Standards in Dentistry

SECOND EDITION

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FGDP (UK)
ADVANCING DENTAL CARE
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The core function of the Faculty of General Dental Practice (UK) is to raise the standards of care delivered to patients, through education of the dental profession and the provision of evidence-based guidance. The FGDP(UK) has long been involved in the development of its own standards, but also has an important role in supporting dental professionals to identify and implement processes which are known to lead to better care outcomes.

The first edition of Standards in Dentistry, published in 2006, was based on the FGDP(UK)’s early publications Self-Assessment Manual and Standards and Guidelines for Structure and Process in Dental Practice, with the aim of developing these guidelines to make them applicable to modern dentistry. Standards in Dentistry was viewed by many as a seminal publication and is widely respected within the dental profession. It is clear that dentistry has changed significantly since the first edition was published, and general dental practitioners find themselves operating within a very different environment to that of 2006. This second edition represents a complete rewrite of the previous publication, which reflects the changing responsibilities and requirements of the dental profession. What has not changed is our continuing desire to promote the highest standards of care for our patients, and this remains at the centre of everything the FGDP(UK) stands for.

Guidelines on safe and effective dental care are produced by a number of reputable organisations and are widely available for assimilation by the dental team. Knowing where and how to access the best quality and most up-to-date information can however be a challenge. The appendices of this edition of Standards in Dentistry have been compiled with the aim of helping the dental team identify and access robust, relevant and readily available guidelines to support effective clinical care.
On behalf of the FGDP(UK) I would like to thank David Moles and the author group from Peninsula Dental School – Ewen McColl, Christopher Tredwin, Robert Witton and Lorna Burns – for their tireless dedication in compiling this edition. Thanks are also owed to members of the FGDP(UK) Board and Divisions who have taken time to read, review and comment upon drafts of this document, the many external consultees who took time to provide feedback and suggestions, to Kenneth Eaton for laying the groundwork in the first edition, and to Mick Horton for his wholehearted support of this project during his term as Dean of the FGDP(UK).

The provision of guidance and standards will remain among our primary purposes as we work with the Royal College of Surgeons of England to establish a new College of General Dentistry. *Standards in Dentistry* is central to this role, and the second edition is an indispensable reference guide which will assist the whole dental team in identifying appropriate standards for the delivery of high quality care.

Ian Mills
Dean, Faculty of General Dental Practice (UK) – 2018
ACKNOWLEDGEMENTS

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David Moles
Ewen McColl
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Robert Witton
Lorna Burns

The authors wish to thank all the individuals and organisations that have generously given their time and expertise to comment on the drafts of the second edition of Standards in Dentistry. Their input has been enormously valuable in shaping this publication. We would particularly like to thank our colleague Timothy O’Brien who was always on hand to act as a sounding board and for his dento-legal expertise.

In some cases we have had to resolve strongly-held but contradictory views held by consultees and peer reviewers. This is an indication of the extent to which members of our profession care passionately about the standards of care we all endeavour to provide and it also illustrates the subjective nature of clinical practice. While the evidence base for primary care dentistry is constantly improving, it is clear that much remains almost as much an art as a science. Often there is not a single best way of providing care, and this publication is just one of several reasonable approaches to the provision of primary dental care.
Acknowledgements
The Faculty of General Dental Practice (UK) would also like to express its thanks to the following individuals and organisations for their review, comments and support during the development of this document:

British Dental Association
British Society of Dental Hygiene & Therapy
Faculty of Dental Surgery, Royal College of Surgeons of England
General Dental Council
Medical and Dental Defence Union of Scotland
Restorative Dentistry UK
Simplyhealth Professionals (Denplan)
Health and Social Services Group, Welsh Government

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<tr>
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<td>Janet Goodwin</td>
<td>Susan Nelson</td>
<td>Jane Woodington</td>
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<td>Matthew Holyoak</td>
<td>Timothy O'Brien</td>
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1.1 CLINICAL STANDARDS AND THE FACULTY OF GENERAL DENTAL PRACTICE (UK)
The mission of the Faculty of General Dental Practice (UK) is “to positively influence oral health, through education of the dental profession and the provision of evidence-based guidance.”¹ For over a quarter of a century, the FGDP(UK) has produced guidance describing and promoting standards in dentistry, beginning with the publication of the Self Assessment Manual and Standards (SAMS) in 1991.² In 2006, under the editorship of Kenneth Eaton, the FGDP(UK) updated and brought together its existing standards and guidelines within the publication of Standards in Dentistry.³ More than a decade has now passed since the first edition, and the time has come to review and update Standards in Dentistry in the light of changes in the evidence base and in the clinical, organisational and dento-legal context in which dentistry is practised.

1.2 DEFINITIONS
This second edition of Standards in Dentistry adopts the following definitions:

- **Clinical guidelines** are systematically-developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.⁴ ⁵
- A **standard** is a definable measure against which existing structures, processes or outcomes can be compared.⁶

1.3 THE PURPOSE OF GUIDELINES AND STANDARDS
It might not be feasible, or even desirable, for all patients to receive identical healthcare. Care provision should be tailored to address individual need and the specific context in which the care is provided. Some variation in healthcare provision is accordingly both inevitable and essential. However, not all variation in practice
is desirable, and the wellbeing of patients can be put at risk through unjustifiable variations, such as the provision of treatments that have been shown to be ineffective or poorly tolerated. Thus patients should not expect to receive identical care, but they do have the right to expect that the care they receive accords with evidence of good practice and is appropriate within the available resources.\(^7\)

Guidelines provide recommendations in the management of clinical conditions where variations in practice occur and where effective care may not be delivered uniformly.\(^5\) Clinical standards are used to describe the specific elements of care that need to be correct in order to optimise the outcomes for patients. Standards must be unambiguous and measurable. These qualities enable practitioners to target and monitor efforts to improve the quality of care they provide and, when used transparently, their use serves an additional purpose of promoting public confidence and accountability.\(^7\)

### 1.4 LEVELS OF STANDARDS
Standards may be set at differing levels depending on their intended purpose, for example, minimal and exemplary. Minimal levels are used to describe essential standards of care. Falling below minimal levels would indicate the need for remedial or possibly punitive action. At the other end of the spectrum, exemplary standards may be used to promote aspirational practice. Standards should represent an agreed level of performance and those involved in delivering and receiving the care should determine the standards.\(^8\)

### 1.5 TYPES OF STANDARDS
Standards may measure either the process or outcome of care. While outcome standards permit an understanding of what is ultimately achieved by healthcare, they remain difficult to apply due to the potential influence of factors that may not be within the control of healthcare providers, and they are often difficult to measure within realistic time scales (e.g. the outcomes of care aimed at reducing the risks of future disease often require long-term monitoring to establish their effectiveness). Consequently, process (and sometimes structure) measures are more commonly used, especially when there is evidence linking the process to the desired outcome. Poor performance on a process measure is used to indicate which aspects of care practice require remedial action.\(^8\)
1.6 COMPLIANCE WITH STANDARDS

Compliance with standards can be promoted through clinical audit, educational activities and feedback from peers or patients. Where standards are considered to represent a minimum essential level of acceptable care, they may additionally be enforced through systems of governance.

1.7 DENTO-LEGAL ISSUES IN RELATION TO GUIDELINES AND STANDARDS

Within a dento-legal context when judging the performance of a practitioner, it is essential that any standards used are measured against a reasonable peer group. For a general dental practitioner (GDP), that means a peer group of other GDPs; not the standard that could be achieved by a specialist. While a GDP is not expected to achieve the same standard of care as a specialist, they should however refer to a specialist when it is appropriate to do so. There has been some debate within the profession as to whether appropriate standards have been applied when measuring the performance of practitioners. Clearly, it is easier to fall seriously short of a standard if the standard is being placed at an unreasonably high level in the first instance. This can occur when aspirational standards that might be achieved by a specialist are misinterpreted as being those of a general dentist. Under such circumstances, a practitioner may be at risk of criticism about their clinical care when their standard of care could have been deemed acceptable, or even desirable, if it were not for the elevated standard against which they are being judged. The standards against which a practitioner is judged are further complicated when guidelines intersperse opinion with evidence-based guidance; where there are multiple guidelines that provide conflicting advice; where guidelines change over time and/or the evidence base is poor, and; where some guidelines are given undue weight on the basis of eminence.

Therefore, any measure of performance has to:

• Be judged against minimum (basic) standards, not aspirational standards, that were acceptable at the time.
• Be considered within the specific context of the particular patient and environment; and
• Take account of the practitioner’s justification which should be evident from the records.
1.8 THE FACULTY OF GENERAL DENTAL PRACTICE (UK) POSITION

The Faculty of General Dental Practice (UK) recognises that clinical guidelines and standards are often used by dental advisers and experts in both a court setting or during General Dental Council (GDC) Fitness to Practise proceedings. The issue of misinterpretation of Faculty guidelines was explicitly addressed in the third edition of *Clinical Examination and Record Keeping* (2016). The FGDP(UK) makes a clear distinction between essential/baseline practice and aspirational/gold standard practice.

Recommendations in this document are categorised as A (Aspirational), B (Basic) and C (Conditional upon circumstances). The FGDP(UK) position is that no practitioner should be censured for failing to meet A grade recommendations. Nor does a failure to meet B or C grade recommendations necessarily imply negligence on the part of the clinician. A clinician must assess each clinical situation on its merits, in the circumstances in which they find themselves, and with the evidence available to them, they must use their clinical judgement to settle on a course of action. It is possible to fail to adhere to our recommendations and still be acting in the patient’s best interests. However, we would recommend that when taking a course of action other than that recommended in these guidelines, a clinician should clearly justify their reasoning in the records.

1.9 APPROACH ADOPTED IN THE SECOND EDITION

In light of the context in which primary care dentistry is delivered, this second edition is based on four principles:

1. The clinical standards described relate specifically to process measures. They describe standards associated with how dentistry is delivered/provided. They do not refer to outcomes of dental care since these may be influenced by a diverse array of factors, many of which are outside the control of practitioners. Thus, for example while we recognise that a good standard of oral hygiene may be an important factor in the likelihood of success of many types of care, it is not listed as a ‘standard’ within this book since it is an outcome in its own right and is highly dependent on the efforts of the patient.

