to practice within their respective scopes. As an aside, if the market

demands, I see no reason why an education provider cannot offer a stand-alone dental hygiene programme, provided it ticks all the accreditation boxes.

With respect to the current dental workforce, we are in good shape here too. Overall, our practitioners are very capable and, in terms of the proportion of complaints and notifications, from an international perspective we are as good as any, better than most. However, as one of our former councillors kept reminding us, the biggest room in the house is the room for improvement. It is still disappointing the number of practitioners who come to the Council's attention, and effort should be made to reduce the number of at-risk practitioners. An obvious starting point is the introduction of a new recertification strategy. Frankly, I think the current continuing professional development regimen does not cut it. At best, it is continuing education; at worst, it is a brownie point, box-ticking exercise. To me, professional development means more than that. I would like to see something along the lines of a continuous quality improvement regimen introduced that embraces assurance of fitness to practise, maintaining up-to-date knowledge and skills, compliance with professional standards and maintaining collegial practice, all of which should be relevant to one's individual practice. The Standards Framework, as introduced by the Council this year, will become a cornerstone for any new recertification framework and I am sure practitioners will embrace a quality improvement approach.

The Council intends to improve its communications with stakeholders. It is surprising to learn how little some practitioners know regarding the workings of the Health Practitioners Competence Assurance Act 2003 and what the Council can and cannot do. While the Council wishes to operate in an unassuming way, practitioners should be well aware of their legal obligations. It is encouraging that after almost twelve years of the commencement of the Act, we finally have unanimous acceptance from the various dental workforce groups that it is indeed Council's role to set professional standards. With this now understood, I look forward to a constructive input from the professional community to assist the Council to write and revise professional and practice standards.

A highlight of my term as Chair has been the formation of the International Society of Dental Regulators (ISDR). Yes, a rather boutique organisation, in which New Zealand has been at the forefront of its inauguration. Currently, Council's Chief Executive, Marie Warner, is the President of the organisation, which is an honour in itself. Dentistry is now part of a global market, and its aim is to align dental regulation globally and to set various

international standards, albeit at a principle level, to ensure dentistry is practised consistently and safely around the world. ISDR developed accreditation standards and competencies for dentists that have been endorsed in principle by member jurisdictions for consultation. Early in the 2016 ISDR will be consulting on these with its stakeholders and dental regulatory bodies. This work aligns well with the academic community that is aiming for international convergence of quality assurance, benchmarking and assessment systems to improve dental education and aid mutual recognition of qualifications. Even the possibility of a global syllabus has been mooted.

In departing, I must make special mention of the work done by Marie Warner. As a chief executive officer, I hold her in my highest esteem, and her business and leadership skills are remarkable. She runs a tight ship. And, like any good ship, it also needs a capable crew. I am constantly amazed by the dedication and hard work that the secretariat staff put in. It is certainly appreciated by the Council. I would also like to thank all our independent contractors whose roles include, but are not limited to, supervisors, reviewers, working party and committee members, professional advisors, educators, professional conduct committees and Tribunal members, and health advisors. Special mention should also be made of those who have made submissions in response to various consultations that the Council is wont to impose upon you on a not infrequent basis. Contrary to popular opinion, the Council does value constructive feedback and takes all submissions into consideration when formulating a position, even if it means conducting a second consultation round on occasions.

Finally, I would like to thank the support of my Deputy Chair, Robin Whyman, and fellow members of the Council. We are an eclectic bunch and are often called upon to make some hard and unpopular decisions. The debate around the table can be vigorous at times yet we always seem to be able to reach a consensus. Your dedication and wise counsel is appreciated. Some members will be leaving the Council at the end of year, but at this point I am unsure as to how many. To those of you who are moving on, I wish you well for the future. For those who are staying, keep up the good work.

That’s it from me.

Merry Christmas

Michael Bain

Message from the Chief Executive

It has been an exciting year and a lot has been achieved. The two highlights for me were:

- The finalisation and embedding of the new Standards Framework for Oral Health Practitioners. It was particularly encouraging to see the overwhelming support and general acceptance of the framework. The engagement during consultation and at the discussion forums held in May were very informative. It provided an opportunity to meet with practitioners face-to-face and engage in very constructive discussions.
- The Council's new Strategic Framework for 2015-2020. This challenged us to critically reflect on the Council's functions and vision for the professions; how to operate more efficiently and effectively. I am looking forward to working closely with the Council next year to ensure the organisation delivers to these strategies. It will also include greater engagement with you in the coming year.

