Appendix one: my 'reflective document'

	Standard	Action	Evidence supplied
1. Put patients' interests first	Listen to your patients	Communication CPD and Liz Gibb Patient questionnaire sent out with every report and available on our website and in our waiting room	CPD Patient questionnaire
	Treat every patient with dignity and respect at all times		
	Be honest and act with integrity		
	Take a holistic and preventative approach to patient care which is appropriate to the individual patient	One hour initial consultation for all patients which includes social, medical and personal histories Written treatment plans Patient questionnaire	Framework template Copy of examination forms
	Treat patients in a hygienic and safe environment	CPD infection control courses and continuous auditing	Audit
	Put patients' interests before your own or those of any colleague, business or organisation	CPD Patient questionnaire	

2. Communicate effectively with patients	Communicate effectively with patients- listen to them, give them time to consider information and take their individual views and communications needs into account	Giving patients time to reflect after treatment strategies presented.	CPD DPL Patient questionnaire Example of report template
	Recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care		
	Give patients the information they need, in a way they can understand, so that they can make informed decisions	Written reports and costs provided	Example of report template
	Give patient clear information about costs		
3. Obtain valid consent	Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs	- CPD courses on consent - Consent sticker/ patient informed - Written treatment plan which requires patients' signature	CPD Report template Consent /patient informed sticker
	Make sure that the patient's consent remains valid at each stage of investigation or treatment	Discuss treatment as it progresses and write an updated report if treatment plan/strategy departs from original treatment plan however trivial that it may appear	Written updated report sent to every patient Patient informed sticker

4. Have a clear and effective complaints procedure	Make sure that there is an effective complaints procedure readily available for patients to use, and follow that procedure at all times	Already well established for years	Complaints procedures and protocols in writing in reception of clinic and on our website. Reviewed annually.
	Respect a patient's right to complain	Providing the complaints procedure protocol in reception and on our website	
	Give patients who complain a prompt and constructive response	As per complaints procedure	
5. Work with colleagues in a way that is in patients' best interests	Be appropriately supported when treating patients	Always supported by registered GDC nurse. If supported by a trainee nurse a registered nurse will be present	Full time GDC registered nurse in employment
	Delegate and refer appro-priately and effectively	Regarding Rubber dam usage and referrals	
	Communicate clearly and effectively with other team members and colleagues in the interest of patients	Be aware of the potential sensitivities of some patients when training staff during treatment. Introduction of protocol of gaining consent from patients beforehand if they mind if a member of staff is undergoing training.	

6. Maintain, develop and work within your professional knowledge and skills	Update and develop your professional knowledge and skills throughout your working life	CPD training in core subjects and Prosthodontics, Restorative Dentistry, Periodontics, Endodontics and Implants	CPD certificates
7. Make sure your personal behaviour maintains patients' confidence in you and the dental profession	Ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession	Publications directed to public press CPD	Publications CPD certificates
	Co-operative with any relevant formal or informal inquiry and give full and truthful information		Evidence give at PCC hearing under oath

Issue	Action taken	Evidence supplied
1. Handling complaints	-Attended courses -.Online courses	CPD course list CPD certificates provided

Reflection

The initial response to this subject has begun with our previous own definition of 'What amounts to a complaint'. Patients leave our clinic for four main reasons which include death (10 cases/year).
Moving geographically which invariably means going overseas as patients who move from the area will continue to make a long journey to us and a small number of patients who have expressed a change in financial circumstances which resulted in a spike in September 2008 when the world banks imploded and let a lot of our entrepreneurial patients struggling.
Finally, an exceedingly small number of patients have left us because they are unhappy with the services provided (less than 12 patients in 24 years amongst a patient population that has now reached 3200).

It is noted that we have established a long term strategy of complaint handling according to guidelines set out by the General Dental Council in addition to gaining patient feedback with in-house surveys.

What has arisen which was not considered previously is the patient who writes to say that they are going elsewhere due to their reduced fiscal circumstances.
In the past, these announcements have been treated wholly administratively by archiving the records and awaiting for the patient to contact us when their circumstances change.

Not infrequently, patients have attended alternative practitioners only to return when they have experienced a loss of confidence with those alternative practices.
However, other than those patients who decease we now have reconsidered an administrative protocol for those patients who decide to move elsewhere whatever the circumstances.
This involves writing a report to summarise all the treatment that they have had with us with a summary of future needs according to our records including a copy of all their records to facilitate continuity of care with the new practitioner. In effect, this is to be likened to our discharge summaries that we effect to GP's when discharging patients from our hospital departments.