2. We have endeavoured to produce standards that are appropriate to the dental primary care environment. Specialist societies often produce standards and
guidelines of their own, often as a result of expert consensus and evidence review. However, these may on occasions relate to a specialised or ideal level of care that is beyond the scope of even aspirational primary care practice. As such we have not reproduced the content of those guidelines and standards in the following chapters as we do not wish to risk perpetuating a dento-legal framework in which practitioners may be unduly sanctioned as the standard they are judged against is not one of a reasonable peer group. We have however, provided signposting to these in appendix A1 for those seeking further information.

3 The recommendations for clinical standards provided follow the classification system used in *Clinical Examination and Record-Keeping (2016)* and *Dementia-Friendly Dentistry (2017)* and should be viewed in the same way.

4 Various tables in this edition present percentages for standards; particularly with regard to radiography. These refer to published standards that apply to practice audits, not to the provision of individual items or the care of individual patients.

### 1.10 STRUCTURE OF THE SECOND EDITION

This edition is structured in a similar manner to the first edition in so far as the following chapters distinguish between **Clinical standards** (now chapter 2) and **Guidelines for structure and process in dental practice** (now chapter 3). Chapter 2 consists of tables of clinical standards that have been produced by the authors using the FGDP(UK)’s ABC categorisation. In all cases, the standards have undergone peer review prior to publication in order to calibrate them as being appropriate for the dental primary care setting. Chapter 3 signposts readers to current sources of relevant guidance for practice management that were available at the time of writing.

The first edition of *Standards in Dentistry* highlighted the dynamic nature of standards and guidelines. This is no less the case now than it was in 2006. While it is impossible to ‘future proof’ any guidance, the second edition now includes an additional section on **Keeping up-to-date** (chapter 4) which directs readers towards some of the most relevant sources of clinical guidelines and standards, and provides some hints and tips so that practitioners can check reasonably rapidly whether they are accessing the most contemporary evidence-based guidance.
1.11 REFERENCES
1. FGDP(UK). Faculty of General Dental Practice (UK). Available at: www.fgdp.org.uk.
2.1 INTRODUCTION

In compiling clinical standards, we were acutely aware that every clinical contact sets a different set of circumstances for the clinician to deal with. Not only is every patient different, but every tooth and every patient contact presents variable factors that make standardising dentistry an extremely challenging task. We based our standardisation on key elements of every patient contact, namely:

- Assessment.
- Diagnosis.
- Valid consent.
- Control of active disease.
- Careful consideration of prognostic indicators for teeth.

While the intricacies of standards for individual disciplines can be accessed via the various specialist bodies (some of which are listed in appendix A1) we were acutely aware that complex as dentistry is, the fundamentals to optimal patient care can be based on these key principles. These principles stand firm whether placing a single surface restoration or undertaking full mouth rehabilitation. While we aspire to these standards, the grading system of Aspirational, Basic and Conditional (ABC) recognises the importance of patient factors which are often beyond our control as clinicians. For example, despite our best efforts, we may not be able to significantly improve the patient’s oral hygiene or systemic risk factors that make control of periodontal disease extremely challenging. This element of compromise is something clinicians face on a daily basis, and the standards are designed to reflect this.
### 2.2 CONSULTATION AND DIAGNOSIS

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Radiographs appropriate for diagnosis and risk have been selected, justified, taken to excellent standard (rating 1)(^1) and reported on.</td>
<td>- Valid consent.</td>
<td>- Hard tissue charting.</td>
</tr>
<tr>
<td>- Appropriate photographs taken.</td>
<td>- Medical and socio-behavioural history checked in accordance with current recommendations.(^2)</td>
<td>- Appropriate written diagnosis and treatment plan provided for hygienist/therapist if patient on referral.</td>
</tr>
<tr>
<td>- Consideration given to all systemic risk factors and evidence that advice has been given to address these.</td>
<td>- Appropriate health screening.</td>
<td>- Appropriate onward referral.</td>
</tr>
<tr>
<td>- Full consideration given to all prognostic indicators (endodontic, periodontic and restorative).</td>
<td>- Oral mucosa screened.</td>
<td>- Appropriate behavioural management techniques utilised on journey to achieve oral health.</td>
</tr>
<tr>
<td>- Written diagnosis, rationale for treatment plan and aim of treatment provided to patient.</td>
<td>- BPE recorded as appropriate.</td>
<td>- Alcohol identification and brief advice given in accordance with guidelines.(^3,5)</td>
</tr>
</tbody>
</table>

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\(^1\) Extent and severity of disease documented and patient advised.
\(^2\) Consideration given to most significant prognostic indicators (endodontic, periodontic and restorative).
\(^3\) Written recording of all relevant information.

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### 2.2 CONSULTATION AND DIAGNOSIS (CONTINUED)

<table>
<thead>
<tr>
<th>BASIC (CONTINUED)</th>
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<tbody>
<tr>
<td>• Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.</td>
</tr>
<tr>
<td>• Oral health and hygiene advice.</td>
</tr>
<tr>
<td>• Recalls in accordance with risk status and recommended guidelines.</td>
</tr>
</tbody>
</table>

# 2.3 MAKING AND RECEIVING REFERRALS

## ASPIRATIONAL

- **General principles:**
  - Indicate if referral is NHS or private.
- **Personal information recorded:**
  - Occupation.
  - Signature for verification.
- **Factors affecting appointment recorded:**
  - Timing.
  - Mobility.
  - Travel considerations.

## BASIC

- **General principles:**
  - Summary of relevant dental and medical history.
  - Clear indication of the condition/reason for referral.
  - All information disclosed with patient’s consent.
  - Options discussed and patient’s preferences noted.
  - Indication of the level of urgency.
  - Contact details of referring practitioner.
  - Referral letter dated and copy kept in patient’s notes.
  - Upon completion of treatment the receiving dentist should send a written report to the referring dentist confirming what has been undertaken and any arrangements for follow-up.
- **Personal information recorded:**
  - Name.
  - Address.

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## CONDITIONAL

- **General principles:**
  - Write ‘cancer suspected’ if applicable.
  - Follow up on all urgent referrals to confirm action has been taken.
  - Copies of relevant test results, including radiographs and photographs, provided.
- **Personal information recorded:**
  - Patient dependent on someone.
  - Email.
  - Relevant specialist practitioner.
  - NHS identification number.
- **Socio-behavioural history recorded:**
  - Smoking.
  - Alcohol consumption.
  - Eating habits.
  - Dietary information.
  - Contact sports.
  - Musical instruments.
- **Previous dental history recorded:**
  - Chewing unrestricted.
  - Restorative procedures.

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2.3 MAKING AND RECEIVING REFERRALS (CONTINUED)

<table>
<thead>
<tr>
<th>BASIC (CONTINUED)</th>
<th>CONDITIONAL (CONTINUED)</th>
</tr>
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<tbody>
<tr>
<td>– Date of birth.</td>
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<tr>
<td>– Telephone numbers.</td>
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<tr>
<td>– Preferred contact method.</td>
<td></td>
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<tr>
<td>– [For children] parental contact details.</td>
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<tr>
<td>– Emergency contact.</td>
<td></td>
</tr>
<tr>
<td>– General medical practitioner.</td>
<td></td>
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<tr>
<td>• Medical history recorded:</td>
<td></td>
</tr>
<tr>
<td>– New form completed or updated.</td>
<td></td>
</tr>
<tr>
<td>– Dated and signed by patient and clinician.</td>
<td></td>
</tr>
<tr>
<td>– Orthodontic care.</td>
<td></td>
</tr>
<tr>
<td>– Endodontic care.</td>
<td></td>
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<tr>
<td>– Oral surgery procedures.</td>
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<tr>
<td>– Oral hygiene routine.</td>
<td></td>
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<tr>
<td>– Anxiety.</td>
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<tr>
<td>• Factors affecting appointment recorded:</td>
<td></td>
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<tr>
<td>– Carer to be present.</td>
<td></td>
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<tr>
<td>– Physical and mental impairments.</td>
<td></td>
</tr>
<tr>
<td>– Need for domiciliary care or special equipment/facilities.</td>
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</tbody>
</table>

More detailed information, including details of what, when, and how to refer is available in:
Faculty of General Dental Practice (UK). *Clinical examination and record-keeping*. London: FGDP(UK); 2016.
### 2.4 Paediatric Dentistry

<table>
<thead>
<tr>
<th><strong>Aspirational</strong></th>
<th><strong>Basic</strong></th>
<th><strong>Conditional</strong></th>
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<tbody>
<tr>
<td>• Advise first visit by age 1.</td>
<td>• Valid consent (parent/guardian).</td>
<td>• Appropriate onward referral.</td>
</tr>
<tr>
<td>• Primary prevention including dietary advice, oral hygiene instruction and fluoride advice starting from first dental visit.</td>
<td>• Medical and socio-behavioural history checked in accordance with current recommendations.</td>
<td>• Appropriate behavioural management techniques utilised on journey to achieve oral health.</td>
</tr>
<tr>
<td>• Radiographs appropriate to management have been selected and taken to excellent standard (rating 1).</td>
<td>• Extent and severity of disease documented and patient/guardian advised.</td>
<td>• Consideration of safeguarding issues where there are grounds for suspicion.</td>
</tr>
<tr>
<td>• Appropriate photographs taken.</td>
<td>• Radiographs appropriate to management have been selected, justified, taken to an acceptable standard (≥70% rating 1, &lt;20% rating 2; &lt;10% rating 3) and reported on.</td>
<td>• Written consent obtained.</td>
</tr>
<tr>
<td>• Consideration given to all systemic risk factors and evidence that advice has been given to address these.</td>
<td>• Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.</td>
<td></td>
</tr>
<tr>
<td>• Written diagnosis, rationale for treatment plan and aim of treatment provided to parent/guardian.</td>
<td>• Recalls in accordance with risk status and recommended guidelines.</td>
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1. Rating scale: 1 = Excellent, 2 = Good, 3 = Satisfactory, 4 = Unsatisfactory.
# 2.5 Orthodontics