Thank you to everyone that has supported Council to achieve its business. It requires commitment outside of your clinical practice which is not always easy. Your expertise and experience are greatly appreciated.

Merry Christmas and happy holidays, and safe travels to you all!

Marie Warner

Strategic framework and priorities 2015–2020

This year, the Dental Council carried out a comprehensive review of its strategic framework – the vision and outcomes it is working towards and the values and principles it operates by. The new framework is designed to give greater transparency to practitioners and the public about what we intend to achieve in the coming years and how we will work to achieve this. The framework will guide where we focus our resources and effort, and provide a basis against which our progress and effectiveness can be measured.

The Council's purpose is to protect public health and safety by ensuring oral health professionals are safe, competent and fit to practise. This is our number-one priority and drives everything we do.

The new framework will help us strike the right balance between protecting public safety and having regulatory activity that is fair, justified and proportionate. By being clear about our vision and outcomes, we will have the greatest positive effect for the public without imposing an undue burden on practitioners. In this way, the framework lays the groundwork for increasing our effectiveness as a regulator.

The new strategic framework has informed the Council's five-year strategic plan. The plan for 2015–2020 sets out five new strategic priorities to help bridge the gap between where we are now and the results our stakeholders expect from us. Over time, these priorities will change to reflect new opportunities, challenges and circumstances.

To achieve our strategic priorities during 2016/17, we will focus on the following areas.

Standards

The Standards Framework for Oral Health Practitioners describes the minimum standards of ethical conduct and clinical and cultural competence that patients and the public can expect from oral health practitioners. The framework was implemented earlier this year and forms the foundation for the setting of Council standards in the future.

Next year, we will develop and review the following four practice standards:

- new and advanced areas of practice
- professional behaviour (currently known as sexual boundaries)

- informed consent
- cultural competence and Māori care.
- Engagement

We want to grow the Council's engagement with practitioners, stakeholders and the people it ultimately serves, the public.

We have already started by asking practitioners and stakeholders for their views on our effectiveness in this area and how they would prefer to communicate with us in the future.

We will be more active and engaged, with a greater presence at practitioner and district health board events and conferences.

We will also establish a consumer forum to make it easier for the public to engage with us.

Lifelong practitioner competence

The Council sets standards for entry into the profession as well as the standards a registered practitioner is required to comply with while practising in New Zealand. A major component of these standards is to maintain competence through lifelong learning. We are not convinced the current continuing professional development system is providing the proper assurance to do this; we need a smarter and more robust approach.

Over the next year, we will start the review of recertification, including annual renewals and continuing professional development, as well as developing options for a future recertification framework and quality assurance system.

A capable organisation

We are committed to ensuring the Council is in the best shape possible to perform and deliver.

Over the next year, we will review resourcing and capability, core policy areas and processes.

We will also begin to introduce an information technology system to save practitioners time and money and support smarter delivery of our functions – for example, online, real-time delivery of services, such as annual practising certificates to practitioners.

Governance

Effective governance is part of being an effective regulator. The Council made a governance model change in 2011 with the disbanding of the workforce boards. Four years on, it is time to take a fresh look at our governance arrangements.

The Council has considered independent advice on its governance model and is in the process of embedding a new model.

In addition, with several current Council members' terms expiring, we will also focus on inducting our new Council members.

Dental Council Strategic Framework 2015–2020

Dental Council
Te Kaunihera Tiaki Niho

Our purpose: To protect public health and safety by ensuring oral health professionals are safe, competent and fit to practise.

Our vision:

Safe oral health care for New Zealand

Long-term outcomes

- The public can trust that they will receive safe and professional oral health care.
- Oral health practitioners are safe, competent and fit to practise their professions.
- Regulation of oral health practitioners is proportionate, fair, transparent and durable.

Intermediate outcomes

- The public has confidence in the regulation of oral health practitioners.
- Entrants to the Dental Register have the competence and fitness to practise safely and independently.
- Registered oral health practitioners understand and apply standards of safety, clinical and cultural competence and ethical conduct.
- Oral health practitioners maintain lifelong competence.
- Action to address practitioner safety, fitness, competence or conduct concerns is timely, fair, proportionate and effective.
- The regulatory system is understood and upheld by our other stakeholders.