Issue	Action taken	Evidence supplied
2. Informing/ awareness of departed treatment strategies	Stickers created to label into patient notes when patients have been informed	Example of sticker

Reflection

Running commentary to keep patients informed is not enough

Information overload

Reliance on patients retaining/hearing the information when experiencing highly charged feelings of fear and anxiety

This is especially so if treatment strategy remains largely unchanged and I have considered the event largely irrelevant

Policy of adverse events established with separate log book and update letter to be sent to patient including all the information of the event copied from the clinical notes

The resonance of these two cases cannot be ignored and whatever was said at the time, the information has not been effectively absorbed by either patient

Adverse events policy established as It is not possible to contradict any patient at later date if reliance has been dependant on verbal information without the separate written report.

We are well aware that we treat a particularly emotionally charged group of patients and in my past hospital history, we have always relied on the verbal running commentary as we never write letters

to patients, we only write to other hospital colleagues. This is a major omission but I suspect that the administration of the demand would be beyond the capacity of the resources. Interestingly, you only have to reflect upon those head and neck cancer patients whom we have just told that they have cancer and then we promptly go into great detail of the treatment strategy proposed when, in all probability, nothing is being absorbed as the patient 'switches off'.

It is wholly untenable and undignified to find ourselves years later in a scene of 'She said.
He said.' as we do now.

Issue	Action taken	Evidence supplied
3. Adverse Events	File created to document and log all adverse events	Examples of logged events

Reflection

Once we considered this topic we realised that our own definition of adverse event invariably meant something serious. A sudden change in the medical status of a patient during their attendance which included two anaphylaxis cases over a 24 year period.

Panic attacks are not infrequent and usually are dealt with sympathetically to assist the patient for a planned procedure to be completed or alternatively to abandon ongoing treatment for reassessment. Counselling and sedation may need to be considered.

Changes in treatment strategy occur many times as treatment occurs and has been primarily managed by keeping the patient informed with ongoing commentary. Unless the event is going to significantly change such as the unexpected loss of a tooth or a significant increase in costs to the patient or a significant change in the treatment strategy we have relied upon the verbal updates as treatment proceeds.
It is not infrequent for changes in treatment strategies throughout a long course of treatment occurs that we constantly update verbally at the time. This has now led to recent criticism and an inability to confirm at a later date. A simple entry in the notes under the title of any change in the treatment plan is to be written in the records followed up by a written report to the patient irrespective of the scale of that event.

Issue	Action taken	Evidence supplied
4. Endodonitics	- Audit carried out of endodontic patients - Audit to be assessed by Endodontic colleague -Audit to be published on website - Audit to be published in journal	Examples of logged events

Reflection

Our endodontic protocols have evolved over 40 years influenced by teachings and philosophies of major players in the field throughout.
We are well aware of clinical outcomes and complications related to longitudinal clinical study publications. We had not been aware of our own statistics. A retrospective and longitudinal follow up documented study of all reviewed patients who have undergone endodontic treatment over the last 20 years has been carried out from February 2013 to the present time which remains ongoing and published on our Clinic website.
The paper has also been presented to colleagues for peer review for proposed presentation to the British Journal of Endodontics to be considered for formal publication.

Issue	Action taken	Evidence supplied
5. Radiographs	- Audit carried out of radiograph grading - Audit carried out of radiograph reporting	Examples of logged events

Reflection

The question of documenting reports of x-Ray's.
We went through a time of producing wet films that could not be viewed until after a patient was discharged from the surgery except diagnostic films during endodontics. This led to scribbling the reports in the patient's file and returning the records to the filing cabinets. We now have dry films that are viewed and reported verbally before the patient is discharged from the surgery with the outcome documented in the notes.

We also realised that all previous audits of x-rays carried out was wholly focused upon the grade and quality of the films and had completely overlooked the documentation of reports. Repeat audits of x-rays are include grading and reports.

Issue	Action taken	Evidence supplied
6. Prescription of antibiotics	Log book used since to document when antibiotics have been prescribed and why Audit to be carried out on antibiotic prescription documenting	- Log book copy - Audit

Reflection

We have established for some considerable time since 06 June 2011 to the present day of recording all prescriptions in a medication log book kept in the drug cabinet recording the name of the patient, the drug prescribed and the clinical reason for the prescription. It is noted that prior to 06 June 2011, we had not established the use of the medicines log book.