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<thead>
<tr>
<th><strong>Aspirational</strong></th>
<th><strong>Basic</strong></th>
<th><strong>Conditional</strong></th>
</tr>
</thead>
</table>
| - Radiographs appropriate to the orthodontic management have been selected, justified, taken to excellent standard (rating 1)\(^1\) and reported on.  
- Appropriate photographs taken. | - Primary preventative advice.  
- Patient, parent/guardian understands reason for orthodontic assessment.  
- Medical and socio-behavioural history checked in accordance with current recommendations.\(^2\)  
- Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.\(^3\)  
- Radiographs appropriate to orthodontic management have been selected, justified, taken to an acceptable standard (\(>70\%\) rating 1;  
\(<20\%\) rating 2; \(<10\%\) rating 3)\(^1\) and reported on.  
- Appropriate orthodontic assessment and referral as necessary.\(^4\) **Deciduous dentition:**  
  - Individuals with cleft lip and/or palate, or other craniofacial anomalies.  
  - Severe maxillary/mandibular | - Patient aware of need for good oral health and diet during treatment.  
- All active dental disease under control prior to commencement of orthodontic treatment.  
- Index of Orthodontic Treatment Need (IOTN) score recorded.  
- When referring a patient to a specialist for orthodontic treatment, the specialist will be able to confirm whether the patient qualifies for NHS treatment on the basis of IOTN.  
- Appropriate advice sought when there are severely hypoplastic/carious first molars of poor long-term prognosis.  
- Any relevant radiographs and salient information included in any referral letter including:  
  - Details of any previous dental treatment especially trauma.  
  - IOTN grade.  
  - Urgency.  
  - Patient awareness of referral. |  > continued on next page |

\(^1\) Continued on next page
### 2.5 ORTHODONTICS (CONTINUED)

<table>
<thead>
<tr>
<th>BASIC (CONTINUED)</th>
<th>CONDITIONAL (CONTINUED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>disproportion (but only if parents are concerned, otherwise wait until the mixed dentition stage).</td>
<td>– Previous orthodontic treatment.</td>
</tr>
<tr>
<td><strong>Occlusal problems in the mixed dentition:</strong></td>
<td>• Written consent obtained.</td>
</tr>
<tr>
<td>– Anterior or posterior crossbites with associated mandibular displacements.</td>
<td>• Check patient committed to wearing appliances during treatment.</td>
</tr>
<tr>
<td>– Class III in the mixed dentition.</td>
<td>• Check patient committed to long-term wear and maintenance of retainers once active treatment is completed.</td>
</tr>
<tr>
<td>– Class II/I malocclusion where there is an underlying skeletal II pattern.</td>
<td></td>
</tr>
<tr>
<td>– Asymmetry in the pattern of tooth eruption.</td>
<td></td>
</tr>
<tr>
<td>– Lack of palpable canine bulges buccally at 10-12 years.</td>
<td></td>
</tr>
<tr>
<td>– Hypodontia.</td>
<td></td>
</tr>
<tr>
<td>– Supernumerary teeth.</td>
<td></td>
</tr>
<tr>
<td>– Submerged deciduous molars.</td>
<td></td>
</tr>
<tr>
<td>– Impacted first permanent molars.</td>
<td></td>
</tr>
<tr>
<td>– Periodontal problems caused by severely ectopic tooth position.</td>
<td></td>
</tr>
<tr>
<td>– Severe crowding of incisors.</td>
<td></td>
</tr>
<tr>
<td><strong>Types of occlusal problem in the permanent dentition:</strong></td>
<td></td>
</tr>
<tr>
<td>– All other malocclusions.</td>
<td></td>
</tr>
</tbody>
</table>

## 2.6 MANAGEMENT OF ACUTE PAIN

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Radiographs appropriate to the diagnosis and management of pain have been selected, justified, taken to excellent standard (rating 1) and reported on.</td>
</tr>
<tr>
<td>• Appropriate photographs taken.</td>
</tr>
<tr>
<td>• Consideration given to all systemic risk factors and evidence that advice has been given to address these.</td>
</tr>
<tr>
<td>• Immediate pain relief at initial appointment.</td>
</tr>
<tr>
<td>• Written diagnosis, differential or definitive noted. Rationale for pain treatment plan and aim of treatment provided to patient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Examination undertaken in accordance with FGDP(UK) guidelines.</td>
</tr>
<tr>
<td>• Valid consent.</td>
</tr>
<tr>
<td>• Medical and socio-behavioural history checked in accordance with current recommendations.</td>
</tr>
<tr>
<td>• Structured pain history.</td>
</tr>
<tr>
<td>• Radiographs appropriate to the diagnosis and management of pain have been selected, justified, taken to an acceptable standard (&lt;70% rating 1; &lt;20% rating 2; &lt;10% rating 3) and reported on.</td>
</tr>
<tr>
<td>• Appropriate action to relieve pain taken.</td>
</tr>
<tr>
<td>• Follow up/review appointment if required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Special tests appropriate to the presenting condition.</td>
</tr>
<tr>
<td>• Oral health/systemic health interactions explained and appropriate advice given to patients with systemic health issues that may be exacerbated by or exacerbate their pain.</td>
</tr>
<tr>
<td>• Where indicated, antibiotics used in line with FGDP(UK) antimicrobial prescribing guidelines.</td>
</tr>
<tr>
<td>• Appropriate management techniques utilised to relieve pain.</td>
</tr>
<tr>
<td>• Written pain relief treatment plan provided to patient.</td>
</tr>
<tr>
<td>• Appropriate signposting for future care to achieve dental health.</td>
</tr>
<tr>
<td>• Written consent obtained.</td>
</tr>
</tbody>
</table>
### 2.7 PERIODONTOLOGY

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
</table>
| - Radiographs appropriate to management of the periodontal condition have been selected, justified, taken to excellent standard (rating 1) and reported on.  
- Appropriate photographs taken.  
- Consideration given to all systemic risk factors and evidence that advice has been given to address these.  
- Full consideration given to all prognostic indicators (endodontic, periodontic and restorative).  
- Written diagnosis, rationale for treatment plan and aim of treatment provided to patient. | - Valid consent.  
- Medical and socio-behavioural history checked in accordance with current recommendations.  
- Appropriate health screening.  
- BPE recorded.  
- Appropriate indices recorded following BPE (gPPC, plaque and bleeding scores) when necessary.  
- Radiographs appropriate to management of the periodontal condition have been selected, justified, taken to an acceptable standard (≥70% rating 1; <20% rating 2; ≤10% rating 3) and reported on.  
- Extent and severity of disease documented and patient advised.  
- Consideration given to most significant prognostic indicators (endodontic, periodontic and restorative).  
- Written treatment plan provided to patient. > continued on next page | - Oral-health/systemic-health interactions explained and appropriate advice given to patients with systemic health issues that may be exacerbated by or exacerbate their periodontal condition.  
- Appropriate written diagnosis, treatment plan and prescription provided for hygienist/therapist.  
- Smoking cessation advice given in accordance with guidelines.  
- Appropriate onward referral.  
- Where indicated, antibiotics used in line with FGDP(UK) antimicrobial prescribing guidelines.  
- Written consent obtained. |
2.7 PERIODONTICS (CONTINUED)

BASIC (CONTINUED)

- Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.¹
- Consideration of oral hygiene and plaque as a causative factor.
- Initial disruption of biofilm by patient and operator in conjunction with elimination of plaque retentive factors.
- Further disruption of biofilm incorporating scaling and root surface debridement in conjunction with patient home-care.
- Appropriate periodontal maintenance plan tailored to risk profile of patient.

### 2.8 DIRECT (PLASTIC), CORONAL AND ROOT SURFACE RESTORATIONS

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appropriate use of rubber dam.</td>
<td>• Valid consent.</td>
<td>• Appropriate material type selection following consultation with patient.</td>
</tr>
<tr>
<td>• Radiographs appropriate to assess and plan restoration have been selected,</td>
<td>• Medical and socio-behavioural history checked in accordance with current recommendations. (\text{rating 1} ) (\text{rating 2} ) (\text{rating 3} ) and reported on.</td>
<td>• Appropriate contact points maintained.</td>
</tr>
<tr>
<td>justified, taken to excellent standard (rating 1) (\text{rating 2} ) (\text{rating 3} ) and reported on.</td>
<td>• Appropriate health screening.</td>
<td>• Appropriate behavioural management technique utilised on journey to achieve oral health.</td>
</tr>
<tr>
<td>• Appropriate photographs taken.</td>
<td>• Radiographs appropriate to assess and plan restoration have been selected, justified, taken to</td>
<td>• Written consent obtained.</td>
</tr>
<tr>
<td>• Full consideration given to prognostic indicators (endodontic, periodontic</td>
<td>an acceptable standard ((&gt;70% \text{ rating 1} ); (&lt;20% \text{ rating 2} ); (&lt;10% \text{ rating 3} )) and reported on.</td>
<td></td>
</tr>
<tr>
<td>and restorative).</td>
<td>• Patient informed of complexities and prognostic indicators relevant to restoration.</td>
<td></td>
</tr>
<tr>
<td>• Consideration given to all systemic risk factors and evidence that advice</td>
<td>• Consideration given to most significant prognostic indicators (endodontic, periodontic and</td>
<td></td>
</tr>
<tr>
<td>has been given to address these.</td>
<td>restorative).</td>
<td></td>
</tr>
<tr>
<td>• Written diagnosis, rationale for treatment plan and aim of treatment</td>
<td>• Written treatment plan provided to patient.</td>
<td></td>
</tr>
<tr>
<td>provided to patient.</td>
<td>• Consideration given to preventable disease risk indicators and appropriate preventative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>advice given in accordance with the prevailing guidelines.</td>
<td></td>
</tr>
</tbody>
</table>

> continued on next page
### 2.8 DIRECT (PLASTIC), CORONAL AND ROOT SURFACE RESTORATIONS (CONTINUED)

<table>
<thead>
<tr>
<th>BASIC (CONTINUED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appropriate materials, equipment and technique tailored to suit case.</td>
</tr>
<tr>
<td>• Preservation of tooth structure where possible.</td>
</tr>
<tr>
<td>• Occlusal harmony sought.</td>
</tr>
<tr>
<td>• No visible plaque-retaining factors caused by restoration.</td>
</tr>
<tr>
<td>• Appropriate instruction on care of restoration.</td>
</tr>
<tr>
<td>• Recalls in accordance with risk status and recommended guidelines.</td>
</tr>
</tbody>
</table>