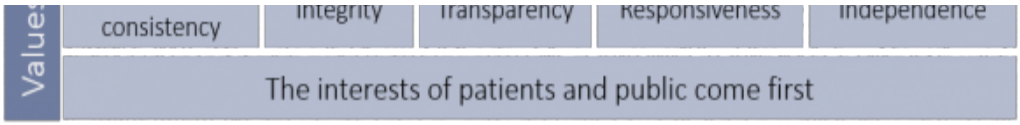
Strategic priorities

1. **Standards**: Complete and embed standards of clinical competence, cultural competence and ethical conduct.
2. **Engagement:** Grow understanding of, and engagement with, the Dental Council.
3. **Lifelong practitioner competence:** Introduce an effective, quality assured framework for ongoing practitioner competence.
4. **A capable organisation:** Ensure we have the policies, systems, skills and processes to deliver our functions – smarter, more consistently and in accordance with our principles and values.
5. **Governance:** Review and refresh our governance model.

Principles

- We are a "right touch regulator" – regulation of the professions is proportionate, consistent and targeted.
- We focus on outcomes.
- We are clear about our mandate and apply our resources accordingly.
- We hold ourselves to high standards of efficiency, effectiveness, quality and accountability.
- We work with partners, locally and internationally, to increase our effectiveness.
- We actively seek the views of practitioners, the public and other groups committed to the quality and safety of oral health care.
- We ensure our actions reflect the changing environment and societal expectations.

s	Fairness and	Integrity	Transparency	Responsiveness	Independence

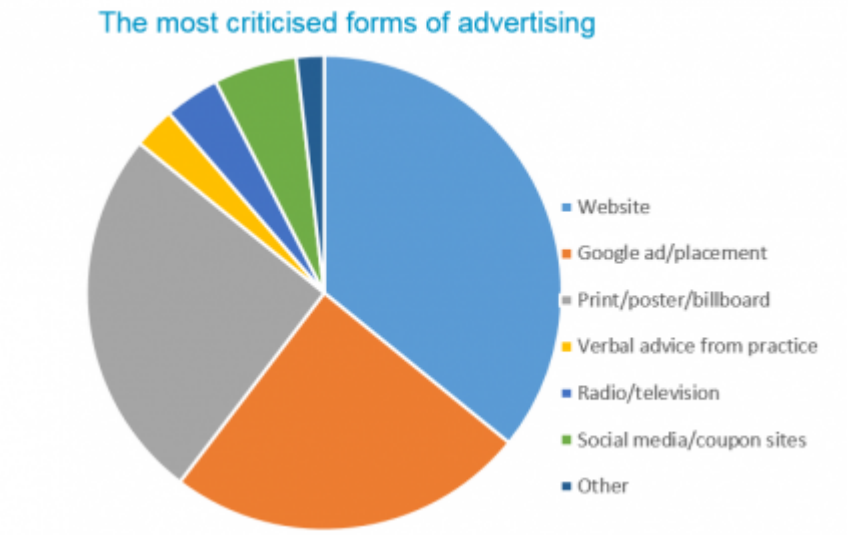

Values
consistency
Integrity
Transparency
Responsiveness
Independence
The interests of patients and public come first

An overview of advertising complaints – two years on

The Dental Council Advertising Practice Standard (previously known as the Code of Practice on Advertising) came into effect on 1 November 2013. Two years have passed, and it is timely to share some statistics and commentary.

As at 30 November 2015 -

- ***88*** advertising complaints received
- ***43*** "individual" complainants
- Some complaints comprised more than one objection to a practitioner's advertising- In total, ***106*** objections considered
- ***56*** objections upheld
- ***50*** objections dismissed.



Source of complaints	
Oral health practitioners	47

Professional associations: NZ Association of Orthodontists NZ Dental Association NZ Institute of Dental Technologists NZ Dentists Orthodontic Society	29 24 3 1 1
Members of the public	11
District health board	1
Total	**88**

Summary

- Most complaints fall into two broad categories: those that allege false or misleading advertising of a practitioner's nature of practice, particularly in the area of orthodontics; and those that allege inaccurate use of a specialist title (most prominently "orthodontist").
- Practitioners and professional associations significantly outnumber the public as the source of advertising complaints – 86 percent compared with 12.5 percent of the total complaints received (1.5 percent from a district health board).
- The main form of advertising attracting complaints appears on the internet, that is, practice websites and Google advertising or search listings.