Issue	Action taken	Evidence supplied
7. Professional support	- To engage additional staff - Dental Specialist - Practitioner - Dental Nurse - Dental Hygienist	Advertisements and colleague emails

Reflection

There have been comments in general of the weaknesses of single handed practitioners that reached epic proportions and media coverage with the notorious case of Dr Howard Shipman in Manchester who had unlimited access to Controlled Drugs.
This has led to much greater restrictions of prescribing and keeping controlled drugs on premises.
However, the situation of a sole practitioner is now frowned upon generally in view of lack of peer influences and the professional isolation that can result.
As a result, proactive efforts are being made to bring additional colleagues into the team to establish a greater collegiate culture.

Issue	Action taken	Evidence supplied
8. Rubber dam usage	- Canvassed endodontists - Introduction of proforma	Advertisements and colleague emails

Reflection

It is well established that the use of rubber dam is considered the gold standard when carrying out root canal treatments. It provides protection form inhalation of instrumentation and the use one of corrosive irritants that are used for irrigation. A number of situations can arise whereby the use of rubber dam is not possible including patient intolerance, gag reflexes, panic attacks, chronic airway obstruction and insufficient tooth structure. Many endodontists consider that if rubber dam cannot be used, the patient is referred back to the general practitioner for extraction of the tooth.

Others have adopted a pragmatic view and find alternative and safe methods of isolation that avoid causing the patient distress. Having considerable hospital and practice experience of managing patients who are unable to cope with the rubber dam and do not wish to have a tooth extracted have been managed for 35 years with alternative strategies.

The risk/benefit analysis is conducted and the risks of injury are minimised to allow for retention of teeth as learnt by experienced clinical pragmatists in the hospital environment.
In view of the criticism received for this adopted pragmatic approach we have carried out our own survey of other endodontists to gain insight into their own historic policies.
The result of the survey reveals that 5% of endodontists have adopted this pragmatic approach although an element of defensive reporting is likely to lead to doubling the real figure. However, irrespective of our alternative strategies when not using rubber dam, the issues of patient safety are entirely legitimate, relevant and recognised. As a consequence, we are adopting the following protocol:

1. The introduction of a proforma to record the initial assessment whether rubber dam can be used.
2. Explain to all patients the gold standard for rubber dam usage
3. Attempt to persuade patients that it is in their best interests if they allow its use.
4. Offer the alternative of loss of the tooth or
5. Refer to another endodontist for assessment/treatment if the rubber dam is rejected by the patient

Issue	Action taken	Evidence supplied
9. Transparency, Openness and Candour	All changes in treatment strategies, however small, are to be put in writing not only in the clinical records but also in a written report addressed to the patient. Attendances to a formal programme of training to review and ensure transparency, openness and candour are fully understood to avoid any subsequent confusion by patients and our peers.	Occupational counselling programme under the auspices of PsychMetrix Ltd

Reflection

We have found ourselves under criticism for failure to inform patients effectively of changes in treatment strategies in the past. All patients have been kept informed with running commentary as treatment proceeds. If a significant event indicates a complete change in treatment strategy we have always written a letter with an explanation and included any revision of costs of the revised treatment indicated. What we have overlooked are the small deviation of treatment strategies that we consider insignificant and minor and which do not incur additional costs for the patient which we have solely relied upon with the verbal commentary.

We have also developed of a culture of understatement of issues to minimise distress particularly with those patients with intense nervous dispositions. This has opened us up to further criticism of candour when our only intention is to avoid needless distress when we are confident that we are able to resolve the event with minimal fuss.

It is to be noted that this sensitive handling of patients is a culture having worked with oncology patients where the emotional levels of anxiety are particularly highly charged. If I were a wholly matter of fact type, I would tell all my head and neck cancer patients that they have a 50% chance of succumbing to their disease within 5 years and the nature of death will be quite ghastly.

What I choose to tell them inspires hope and reassurance that we will support them through the surgery, radiotherapy and prosthetic rehabilitation and avoid, altogether, mentioning the statistics of mortality unless specifically requested by a patient. If the patient wants to know, answering truthfully with sensitivity is essential. If they don't ask, our senior peers have always advised to say no more than is asked.