### 2.9 INDIRECT CORONAL RESTORATIONS (CROWNS, BRIDGES, ONLAYS, VENEERS)

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Radiographs appropriate to assess and plan restoration have been selected, justified, taken to excellent standard (rating 1)³ and reported on.</td>
<td>• Valid consent.</td>
<td>• Appropriate onward referral.</td>
</tr>
<tr>
<td>• Appropriate photographs taken.</td>
<td>• Medical and socio-behavioural history checked in accordance with current recommendations.²</td>
<td>• Appropriate disease management undertaken prior to provision of restoration.</td>
</tr>
<tr>
<td>• For veneers: preparation remains entirely in enamel if possible.</td>
<td>• Appropriate health screening.</td>
<td>• Material consideration to suit both aesthetic and functional needs of final restoration.</td>
</tr>
<tr>
<td>• Consideration given to all systemic risk factors and evidence that advice has been given to address these.</td>
<td>• Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.³</td>
<td>• Appropriate tissue retraction techniques.</td>
</tr>
<tr>
<td>• Full consideration given to prognostic indicators (endodontic, periodontic and restorative).</td>
<td>• Radiographs appropriate to assess and plan restoration have been selected, justified, taken to an acceptable standard (rating 1; &lt;20% rating 2; &lt;10% rating 3)³ and reported on.</td>
<td>• Appropriate assessment of occlusion.</td>
</tr>
<tr>
<td>• Written diagnosis, rationale for treatment plan and aim of treatment provided to patient.</td>
<td>• Consideration given to most significant prognostic indicators (endodontic, periodontic and restorative).</td>
<td>• Written consent obtained.</td>
</tr>
</tbody>
</table>

> continued on next page
### 2.9 INDIRECT CORONAL RESTORATIONS (CROWNS, BRIDGES, ONLAYS, VENEERS) (CONTINUED)

<table>
<thead>
<tr>
<th>BASIC (CONTINUED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Written treatment plan provided to patient.</td>
</tr>
<tr>
<td>• Preservation of tooth tissue.</td>
</tr>
<tr>
<td>• Adequate form and reduction to suit final restoration.</td>
</tr>
<tr>
<td>• Selection and use of appropriate impression material or digital impression technique to suit individual case.</td>
</tr>
<tr>
<td>• Tooth preparation recorded suitably with impression.</td>
</tr>
<tr>
<td>• Sufficient other teeth recorded suitably in impressions.</td>
</tr>
<tr>
<td>• Appropriate prescription to dental technician.</td>
</tr>
<tr>
<td>• No damage to teeth adjacent to preparation and un-prepared tooth tissue.</td>
</tr>
<tr>
<td>• Maintenance of space/gingival health.</td>
</tr>
<tr>
<td>• Occlusal harmony sought.</td>
</tr>
<tr>
<td>• Appropriate instruction on care of restoration.</td>
</tr>
<tr>
<td>• Recalls in accordance with risk status and recommended guidelines.</td>
</tr>
<tr>
<td>• Statement of manufacture retained and offered to patient.</td>
</tr>
</tbody>
</table>

---

## 2.10 ENDODONTICS

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Radiographs appropriate to management of the endodontic condition have been selected, justified, taken to excellent standard (rating 1)&lt;sup&gt;1&lt;/sup&gt; and reported on.</td>
<td>• Valid consent.</td>
<td>• Appropriate onward referral.</td>
</tr>
<tr>
<td>• Appropriate photographs taken.</td>
<td>• Medical and socio-behavioural history checked in accordance with current recommendations.&lt;sup&gt;2&lt;/sup&gt;</td>
<td>• Straight line access and use of appropriate burs.</td>
</tr>
<tr>
<td>• Full consideration given to prognostic indicators (endodontic, periodontic and restorative).</td>
<td>• Appropriate use of rubber dam.</td>
<td>• Use of heated techniques to fill the 3D root canal space.</td>
</tr>
<tr>
<td>• Consideration given to all systemic risk factors and evidence that advice has been given to address these.</td>
<td>• Primary disease (caries and periodontal diseases) addressed and controlled.</td>
<td>• Appropriate canal enlargement to permit flow of irrigants.</td>
</tr>
<tr>
<td>• Use of electronic apex locator.</td>
<td>• Pain history, sensibility testing and diagnosis.</td>
<td>• Radiographic confirmation of working length.&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Written diagnosis, rationale for treatment plan and aim of treatment provided to patient.</td>
<td>• Sufficient coronal dentine to permit post root treatment restoration.</td>
<td>• Root filling which extends to within 2mm of full working length.</td>
</tr>
<tr>
<td></td>
<td>• Radiographs appropriate to management of the endodontic condition have been selected, justified, taken to an acceptable standard (&gt;70% rating 1; &lt;20% rating 2; &lt;10% rating 3)&lt;sup&gt;1&lt;/sup&gt; and reported on.</td>
<td>• Root canal material trimmed back to allow retention of post or core material, leaving at least 3-5mm of apical GP.</td>
</tr>
<tr>
<td></td>
<td>• Extent and severity of endodontic problems documented and patient advised.</td>
<td>• Appropriate protection of remaining tooth structure.</td>
</tr>
<tr>
<td></td>
<td>• Consideration given to most significant prognostic indicators (endodontic, periodontic and restorative).</td>
<td>• Written consent obtained.</td>
</tr>
</tbody>
</table>

<sup>1</sup> continued on next page
2.10 ENDODONTICS (CONTINUED)

<table>
<thead>
<tr>
<th>BASIC (CONTINUED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.¹</td>
</tr>
<tr>
<td>• Written treatment plan provided to patient.</td>
</tr>
<tr>
<td>• Access cavity appropriate to allow entry into root canal system, preserving as much tooth structure as possible.</td>
</tr>
<tr>
<td>• Appropriate use of irrigants to reduce bacterial load.</td>
</tr>
<tr>
<td>• Working length determination.</td>
</tr>
<tr>
<td>• Appropriate canal obturation.</td>
</tr>
<tr>
<td>• Appropriate coronal seal.</td>
</tr>
<tr>
<td>• Recalls in accordance with risk status and recommended guidelines.²</td>
</tr>
</tbody>
</table>

1. Faculty of General Dental Practice (UK). *Selection criteria for dental radiography.* London: FGDP(UK); 2018.
2. Faculty of General Dental Practice (UK). *Clinical examination and record-keeping.* London: FGDP(UK); 2016.
### 2.11 REMOVABLE PARTIAL DENTURES

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
</table>
| • Radiographs appropriate to provision of removable partial dentures have been selected, justified, taken to excellent standard (rating 1) and reported on. | • Valid consent.  
• Medical and socio-behavioural history checked in accordance with current recommendations.²  
• Appropriate health screening.  
• Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.³  
• Radiographs appropriate to provision of removable partial dentures have been selected, justified, taken to an acceptable standard (>70% rating 1; <20% rating 2; <10% rating 3)¹ and reported on.  
• Consideration given to most significant prognostic indicators (endodontic, periodontic and restorative).  
• Patient informed of complexities and prognostic indicators relevant to partial denture construction including any denture-bearing teeth.  
• Written treatment plan provided to patient.  |
| • Appropriate onward referral.  
• Healthy oral environment achieved prior to construction of dentures.  
• Denture design to allow optimal hygiene and care.  
• Written consent obtained. |

> continued on next page
2.11 REMOVABLE PARTIAL DENTURES (CONTINUED)

<table>
<thead>
<tr>
<th>BASIC (CONTINUED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Denture design undertaken and recorded.</td>
</tr>
<tr>
<td>• Appropriate denture material and design used to suit clinical situation.</td>
</tr>
<tr>
<td>• Selection and use of appropriate impression material or digital impression technique to suit individual case.</td>
</tr>
<tr>
<td>• Impression records key anatomical structures to allow construction of denture.</td>
</tr>
<tr>
<td>• Appropriate prescription to dental technician.</td>
</tr>
<tr>
<td>• Occlusal harmony sought.</td>
</tr>
<tr>
<td>• Denture care and hygiene advice.</td>
</tr>
<tr>
<td>• Recalls in accordance with risk status and recommended guidelines.</td>
</tr>
<tr>
<td>• Statement of manufacture retained and offered to patient.</td>
</tr>
</tbody>
</table>

## 2.12 COMPLETE DENTURES

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
</table>
| - Any unstable lower complete dentures retained by a minimum of two dental implants.  
- Appropriate photographs taken.  
- Written diagnosis, rationale for treatment plan and aim of treatment provided to patient.  
- Consideration given to all systemic risk factors and evidence that advice has been given to address these. | - Valid consent.  
- Medical and socio-behavioural history checked in accordance with current recommendations.  
- Appropriate health screening and advice.  
- Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.  
- Patient informed of complexities and prognostic indicators relevant to complete denture construction.  
- Written treatment plan provided to patient.  
- Selection and use of appropriate impression material or digital impression technique to suit individual case. The impression should record key anatomical structures to allow construction of denture.  
- Appropriate prescription to dental technician. | - Appropriate onward referral.  
- Healthy oral environment achieved prior to provision of dentures.  
- Written consent obtained.  
- Radiographs, where appropriate for provision of complete dentures, have been selected, justified, taken to an acceptable standard (>70% rating 1; <20% rating 2; <10% rating 3) and reported on.  
- Statement of manufacture, when not accepted by patient, retained by practice for lifetime of device.  
- Smoking cessation advice given in accordance with guidelines. |

> continued on next page
2.12 COMPLETE DENTURES (CONTINUED)

**BASIC (CONTINUED)**

- Occlusal harmony sought.
- Denture care and hygiene advice.
- Recalls in accordance with risk status and recommended guidelines.
- Statement of manufacture offered to patient.

**References**

## 2.13 ORAL MEDICINE

### ASPIRATIONAL
- Consideration given to all systemic risk factors and evidence that advice has been given to address these.
- Rationale for treatment plan and aim of treatment provided to patient.

### BASIC
- Valid consent.
- Medical and socio-behavioural history checked in accordance with current recommendations.\(^1\)
- Appropriate health screening.
- Extra-oral examination including:
  - Lymph nodes.
  - Temporomandibular joint palpation.
  - Facial symmetry.
  - Assessment of skin and lips.
- Intra-oral examination including:
  - Inspection and assessment of all hard and soft tissues.
  - Assessment of changes in saliva.
- Appropriate initiation of care within the scope of the practitioner.
- Written treatment plan provided to patient.
- Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.\(^3\)

### CONDITIONAL
- Radiographs/scans, where indicated for diagnosis, risk and treatment planning, have been selected, justified, taken to an acceptable standard (>[70% rating 1; <20% rating 2; <10% rating 3)]\(^1\) and reported on.
- Appropriate onward referral for presenting condition.
- Appropriate onward referral for co-morbid illness that may affect the management.
- Two-week referral for any lesions where there is a suspicion of cancer.
- Oral-health/systemic-health interactions explained and appropriate advice given to patients with systemic health issues.
- Smoking cessation advice given in accordance with guidelines.\(^3\)
- Alcohol identification and brief advice given in accordance with guidelines.\(^3,4\)
- Appropriate pain history of orofacial pain, dysesthesia, paraesthesia and numbness.