More often than not, advertising indiscretions brought to the Council's attention have not been motivated by dishonesty or blatant attempts to mislead. Practitioners have typically responded favourably to the Council and promptly made changes to their advertising when asked to do so.

Sometimes factors outside the immediate control of a practitioner may affect whether or not, or how, they meet advertising standards at a given time. However, if a practitioner does not take steps to remedy a breach of the advertising practice standard notified to them, they will face closer scrutiny. The Council will consider all the options available and take appropriate action.

Finding simple solutions

Managing advertising complaints is costly and, in some cases, an unnecessary use of Council resources. In most cases, it is likely that a direct and professional communication between practitioners about an advertising concern could remedy the issue simply, without involving the Council. This is supported by our experience that most advertising complaints made to us have involved practitioner oversight or misunderstanding, rather than an intention to mislead the public. It is the practitioner's individual responsibility to ensure all forms of advertising related to their practice comply with the Advertising Practice Standard; the responsibility cannot be delegated.

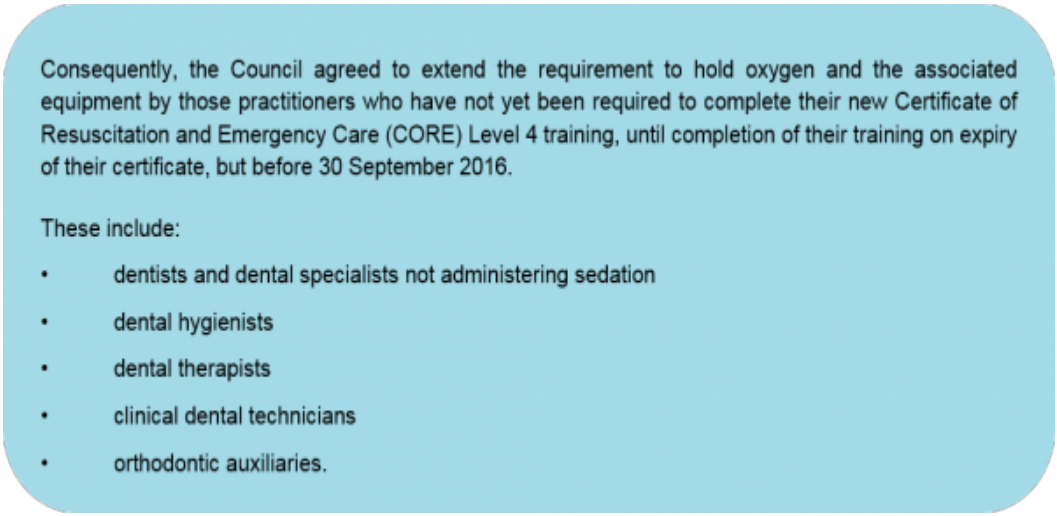
We encourage practitioners, in the first instance, to consider raising their concerns about another practitioner's advertising with that practitioner directly. If direct contact is not possible or else inappropriate, or the concerns raised with the practitioner have not been satisfactorily addressed, a notification to the Council would be appropriate.

Medical emergencies practice standard – oxygen requirement

At its October 2015 meeting, the Council considered a concern expressed by the New Zealand Institute of Dental Technologists about “keeping and administering of oxygen by clinical dental technicians”.

After careful consideration the Council agreed it would not revise its original decision for clinical dental technicians to keep oxygen, to enable practitioners to use it when required in the management of a medical emergency.

However, the Council acknowledged there were inconsistencies in resuscitation training courses offered, in particular, on the appropriate use of emergency drugs. The same concern can be extended to other oral health professionals. In particular, those practitioners whose resuscitation training levels have been increased from Level 3 to Level 4 – being dental hygienists, dental therapists, clinical dental technicians and orthodontic auxiliaries.



Consequently, the Council agreed to extend the requirement to hold oxygen and the associated equipment by those practitioners who have not yet been required to complete their new Certificate of Resuscitation and Emergency Care (CORE) Level 4 training, until completion of their training on expiry of their certificate, but before 30 September 2016.

These include:

- dentists and dental specialists not administering sedation
- dental hygienists
- dental therapists
- clinical dental technicians
- orthodontic auxiliaries.

Furthermore, the Council will revisit the medical emergencies practice standard following the New Zealand Resuscitation Council updates to the resuscitation guidelines and the CORE Review – anticipated in April 2016.