---

\(^1\) Valid consent.
\(^2\) Medical and socio-behavioural history checked in accordance with current recommendations.
\(^3\) Appropriate health screening.
\(^4\) Extra-oral examination including:
  - Lymph nodes.
  - Temporomandibular joint palpation.
  - Facial symmetry.
  - Assessment of skin and lips.

---

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consideration given to all systemic risk factors and evidence that advice has been given to address these.</td>
<td>• Valid consent.</td>
<td>• Radiographs/scans, where indicated for diagnosis, risk and treatment planning, have been selected, justified, taken to an acceptable standard (&gt;[70% rating 1; &lt;20% rating 2; &lt;10% rating 3)](^1) and reported on.</td>
</tr>
<tr>
<td>• Rationale for treatment plan and aim of treatment provided to patient.</td>
<td>• Medical and socio-behavioural history checked in accordance with current recommendations.(^1)</td>
<td>• Appropriate onward referral for presenting condition.</td>
</tr>
<tr>
<td>• Appropriate health screening.</td>
<td>• Appropriate health screening.</td>
<td>• Appropriate onward referral for co-morbid illness that may affect the management.</td>
</tr>
<tr>
<td>• Extra-oral examination including:</td>
<td>• Extra-oral examination including:</td>
<td>• Two-week referral for any lesions where there is a suspicion of cancer.</td>
</tr>
<tr>
<td>- Lymph nodes.</td>
<td>- Lymph nodes.</td>
<td>• Oral-health/systemic-health interactions explained and appropriate advice given to patients with systemic health issues.</td>
</tr>
<tr>
<td>- Temporomandibular joint palpation.</td>
<td>- Temporomandibular joint palpation.</td>
<td>• Smoking cessation advice given in accordance with guidelines.(^3)</td>
</tr>
<tr>
<td>- Facial symmetry.</td>
<td>- Facial symmetry.</td>
<td>• Alcohol identification and brief advice given in accordance with guidelines.(^3,4)</td>
</tr>
<tr>
<td>- Assessment of skin and lips.</td>
<td>- Assessment of skin and lips.</td>
<td>• Appropriate pain history of orofacial pain, dysesthesia, paraesthesia and numbness.</td>
</tr>
<tr>
<td>• Intra-oral examination including:</td>
<td>• Intra-oral examination including:</td>
<td>• Appropriate pain history of orofacial pain, dysesthesia, paraesthesia and numbness.</td>
</tr>
<tr>
<td>- Inspection and assessment of all hard and soft tissues.</td>
<td>- Inspection and assessment of all hard and soft tissues.</td>
<td></td>
</tr>
<tr>
<td>- Assessment of changes in saliva.</td>
<td>- Assessment of changes in saliva.</td>
<td></td>
</tr>
<tr>
<td>• Appropriate initiation of care within the scope of the practitioner.</td>
<td>• Appropriate initiation of care within the scope of the practitioner.</td>
<td></td>
</tr>
<tr>
<td>• Written treatment plan provided to patient.</td>
<td>• Written treatment plan provided to patient.</td>
<td></td>
</tr>
<tr>
<td>• Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.(^3)</td>
<td>• Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.(^3)</td>
<td></td>
</tr>
</tbody>
</table>
### 2.14 MINOR ORAL SURGERY

<table>
<thead>
<tr>
<th><strong>ASPIRATIONAL</strong></th>
<th><strong>BASIC</strong></th>
<th><strong>CONDITIONAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiographs appropriate to oral surgical management have been selected, justified, taken to excellent standard (rating 1)(^1) and reported on.</td>
<td>Valid consent.</td>
<td>Treatment plan in accordance with current guidelines.(^6)</td>
</tr>
<tr>
<td>Appropriate photographs taken.</td>
<td>Medical and socio-behavioural history checked in accordance with current recommendations.(^3)</td>
<td>Where indicated, antibiotics used in line with FGDP(UK) antimicrobial prescribing guidelines.(^7)</td>
</tr>
<tr>
<td>Full consideration given to prognostic indicators (endodontic, periodontic and restorative) prior to extraction.</td>
<td>Appropriate health screening.</td>
<td>Appropriate behavioural management techniques utilised.</td>
</tr>
<tr>
<td>Consideration given to all systemic risk factors and evidence that advice has been given to address these.</td>
<td>Consideration given to all systemic risk factors.</td>
<td>Achieve adequate local anaesthesia.</td>
</tr>
<tr>
<td>Written diagnosis, rationale for treatment plan and aim of treatment provided to patient.</td>
<td>Radiographs appropriate to oral surgical management have been selected, justified, taken to an acceptable standard ((&gt;70%) rating 1; (&lt;20%) rating 2; (&lt;10%) rating 3)(^1) and reported on.</td>
<td>Tooth sectioning as appropriate.</td>
</tr>
<tr>
<td>Use of Local Safety Standards for Invasive Procedures (LocSSIPs) for preventing wrong site extraction.(^2)</td>
<td>Consideration given to most significant prognostic indicators (endodontic, periodontic and restorative) prior to extraction.</td>
<td>When surgical extraction indicated, flap design allowing adequate access and appropriate bone removal.</td>
</tr>
<tr>
<td></td>
<td>Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.(^4)</td>
<td>Where sedation is used, appropriate protocols and guidelines utilised.</td>
</tr>
<tr>
<td></td>
<td>Written treatment plan provided to patient.</td>
<td>Written consent obtained.</td>
</tr>
<tr>
<td></td>
<td>&gt; continued on next page</td>
<td>Appropriate onward referral.</td>
</tr>
</tbody>
</table>
2.14 MINOR ORAL SURGERY (CONTINUED)

BASIC (CONTINUED)

- No iatrogenic damage to adjacent teeth or structures where possible.
- Bone preservation where possible.
- Haemostasis achieved.
- Post-operative advice and instructions given.
- Appropriate analgesic regime established.
- Follow up/review appointment if required.
- Recalls in accordance with risk status and recommended guidelines.5

## 2.15 IMPLANT DENTISTRY

### ASPIRATIONAL
- Full consideration given to prognostic indicators (endodontic, periodontic and restorative).
- Consideration given to all systemic risk factors and evidence that advice has been given to address these.
- Radiographs/scans appropriate for diagnosis, risk and treatment planning have been selected, justified, taken to excellent standard (rating 1)¹ and reported on.
- Appropriate photographs taken.
- Patient-specific document accompanies consent.

### BASIC
- Valid consent.
- Medical and socio-behavioural history checked in accordance with current recommendations.²
- Appropriate health screening.
- Consideration given to all systemic risk factors and evidence that advice has been given to address these.
- Radiographs/scans appropriate for diagnosis, risk and treatment planning have been selected, justified, taken to an acceptable standard (>70% rating 1; <20% rating 2; <10% rating 3)¹ and reported on.
- Extent and severity of disease documented and patient advised.
- Consideration given to most significant prognostic indicators (endodontic, periodontic and restorative).
- Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines.³

### CONDITIONAL
- Oral-health/systemic-health interactions explained and appropriate advice given to patients with systemic health issues.
- Appropriate onward referral.
- Written consent obtained.
- Bone augmentation methodology and materials recorded in notes.

> continued on next page
### 2.15 IMPLANT DENTISTRY (CONTINUED)

<table>
<thead>
<tr>
<th>BASIC (CONTINUED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Written diagnosis, treatment plan, rationale and aim of treatment provided to patient.</td>
</tr>
<tr>
<td>• Anatomical and functional factors incorporated in planning and execution of treatment.</td>
</tr>
<tr>
<td>• Implant specifications recorded.</td>
</tr>
<tr>
<td>• Statement of manufacture retained and offered to patient.</td>
</tr>
<tr>
<td>• Appropriate implant maintenance plan tailored to risk profile of patient.</td>
</tr>
<tr>
<td>• Implant care and hygiene advice.</td>
</tr>
</tbody>
</table>

---

### 2.16 MANAGEMENT OF DENTAL TRAUMA

<table>
<thead>
<tr>
<th>ASPIRATIONAL</th>
<th>BASIC</th>
<th>CONDITIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Radiographs appropriate to management of trauma have been selected, justified, taken to excellent standard (rating 1) (^3) and reported on.</td>
<td>• Valid consent.</td>
<td>• Appropriate onward referral.</td>
</tr>
<tr>
<td>• Aesthetics restored if possible.</td>
<td>• Medical and socio-behavioural history checked in accordance with current recommendations. (^3)</td>
<td>• Valid consent from parent/guardian.</td>
</tr>
<tr>
<td>• Appropriate photographs taken.</td>
<td>• Trauma history checked.</td>
<td>• Structured pain history.</td>
</tr>
<tr>
<td>• Written diagnosis, rationale for trauma treatment plan and aim of treatment provided to patient.</td>
<td>• Radiographs appropriate to management of trauma have been selected, justified, taken to an acceptable standard (&gt;70% rating 1; &lt;20% rating 2; &lt;10% rating 3) (^3) and reported on.</td>
<td>• Haemostasis achieved.</td>
</tr>
<tr>
<td>• Consideration given to all systemic risk factors and evidence that advice has been given to address these.</td>
<td>• Complete clinical examination of all the teeth and surrounding tissues including sensibility status of any affected teeth.</td>
<td>• Wounds washed and all foreign debris removed.</td>
</tr>
<tr>
<td>• Consideration given to preventable disease risk indicators and appropriate preventative advice given in accordance with the prevailing guidelines. (^2)</td>
<td>• Extent and severity of trauma documented and patient advised.</td>
<td>• Anti-tetanus prophylaxis if indicated.</td>
</tr>
<tr>
<td>• Appropriate trauma guidelines followed.</td>
<td>• Appropriate action taken to stabilise trauma.</td>
<td>• Where indicated antibiotics used in line with FGDP(UK) antimicrobial prescribing guidelines. (^4)</td>
</tr>
<tr>
<td>• Appropriate follow-up plan developed.</td>
<td>• Written trauma treatment plan provided to patient.</td>
<td>• Provision of appropriate splint and dietary advice.</td>
</tr>
<tr>
<td></td>
<td>• Written consent obtained.</td>
<td>• Immediate pain relief at initial appointment.</td>
</tr>
</tbody>
</table>

2.16 Management of dental trauma table.
Standards in Dentistry

Faculty of General Dental Practice (UK).

3.1 INTRODUCTION

In the context of this section of Standards in Dentistry the term ‘structure’ encompasses all items and people at a location that enable oral healthcare to be provided; the premises, the instruments and equipment and the practice team are covered by the term. ‘Process’ refers to the manner in which the ‘structure’ is used to provide oral healthcare.

This section of the publication will be particularly useful in helping to support those individuals who aspire to Fellowship of the Faculty of General Dental Practice (UK) (the FF GDP[UK]) or undertaking the FGDP(UK)’s Key Skills in Primary Dental Care e-learning programme. Additionally, it refers to the standards of the various healthcare regulatory bodies that all healthcare workers (including dental professionals, providing services to the NHS and independent sectors) are required to understand and meet.

All dental professionals are also required to meet the standards set out by the General Dental Council (GDC) in Standards for the dental team (www.gdc-uk.org/professionals/standards). The GDC standards set out what you must do as a dental professional and the individual responsibility to behave professionally and follow these principles at all times. The GDC advises that those individuals not meeting these standards may be removed from the register and be prevented from working as a dental professional.

In addition to these standards, the British Dental Association (BDA) has a good practice accreditation scheme. BDA Good Practice is a quality assurance programme that allows its members to communicate to patients an ongoing commitment to working to standards of good practice on professional and legal responsibilities. The ‘good
standards in dentistry faculty of general dental practice (UK)

practice’ requirements can be used by all providers of primary dental care, including general dental practices (both private and those providing NHS services), specialist practices, salaried primary dental care services, armed forces clinics and outpatient departments (https://bda.org/goodpractice). Other providers offer accreditation for dental practices and these schemes will set their own eligibility criteria.

other guidelines and standards include the BDA advice sheets and evidence summaries, which BDA members can download directly from www.bda.org. They cover a wide range of subjects relating to all aspects of dental practice. Further standards for structure and process in dental practice include the International Organization for Standardization 9000 series (ISO-9000) which are standards in administration and business practice. The Health and Safety Executive (HSE) is the UK independent regulator of health and safety in the workplace, and the Medicine and Healthcare Products Regulatory Agency (MHRA) is the agency responsible for ensuring all medicines and medical devices (including dental appliances) are effective and safe to use. The Dental Appliance Manufacturers Audit Scheme sets out standards for dental laboratories to follow (www.damas.co.uk).

one major problem with standards for process and structure in dental practice is that unlike those for most clinical care, they are constantly evolving as new polices are developed and legislation is introduced. Today’s ‘good practice’ may well be considered as inadequate or even negligent in years to come. For this reason, printed publications that set out these standards may soon become outdated. In order to avoid this problem, this section of the publication does not provide detailed information in some areas, instead referring the reader to other sources and where possible websites, where up-to-date information may be found.

3.2 overview of mandatory standards
Health and social care is managed and regulated differently in the four nations of the UK. The Department of Health and Social Care is the UK Government department with responsibility for health and social care in England. The devolved Governments of the UK each have their own health departments; the Department of Health and Social Services (Welsh Assembly Government), NHS Scotland and its Directorates (Scottish
Executive) and the Department of Health, Social Services, and Public Safety (Northern Ireland Executive). Each department is responsible for its own health and social care policy with the Department of Health and Social Care retaining overall responsibility for matters and issues common to all systems.

3.2.1 General Dental Council (GDC)
The GDC has nine core ethical principles of practice that apply to all dental professionals in the UK.²
- Put patients’ interests first.
- Communicate effectively with patients.
- Obtain valid consent.
- Maintain and protect patients’ information.
- Have a clear and effective complaints procedure.
- Work with colleagues in a way that is in patients’ best interests.
- Maintain, develop and work within your professional knowledge and skills.
- Raise concerns if patients are at risk.
- Make sure your personal behaviour maintains patients’ confidence in you and the dental profession.

For each of the principles there is a list of the standards expected, what patients should expect and supporting guidance. Throughout the document ‘must’ is used where the duty is compulsory and ‘should’ is used where the duty would not apply in all situations and where there are exceptional circumstances outside the control of the dental professional that could affect whether, or how, the guidance is complied with. Additional guidance documents to help dental professionals to meet the standards can be found on the GDC website (www.gdc-uk.org).

3.2.2 Dental regulation
Dental regulation has become an increasingly prominent area of dental practice and is in constant flux of change. The Health and Social Care Act 2008 established the Care Quality Commission (CQC) to replace the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection to form a new independent regulator for the quality and safety of health and social care in England. The CQC
operates at the ‘provider’ level (for example an individual, hospital trust, dental practice, care home or voluntary organisation) and describes what providers should do to ensure the public receive services that meet essential quality and safety standards. The guidance is based on outcomes rather than systems and processes and places the views and experiences of those using services at its centre (www.cqc.org.uk). The CQC currently inspect providers against a series of 12 fundamental standards which apply to all sectors of health and social care, and therefore interpretation of these generic outcomes and how they apply to dentistry is necessary.5

There are different regulators in Wales (Healthcare Inspectorate Wales),6 Scotland (Health Improvement Scotland)7 and Northern Ireland (Regulation and Quality Improvement Authority)8 and while there are minor differences in the regulatory responsibilities and frameworks, all work to the same principles of ensuring essential quality and safety standards are met. For the most up-to-date guidance on standards in each of the UK nations, the respective regulator should be consulted (see reference list for their websites).

3.2.3 Health and Safety Executive (HSE)
The HSE is the independent regulator for health and safety in the workplace and includes all health and social care settings in the UK. HSE sets out its overall public safety policy and priorities for enforcement on its website (www.hse.gov.uk). The HSE work with other regulators to inspect, investigate and where necessary take enforcement action. There are specific requirements for dental practices to report non-clinical accidents or injuries under the Reporting of Injuries, Disease and Dangerous Occurrence Regulations 2013 (RIDDOR)9 and to register with HSE for work with ionising radiation. Further information can be found on their website along with guidance on risk assessment, control of hazardous substances (COSHH) and health and safety legislation.

3.3 CLINICAL GOVERNANCE
Traditionally clinical governance has been described using the seven pillars model. This early model has continued to be refined over the years to feature themes covering the following domains:
• Clinical effectiveness and research.
• Audit.
• Risk management.
• Education and training.
• Service user, carer and public involvement.
• Clinical information and IT.
• Staffing and staff management.

Clinical governance has seen a significant shift in recent years, with increasing focus given to patient safety as its primary outcome. This has been brought about in response to adverse patient events within the NHS including the events at Mid Staffordshire NHS Trust. The subsequent Francis report (2012) made a number of recommendations about the standards that should be met by organisations providing health and social care, particularly with regards to the culture of openness and the duty of candour. Each dental practice must be able to demonstrate a culture which encourages openness and transparency in the reporting of patient safety incidents and complaints, so that any learning resulting from root cause analysis can be shared in teams, and system improvements made when appropriate. In addition, all staff should understand their professional responsibilities to raise concerns about the quality of any care they feel falls below acceptable standards without fear of personal reprisal. This used to be called ‘whistleblowing’ but has been superseded by the phrases ‘raising a concern’ or ‘freedom to speak up’ and new guidance is being developed by the Department of Health to support healthcare professionals in raising concerns when necessary.

Patient safety is now a routine component of governance frameworks in many healthcare settings, but is still underdeveloped in primary dental care. This is in part due to the complexity of overlapping dental regulation, the lack of a centralised reporting system and patient safety initiatives (such as checklists to prevent wrong site tooth extraction) being a relatively new concept in primary dental care, still requiring full scale implementation in practice. However, there is increasing research and policy interest in this area and it is likely patient safety reporting in primary dental care will become easier, better defined and more routine in years to come.
3.4 FGDP(UK) GUIDANCE FOR DENTAL PRACTICE – KEY SKILLS

The FGDP(UK) has developed its own framework to highlight key areas of clinical governance that will help dentists at any stage of their career achieve a quality standard endorsed by the FGDP(UK), and demonstrate that their practice is compliant in these areas. The Key Skills format is also used widely as an integral part of the foundation training programme, and Key Skills in Primary Dental Care is highly recommended to support this training. The key skills are:

• Medical emergencies.
• Infection prevention and control.
• Clinical record-keeping.
• Radiography.
• Legislation and good practice guidelines.
• Team training.
• Risk management and communication.

3.4.1 Examples

This section covers in more detail related guidelines and requirements in each of the seven key skills areas. It is not intended to provide an exhaustive list of requirements in each area but to highlight key minimum safety and quality standards and to refer to other sources of information. It is important to remember that dental regulation is different in each part of the UK and therefore practices should refer to their local guidance in providing evidence of compliance with fundamental standards. For example in England, CQC inspectors report their findings in dental practice under five key questions:

• Are they safe? (To ensure people are protected from abuse and avoidable harm).
• Are they effective?
• Are they caring?
• Are they responsive to people’s needs?
• Are they well led?

The BDA produce advice sheets to help practices identify what type of evidence is advisable to demonstrate compliance with fundamental standards in each of the UK nations (www.bda.org).
### 3.4.1.1 Medical emergencies

Medical emergencies can occur in dental practice at any time and dental practices have a duty of care to ensure that patient safety is prioritised in delivering care. The GDC states it is important to ensure that:

- There are arrangements for at least two people to be available within the working environment to deal with medical emergencies when treatment is planned to take place. In exceptional circumstances the second person could be a receptionist or a person accompanying the patient.
- All members of staff, including those not registered with the GDC, know their role if there is a medical emergency.
- All members of staff who might be involved in dealing with a medical emergency are trained and prepared to do so at any time, and practice together regularly in a simulated emergency so they know exactly what to do.

The *Medical emergencies in the dental practice* section of the British National Formulary (BNF) provides guidelines on the management of the more common medical emergencies which may arise in the dental practice.

The Resuscitation Council (UK) no longer provides specific guidance on medical emergencies in the dental practice (formerly provided in their publication *Medical emergencies and resuscitation standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice*). This was superseded in November 2013 by its publication *Quality standards for cardiopulmonary resuscitation practice and training in primary dental care*, in which the Resuscitation Council (UK) continues to provide helpful guidance on all aspects relating to cardiopulmonary resuscitation in the dental practice.