Accreditation outcomes: 2015

The following accreditations of New Zealand programmes were conducted in September 2015. The site evaluation team reports have been considered by the Australian Dental Council/Dental Council (New Zealand) Accreditation Committee and the Council.

In future, all final accreditation reports will be published on the Council's website (/resources-and-publications/education/accreditation-reports/).

Dental technology programmes

The site evaluation team members who conducted the review were:

- Associate Professor David Thomson (Chair) – Associate Professor, Academic Clinical Director, University of Queensland, Prosthodontists registered in Australia
- Mr Brent Norton – Clinical Dental Technician and Dental Technician registered in New Zealand, Wellington
- Ms Leah Taylor – Clinical Dental Technician and Dental Technician registered in New Zealand, Auckland
- Ms Phyllis Huitema – Lay member, Hamilton.

The Council made the following accreditation decisions:

- University of Otago Bachelor of Dental Technology and Bachelor of Dental Technology (honours) programmes: re-accredit for five years, ending 31 December 2020
- University of Otago Postgraduate Diploma in Clinical Dental Technology: re-accredit for five years, ending 31 December 2020.

Various quality improvement recommendations were made for the programmes – these are available in the accreditation reports, available here. (/resources-and-publications/education/accreditation-reports/)

DClinDent (oral surgery)

The site evaluation team members who conducted the review were:

- Associate Professor David Thomson (Chair) – Associate Professor, Academic Clinical Director, University of Queensland, Prosthodontists registered in Australia
- Dr David Chrisp – Oral Surgeon registered in New Zealand, Tauranga
- Dr Stephen Cox – Senior Lecturer and Head of Discipline of Oral Surgery, University of Sydney, Oral Surgeon registered in Australia
- Dr Don Macalister – Oral Surgeon registered in New Zealand, Auckland
- Mr John Robertson – Lay member, Strategic Projects Ltd, Auckland.

The Council accredited the University of Otago DClinDent (oral surgery): accredit for five years, ending 31 December 2020.

The quality improvement recommendations for the programme is contained in the accreditation report, available here. (/resources-and-publications/education/accreditation-reports/)

Current consultations

The Council is currently consulting on the following:

- Infection Prevention and Control Practice Standard (resources-and-publications/publications/current-consultations/infection-prevention-and-control-practice-standard-consultation/) – closing date 18 December 2015
- Proposed entry-level competencies for dental specialties (resources-and-publications/publications/current-consultations/proposed-entry-level-competencies-for-dental-specialties-consultation/) (joint consultation with the Dental Board of Australia) – closing date 15 February 2016
- 2016/17 draft budgets, annual practising certificate and other fees and disciplinary levies, effective from 1 April 2016 – closing date 27 January 2016. (/current-consultations/consultation-on-the-201617-draft-budgets-annual-practising-certificate-fees-disciplinary-levies-and-other-fees-effective-from-1-april-2016/)

We invite all stakeholders to provide feedback on any of these matters.

Publishing of submissions on the Council's website

To facilitate transparency, all submissions received in response to Council consultations will be published on the Council's website shortly after receipt and will remain there as a public document.

All personal contact details will be removed from submissions received by individuals.

Because this is a public consultation, "in confidence" information will only be accepted under special circumstances. Contact the Council before submitting this material.

The Council holds the right not to publish any derogatory or inflammatory submissions.

Council reconfirms Statement on the Administration of Botulinum-A by Dentists

In response to receiving inquiries about dentists administering Botulinum-A (Botox) and a patient complaint on the matter, the Council recently considered the professional obligations of dentists in this area. The Council's Statement on the Administration of Botulinum-A by Dentists was first approved in May 2005 by the then Dentist Board.

At its September 2015 meeting, the Council reconfirmed the positions expressed in the statement.

The statement reads:

The scope of general dental practice includes the administration of Botulinum-A restricted to the nasolabial folds and/or perioral area.

The administration of Botulinum-A is regarded as an advanced area of practice.

This means that dentists wishing to administer Botulinum-A (in the nasolabial folds and/or perioral area):

- must be able to demonstrate they have the requisite knowledge and training to undertake this procedure including knowledge of the relevant scientific literature. This means having documented evidence of training including formal qualifications, courses, continuing professional development and supervised or self-directed training and evidence of logged experience in this area
- must ensure the patient's informed consent for the procedure. The patient should be aware of the methods the practitioner has been trained in and the other options available to them such as treatment by a specialist or another practitioner; must understand the nature of the service/procedure and the possible risks and side effects; and should have a realistic expectation of the results that can be achieved. There must be a clear and comprehensive record of the consent process
- should be aware of the indemnity position in relation to new techniques and procedures.