### 3.4.1.2 Infection prevention and control

All practices must maintain high standards in infection control and prevention and take the necessary steps to provide a clean and safe environment for dental care. The underlying principles of infection control are to apply standard precautions to minimise the risk of transmission of harmful micro-organisms regardless of the health status of the patient or healthcare worker. GDC guidance states that registrants must
treat patients fairly and without discrimination, including on health grounds.

Standard cross-infection precautions include:

• Hand hygiene.
• Personal protective equipment.
• Safe working with sharps.
• Sterilisation and disinfection of dental instruments.
• Surgery design and disinfection.
• Dental unit waterlines.
• Waste management.
• Immunisations and screening.

Standards have been set out in Health Technical Memorandum (HTM) 01-05 published by the Department of Health in 2013. This established two specific benchmarks – essential quality requirements and best practice, although there is no timescale for implementation of best practice. HTM 01-05 is intended to raise the quality of decontamination work in primary care dental services by covering the decontamination of reusable instruments within dental facilities. An audit tool to help dental practices to self-assess their compliance with HTM 01-05 is available from the Department of Health and Social Care website. Scotland has its own series of infection control guidance documents published by the Scottish Dental Clinical Effectiveness Programme (SDCEP) available at www.sdcep.org.uk. Wales and Northern Ireland have their own editions of HTM 01-05 which both differ slightly from the original.

Legionella is of specific concern in dental practice if dental unit waterlines are not adequately managed. Legionella pneumophila lives in water systems and can survive in biofilm where it is protected from disinfection agents. All dental practices in the UK have a legal duty to identify and assess sources of risk and to have processes in place to monitor and record all precautions and control measures. The HSE guidance is available at: www.hse.gov.uk/legionnaires.

3.4.1.2.1 Further reading

• Health and Safety Executive. Health and Safety (Sharp Instruments in Healthcare) Regulations (2013) Guidance for employers and employees.\textsuperscript{15}
• Health and Safety Executive. Legionella and legionnaires disease.\textsuperscript{16}

3.4.1.3 Clinical record-keeping
Dental professionals are required to make and keep accurate dental records of care provided to patients, whether under NHS or private arrangements. The GDC imposes a professional obligation to create records to document dental treatment that is provided to patients. The GDC states in Standards for the dental team you must:
• Make and keep contemporaneous, complete and accurate patient records.
• Protect the confidentiality of patients’ information and only use it for the purposes for which it was given.
• Only release a patient’s information without their permission in exceptional circumstances.
• Ensure that patients can have access to their records.
• Keep patients’ information secure at all times, whether your records are held on paper or electronically.

There are a number of guidelines and support tools to assist dental professionals in producing accurate, comprehensive and contemporaneous patient records. The dental indemnity providers offer expert advice and resources on clinical record-keeping, and the FGDP(UK) has produced good practice guidelines which provide a comprehensive review of the subject – Clinical examination and record-keeping.\textsuperscript{17}

3.4.1.4 Radiography
Dental practices have a legal duty to minimise the risk to patients, staff, visitors, contractors and the environment from the effects of ionising radiation in accordance with approved codes of practice issued by the HSE and other statutory agencies. There are two sets of regulations in the UK governing the use of ionising radiation. The Ionising Radiations Regulations 2017 (IRR17) is principally concerned with the safety of workers and the general public but also addresses the equipment aspects of patient protection. The Ionising Radiation (Medical Exposure) Regulations 2018 (IR(ME)R 2018) is concerned with the safety of patients and defined new positions of responsibility; the employer,
the referrer, the practitioner and the operator. Every practice must appoint a Radiation Protection Adviser (RPA), so expert advice is available on effective radiation safety and protection. Practices must also employ a set of local radiography rules specific to each machine which describe working arrangements and is usually administered by a Radiation Protection Supervisor (RPS), who is a member of the dental team. Radiation protection is included in the remit of the various dental regulators across the UK.

The techniques adopted in dental practice for the taking and processing of radiographs must ensure that they are of maximum diagnostic value, while at the same time minimising the radiation dose. Further details can be found in the FGDP(UK) publication *Selection Criteria for Dental Radiography*.^18

### 3.4.1.5 Legislation and good practice guidelines

It is important all dental professionals are aware of essential practice standards that provide a safe and suitable environment for staff, patients and members of the public who work in, or visit the practice. This includes legislation relating to practice premises, materials, medicines and equipment, hazardous substances and fire safety procedures. A practice must have sufficient space, heating, lighting, ventilation and facilities to provide a pleasant and comfortable environment for staff, patients and visitors and where possible the requirements of the Equality Act 2010 should be met. If it is not possible to meet the requirements by making alterations to the premises, the practice should make suitable alternative arrangements for care to meet the patient’s needs. All equipment used in the practice must be serviced and maintained in accordance with manufacturer’s instructions and purchased from reputable sources to guarantee safety and technical standards meet UK legislation.

Effective practice management procedures and systems should be in place to provide business continuity in the event of an emergency situation such as flooding, fire or power failure which prevents normal services being delivered, with a plan developed for managing practice communications with staff, patients and the public in such an event. Security of the premises and policies and procedures to protect staff from occupational hazards as well as aggressive or violent behaviour are also important in providing a safe environment for everyone. The BDA provides comprehensive
information to assist practices in meeting these requirements through advice, model policies and protocols, and changes in policy made by regulators (www.bda.org).

3.4.1.6 Team training

Governance systems are there to protect patients but they also depend on the performance of the entire dental team to ensure services are consistently delivered in a safe and effective way. The GDC recognises the importance of teamwork and state that ‘the quality of teamwork is closely linked to the quality of care the team provides’. Clinical leadership is important to demonstrate that services are well-led and are delivered in a governance structure that has clear lines of responsibility and accountability within the practice to ensure everyone is aware of their own role in the team, and how they contribute to the overall quality of the service. Developing members of the dental team through regular appraisal, training and professional development is a key component in achieving this, along with regular team meetings and training to create a culture that promotes delivery of high practice standards at all times. Broadening the skill mix in the practice team can also assist in delivering oral care in a more efficient and resilient way.

All practices must operate robust and systematic recruitment procedures to ensure anyone employed in practice is of good character, has the correct work permissions and registrations, and is competent and indemnified to perform the role. The practice must ensure induction, regular training and continuing professional development is available for all staff, and a system is in place for identifying and managing poor performance within an overall supportive environment.

The Investors in People award has set standards for people management and can be a useful process for practices to undertake.

3.4.1.7 Risk management and communication

Identifying and managing risks in dental practice is an increasingly complex area covering a diverse range of topics. Risk assessment is a systematic examination of work activities to identify what could go wrong and cause harm, and whether adequate controls are in place. The BDA recommend practices should risk assess the following areas:

Standards in Dentistry                                      Faculty of General Dental Practice (UK)
• A general practice risk assessment (e.g. premises, equipment, security, etc).
• Specific assessment of hazardous substances (COSHH).
• Employees and patients with disabilities.
• Display screen equipment use.
• Fire risks and evacuation procedures.
• Manual handling and occupational health.
• Risk affecting new and expectant mothers.
• Radiation risks.
• Risk for those undertaking work experience or visiting the practice.

There are specific risks associated with using personal information and practices must comply with Information Governance approved codes of conduct covering areas such as data protection, confidentiality of patient information, Caldicott principles, records management and information security procedures. The Information Commissioner’s Office (ICO) (www.ico.org.uk) requires organisations, including dental practices, to demonstrate implementation of good practice, compliance with the law and year-on-year improvement plans.

All practices must have in place effective safeguarding systems to protect adults and children from improper treatment and abuse. This is an important fundamental standard which all dental professionals should understand and know how to act upon should they have concerns. The practice safeguarding policy should indicate how to refer a matter to the local authority safeguarding team and where to go for advice. Safeguarding information should be available to patients and members of the public so they know who in the practice is responsible should they wish to raise a concern. Specific advice for dental professionals is available from national guidelines, such as HM Government’s Working together to safeguard children (2015) and specialist societies such as the British Society of Paediatric Dentistry and the dental indemnity companies.

Person-centred care is essential to providing services which meet patients’ needs. Practices must demonstrate robust patient and public involvement to satisfy regulators that care is delivered in partnership with patients, and that they have opportunities
to feedback on areas of concern or where service improvements can be made. Person-centred care includes the need for consent, and dental professionals should only provide care to a patient that has consented to it. The professional view of consent is shifting to incorporate the patient as a joint decision-maker with active involvement in deciding upon appropriate care and treatment options, taking into consideration all the relevant information. Gillick competence is the principle used to judge capacity in a child under 16 years of age. Where a person under the age of 16 is not Gillick competent and therefore deemed to lack the capacity to consent, it can be given on their behalf by someone with parental responsibility, or by the Court. Where a patient over the age of 16 lacks the capacity to consent, the Mental Capacity Act 2005 (MCA) must be taken into consideration. Treating all patients fairly, and with dignity and respect, is a key principle of the NHS Constitution in England and practices must not discriminate in the way they deliver care to any person with any of the nine protected characteristics described in the Equality Act 2010.

Feedback may also be received in the practice through patient complaints, and all practices must have an effective and accessible complaints process that provides patients with easy access to the policies which clearly describe how patients concerns and complaints are listened and responded to. Patients must be told the process (which may differ depending on whether the complaint relates to NHS or private care), the timescales for managing their complaint and how they will be kept informed. Patients must also be provided with information on where to refer their complaint should they be dissatisfied with the outcome provided by the practice.

All regulators expect practices to demonstrate how they continuously monitor the quality of the services they provide and document what quality improvement plans are in place. Monitoring quality may come from a variety of sources, such as patient and public feedback, adopting an evidence-based approach to patient care and treatment, implementing national guidance or measuring compliance with practice protocols and policies. This is usually done through clinical audit – ‘a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and standards which leads to implementation of change’. Clinical audit is a professional obligation and every dental professional should be
involved in audit activity. It is good practice to involve the entire dental team so there is a systematic approach to improving standards across the practice. Audit is a useful tool in measuring performance in a structured way and sustaining improvement (including through re-audit) by continuously identifying where positive changes can be made to processes, and then shared as learning opportunities for the dental team.