Dentists administering Botulinum-A are reminded of their professional obligation to comply with the statement expressed above.

Orthodontic working group established

The Council has been receiving an increasing number of expressions of concern and complaints from patients, general dentists and orthodontic specialists concerning the quality and appropriateness of orthodontic treatment provided by general dentists practising orthodontics.

The concerns expressed have primarily related to both inappropriate treatment and poor quality of treatment provided to patients; complex treatment undertaken beyond the practitioner's competence; further orthodontic education and training marketed to dentists who do not hold an orthodontic dental specialist post-graduate qualification; and the potential for irreversible harm being suffered by patients, particularly children and young people.

We have established an orthodontic working group to advise on the provision of orthodontic treatment by general dentists. In particular:

(i) To what extent may general dentists provide orthodontic treatment to patients within their scope of practice?

(ii) Is the scope of practice for general dentistry defined sufficiently that, when considered in concert with the curriculum for the Bachelor of Dental Surgery, University of Otago, the extent of orthodontic treatment that may be provided by a general dentist is readily identifiable?

(iii) To what extent do further education and training post-graduation, not dental specialist post-graduate training, advance practitioner skills and competencies to undertake orthodontic treatment?

(iv) How do practitioners ensure patients, in particular, where children and young people are to be treated, have an appropriate level of understanding:

- to provide informed consent and ongoing assent to a treatment plan that may involve treatment over several years;
- that such treatment is being provided by a general dentist as opposed to a specialist orthodontist; and
- of the differences between a general dentist, or a general dentist practising orthodontics, and a specialist orthodontist?

(v) How do practitioners ensure patient safety when outsourcing the diagnosis and treatment planning, in particular, to overseas-based specialists?

The working group composition and appointees are:

- Dental Council member (working group Chair): Dr Robin Whyman
- registered dentist – performing orthodontic treatments: Dr Brett Hawkins
- registered orthodontist specialist: Dr Winifred Harding
- "Independent" specialist (not orthodontics): Dr Chris Waalkens
- dentist with no particular practice interest in orthodontics: Dr James Talbot
- senior dental academic: Prof Paul Brunton
- children's advocate – Ms Andrea Jamison
- external lay member: Ms Sue Ineson.

Update on the proposed Oral Health Therapy Scope of Practice

The Council consulted on a proposed oral health therapy scope of practice with its stakeholders, with the closing date 20 February 2015.

Because of the large number and the complexity of the submissions received, the Council formed a sub-committee of Council members to undertake a detailed consideration of the submissions and provide the Council with associated recommendations on the various proposals.

In response to the submitters' concerns, the curriculum mapping of programmes was revisited, and further clarification was sought from the Otago Faculty of Dentistry on its Bachelor of Oral Health programme.

This focus resulted from the continued recognition that the education delivered currently in the oral health programmes must underpin the development of the oral health therapy scope of practice.

The committee's recommendations will be considered by the Council early in the new year.

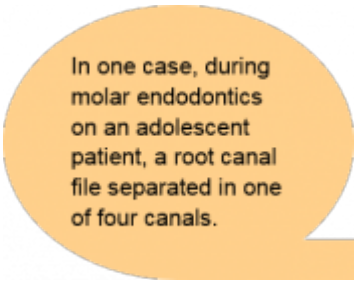
Disciplinary update: Dentist found guilty of professional misconduct

The Health Practitioners Disciplinary Tribunal has found charges laid by the Health and Disability Director of Proceedings against Dr Gaurav Lakra, a dentist of Taumarunui to be proven. The Director of Proceedings alleged that Dr Lakra's conduct in relation to his treatment of a patient between 2008 and 2010 amounted to professional misconduct, and that it brought, or was likely to bring, discredit to the dental profession. The treatment concerned a root canal performed by Dr Lakra where an instrument separated in the canal. Dr Lakra failed to discharge his professional obligations to his patient by failing to inform him that the instrument had separated and had remained in the canal; to advise him of treatment options following the instrument separation; to disclose the real reasons for ongoing treatment and obtain informed consent; and to keep adequate clinical records. As to penalty, the Tribunal ordered that Dr Lakra be censured for his professional misconduct; fined $3,000; and ordered to pay 30 percent of the costs of the proceedings. The Tribunal's full decision is available here (http://hpdt.org.nz/portals/0/den15309ddecisionweb.pdf (http://hpdt.org.nz/portals/0/den15309ddecisionweb.pdf)).

Practitioners’ corner - Knowing when to stop

Patient complaints to the Council are referred on to the Health and Disability Commissioner’s (HDC’s) office. Often, if a complaint raises concerns about a practitioner’s competence, the matter will be referred back to the Council for consideration. Recently, several cases have raised concerns about practitioners’ judgement on when to stop a procedure and reassess before adverse consequences occur.

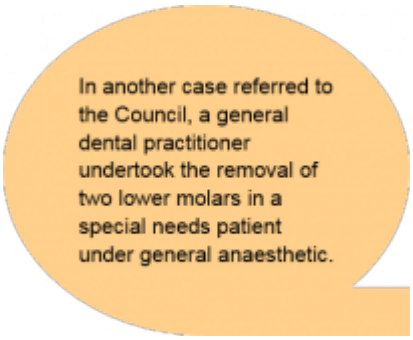
We wanted to share some of these cases with you to show how even small lapses in concentration or judgement can result in harm to the patient.



The practitioner made the decision to book an extra appointment to attempt to bypass the fractured file and complete the treatment. Neither the patient nor the parents were told what had occurred. Bypassing the file proved difficult so a further appointment was scheduled and that attempt resulted in a perforation and a completely unsatisfactory result. Some time later, further symptoms required attention from another practitioner and the patient and parents finally became aware of the true situation. They formally complained to the HDC.

There were several missed opportunities to minimise the risk of complaint, including:

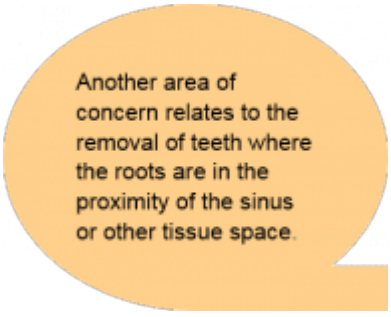
- informed consent: a fractured instrument is an acknowledged risk, but the patient needs to be fully informed before starting treatment
- full and open disclosure when an incident occurs and a discussion of all options available
- careful reflection by the practitioner on their ability (training and experience) to continue and to consider whether a referral to a specialist, or more experienced colleague, would be more appropriate.



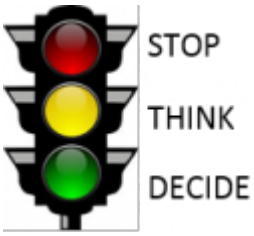
The lower second molar was straightforward (because of substantial alveolar bone loss) but the third molar was vertically impacted and the decision was made to remove bone to access the tooth and facilitate help its removal. Subsequently, the patient returned with pain and swelling and it became clear there was a fracture of the mandible.

Missed opportunities included:

- assessment of the degree of difficulty and the most appropriate technique to be employed
- periodical assessment of progress and consideration of the wider situation (was the bone removal leading to a predisposition to fracture?)
- consideration of whether it was time to stop and refer to a more experienced colleague or specialist
- recognition of a predisposition to fracture and treat accordingly.

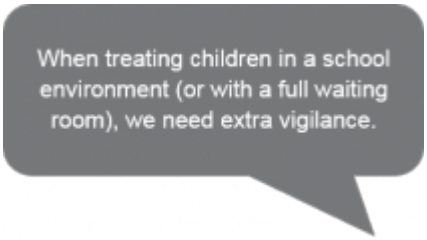


A practitioner attempted to remove a fractured palatal root from an upper molar only to have it disappear into the sinus. The missed opportunities included a careful preoperative assessment; adapting the technique to the clinical situation; and the ability to stop, reflect and perhaps refer to an appropriate colleague.



Take a second look…

A practitioner recommended the removal of third molars for a 20 year old. The lower molars were visible and impacted. An OPG radiograph, taken at another practice, showed upper third molars present but unerupted. The decision was taken to remove the uppers as well, but on raising a flap the practitioner was surprised to see there was no tooth present. On a closer inspection, it became apparent the OPG belonged to someone else – it had been incorrectly labelled at the other practice.

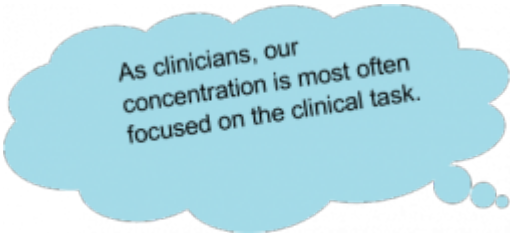


A patient was scheduled to have a small interproximal restoration and was summoned from the classroom to the clinic. After starting the cavity preparation, it became clear there were in fact no caries present. The patient had the same first name as another person who was scheduled to have something completely different. A simple question such as “where do you live?” to confirm identity, may have been sufficient to avoid this adverse outcome.

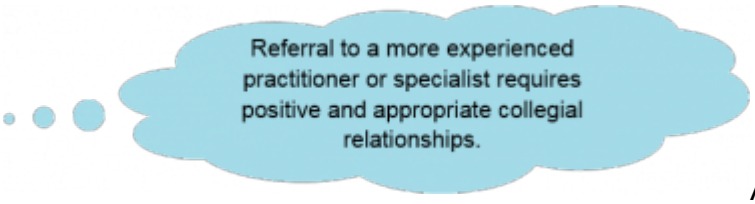
A dentist was asked to remove a second deciduous molar because there was no permanent successor. The dentist was expecting a deciduous second molar to be the second tooth from the back but, unfortunately, the second lower molar was erupted, so the forceps were placed on the first molar and, as the tooth came out, it became clear a major error had occurred.

The patient came in early, antibiotics were given and the patient waited for an hour before treatment started, although the local anaesthetic was administered after 30 minutes. The local anaesthetic was profound and treatment started. The patient complained about the temperature so the window was opened for ventilation. The patient became restless and their skin appeared red so the patient was given time to sit up and rinse. The patient vomited. Then treatment continued, and after 20 minutes it became clear the patient was becoming breathless so treatment was stopped and the patient sat up. The dentist suggested the patient go to a nearby medical practice to be seen by a doctor. A short time later, the patient was in complete anaphylactic shock and required resuscitation and hospitalisation.

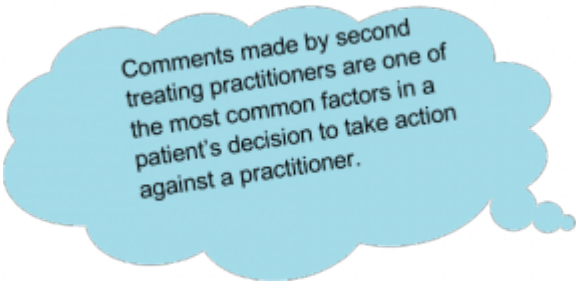
Teamwork…



Our chairside assistants, and other staff members, can bring a fresh perspective and can often see a bigger picture. We need to have an environment where our practice staff feel free to speak up. We need to encourage our staff to be vigilant and to be able to raise concerns with the clinician when they arise. If they get it wrong, they should still be thanked and encouraged to continue to raise concerns in the future.



A supportive, educational relationship encourages practitioners to be more ready to share experiences, seek advice and refer patients when challenging clinical situations arise.



It is important to appreciate, in commenting on the treatment by someone else, that you may not have all of the facts, and any comments you make may well have to be repeated under careful scrutiny at a later date.

Checklists…

- When things go wrong during treatment, our initial reaction can often be adrenalin based – a fight or flight response, which can be less than helpful.
- In medical emergencies, we refer to the "DrsABCD" of resuscitation.
- When other crises arise, it can also be helpful to have checklists or protocols to follow.
- Checklists and protocols allow us to stop and reconsider the position in a reasoned or logical way, which may help us to decide on what steps to take to ensure the best outcome for the patient in what can often be difficult and challenging situations.

And, finally, a word on the Council's practice standards…

Practice standards have been established by the Council to ensure public safety by requiring oral health practitioners to maintain competence throughout their practising career.

By adhering to these standards, we can minimise the risks of adverse outcomes and claims or complaints from our patients.

In the scenarios described above, it is clear numerous incidents occur where standards are not met. The Council's practice standards are available here (/i-practise-in-new-zealand/standards-framework/). It is

useful to familiarise yourself with these from time to time, with practice staff, to ensure ongoing compliance with the standards and to minimise the risk of harm to our patients.

Sometimes, small changes to the way you practise will help avoid harming patients.

Christmas wishes

Office closure

The Dental Council office will close at 1pm on 18 December 2015 and re-open on 5 January 2016.