3.5 OTHER STANDARDS AND GUIDELINES
A number of organisations produce standards and guidelines of relevance to dental professionals and primary dental care. These include National Institute of Health and Care Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), the British Dental Association (BDA), Dental Faculties of the Royal Surgical Colleges, Medicine and Healthcare Products Regulatory Agency (MHRA), Dental Appliance Manufacturers Audit Scheme (DAMAS), and dental indemnity providers. Brief details of some of these are as follows:

3.5.1 British Dental Association (BDA)
The BDA’s advice sheets cover a wide range of topics. They are regularly updated to reflect latest evidence or best practice and cover key areas such as patient care, compliance, monitoring quality, legal obligations and employment. BDA members can access all of the advice sheets from the BDA website (www.bda.org).

In addition to advice sheets, the BDA can also offer members additional guidance and resources for dental practitioners, such as policy templates, evidence summaries and advice in meeting regulatory standards.

3.5.2 Dental Faculties of the Royal Surgical Colleges
The Royal Colleges are charities dedicated to promoting excellence in surgery including dental surgery. They offer educational courses and examinations in dental specialities as well as producing policy documents and their own clinical guidelines. They act as advisory bodies to other organisations such as the Department of Health and Social Care and GDC, and increasingly use their expertise to produce position papers to influence dental policy-making.
3.5.3 **International Organization for Standardization (ISO)**

The International Organization for Standardization (ISO) has developed a number of systems in administration and business practice providing an international quality standard. They include the ISO-9000 series. They do not assess clinical processes or outcomes. However, the series of standards are applicable to other aspects of structure and process in dental practice and have been attained by a number of dental practices. More information on ISO-9000 can be found at: www.iso.org.

3.5.4 **Medicine and Healthcare Products Regulatory Agency (MHRA)**

The MHRA is the UK-wide regulator for ensuring medicines and medical devices are fit for use and are safe. The MHRA is responsible for the regulation of medicines and medical devices and equipment used in healthcare and the investigation of harmful incidents. There are specific requirements for dental practices that manufacture dental appliances to register with the MHRA under the Medical Devices Directive 93/42/EC (MDD) providing the business address of the practice and a description of the devices provided. In addition a ‘Statement of Manufacture’ for each device should be offered to each patient and a copy of the statement retained for the lifetime of the product.

It is recommended that dental practices sign up to MHRA’s drug and device alerts using the following link: www.gov.uk/drug-device-alerts/email-signup to receive important public health messages and other critical safety information. If dental practitioners encounter adverse drug reactions, these can be reported via the ‘yellow card’ system, either online or using the paper copy in the BNF. More information on the MHRA can be found at: www.mhra.gov.uk.

3.5.5 **Dental Appliance Manufacturers Audit Scheme (DAMAS)**

DAMAS is a quality management system designed specifically for the manufacturers of custom-made dental appliances and based on the principles of ISO. DAMAS is an inspection and quality system within the dental laboratory industry that provides a framework for effective quality management which enables dental laboratories to prove to their clients that they are operating within legislation.
DAMAS provides laboratories with a set of processes that ensure a systematic approach to the management of the organisation. The system ensures consistency and improvement of working practices, which in turn should provide products and services that meet customer’s requirements. More information can be found at: www.damas.co.uk.

3.5.6 Dental indemnity providers
It is a mandatory requirement that all dental registered professionals have arrangements for indemnity insurance in place for patients to be fully compensated when appropriate. In addition to providing personal guidance and legal defence to members in need, they also offer education and training resources to mitigate the risks of complaints or litigation in practice, and offer guidance on meeting regulatory requirements such as NHS standards and dental regulators. There are a range of providers and more information is available from them.

3.6 STANDARDS IN RESEARCH (RESEARCH GOVERNANCE)
It is increasingly recognised that primary dental care offers a rich environment for clinical research that has greater focus on the needs of dental professionals, patients and the public. The mission of the Health Research Authority (HRA) is to provide a health research system in which the NHS supports research of the highest quality. It is universally acknowledged that all scientific research should meet internationally agreed standards.

The UK Policy Framework for Health and Social Care Research (2017) outlines principles of good governance that apply to all research undertaken in health and social care within the UK. The framework is designed to ensure the safety, dignity and rights of research participants and to provide safeguards to also protect the research team. Its standards cover five domains:

• Ethics.
• Science.
• Information.
• Health, safety and employment.
• Finance and intellectual property.

All health and social care organisations participating in research are required to have
Standards in Dentistry

local implementation plans in place to ensure that the appropriate research governance standards have been met. This includes ensuring ethical approval is obtained from an NHS Research Ethics Committee for research involving the NHS, its patients and NHS employees (or contractors). There are now co-ordinated systems in place for NHS Research and Development reviews across the UK, and the HRA is developing a common approach to research approval across the UK nations.

The FGDP(UK) is active in promoting research in general dental practice and has a number of resources available on its website (www.fgdp.org.uk/research). This includes details of academic collaborators who can support research in dental practice and research information leaflets to provide dental teams with local sources of advice and guidance on oral healthcare research.

3.7 REFERENCES

1. FGDP(UK). Faculty of General Dental Practice (UK). Available at: www.fgdp.org.uk.
4. DAMAS. Dental Appliance Manufacturers Audit Scheme. Available at: www.damas.co.uk.
8. Regulation and Quality Improvement Authority. Homepage. Available at: www.rqia.org.uk.
4 KEEPING UP-TO-DATE

This second edition of *Standards in Dentistry* brings together standards and guidelines relating to the practice of primary care dentistry in the UK. However, it provides a snapshot in time and inevitably this book will become out-of-date as new standards and guidelines are published and existing ones are reviewed and updated. The online version of this book (www.fgdp.org.uk/guidance-standards/standards-dentistry) will provide information regarding the scheduled updates for the *Standards in Dentistry*, which is likely to be reviewed every four years. Many guideline producers have a formal programme of review and update for each guideline. At other times, guidelines may be updated prior to the stated review date, in response to fresh evidence in the field. Practitioners should be confident that they are consulting the most recent guideline, and there are a number of ways in which they can be sure they are keeping up-to-date.

4.1 PROFESSIONAL ORGANISATIONS
Membership of professional organisations is often the best way of keeping up-to-date. Meetings and CPD resources, such as Local Dental Committees and local independent practitioner events, allow practitioners to network and share expertise and best practice. These are especially valuable for dentists who work in small practices. In addition to face-to-face events, most professional organisations produce newsletters for their members and these will include updates on policy and guidelines. Many of these newsletters are available online even to non-members and are a useful source of current awareness. The following table provides some useful examples:
<table>
<thead>
<tr>
<th>NEWS PUBLICATION</th>
<th>SCOPE</th>
<th>WEB LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDJ In Practice</td>
<td>Latest developments, trends and issues affecting dental practice in the UK</td>
<td><a href="https://bda.org/dentists/publications">https://bda.org/dentists/publications</a> Subscription access only</td>
</tr>
<tr>
<td>BDJ Team</td>
<td>News, views and stories</td>
<td><a href="http://www.nature.com/bdjteam">www.nature.com/bdjteam</a> Free online</td>
</tr>
<tr>
<td>Dental Update</td>
<td>Continuing education and forum for discussion aimed at general dental practitioners and specialists</td>
<td><a href="http://www.dental-update.co.uk">www.dental-update.co.uk</a> Subscription access only</td>
</tr>
<tr>
<td>FGDP(UK) 'Bites' e-newsletter</td>
<td>Latest news, events, courses, research, policy, standards and guidance</td>
<td>Free e-mail newsletter. Register to receive it: <a href="mailto:fgdp-comms@fgdp.org.uk">fgdp-comms@fgdp.org.uk</a></td>
</tr>
<tr>
<td>Faculty Dental Journal</td>
<td>Contemporary issues</td>
<td><a href="http://publishing.rcseng.ac.uk/journal/fdj">http://publishing.rcseng.ac.uk/journal/fdj</a> Free for members of the Faculty of Dental Surgery of the Royal College of Surgeons of England</td>
</tr>
<tr>
<td>Primary Dental Journal</td>
<td>General interest articles relevant to the primary care dental profession</td>
<td><a href="http://www.fgdp.org.uk/practice">www.fgdp.org.uk/practice</a> Online and print editions available to members of the FGDP(UK) and non-member subscribers</td>
</tr>
<tr>
<td>Dentistry</td>
<td>News, news analysis, clinical, business, lifestyle articles</td>
<td><a href="http://www.dentistry.co.uk">www.dentistry.co.uk</a> Free online. Register to receive by e-mail</td>
</tr>
</tbody>
</table>

Standards in Dentistry Faculty of General Dental Practice (UK)
Dental practices also receive communications from their indemnity providers, the commissioning bodies and corporate providers. It is recommended to make all newsletters and updates available for the whole dental team to access, for example by placing them in a shared staff area.

4.2 SOCIAL MEDIA
Social media is a rich source of current affairs and updates for the dentist. All the major professional bodies have organisational Twitter accounts that provide updates and reactions to news. You don’t have to be a ‘tweeter’ (a Twitter user who posts content) to take advantage of Twitter as an information source. To make best use of the platform, follow only a few reputable organisations (rather than following too many accounts, which will result in your feed becoming too full to properly monitor). It is also advised to create a separate account for this purpose, which is separate from other wider professional or personal interests. Some suggested useful bodies to follow and their Twitter handles include:

<table>
<thead>
<tr>
<th>British Dental Association</th>
<th>@TheBDA</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Dental Journal</td>
<td>@The_BDJ</td>
</tr>
<tr>
<td>Faculty of Dental Surgery, Royal College of Surgeons of Edinburgh</td>
<td>@RCSEdFDS</td>
</tr>
<tr>
<td>Faculty of Dental Surgery, Royal College of Surgeons of England</td>
<td>@FDS_RCS</td>
</tr>
<tr>
<td>Faculty of General Dental Practice (UK)</td>
<td>@FGDP_UK</td>
</tr>
<tr>
<td>General Dental Council</td>
<td>@GDC_UK</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>@NicEcomms</td>
</tr>
<tr>
<td>Oral Health Foundation</td>
<td>@dentalhealthorg</td>
</tr>
<tr>
<td>Scottish Dental</td>
<td>@SDentWeb</td>
</tr>
<tr>
<td>The Dental Elf</td>
<td>@TheDentalElf</td>
</tr>
</tbody>
</table>
Type the Twitter handle (e.g. @TheBDA) into the search box on www.twitter.com. The tweets of these organisations can be browsed, and if you have a Twitter account, you can choose to have their tweets automatically sent to your phone. Many organisations also have corporate Facebook pages.

Social media tools allow people to communicate over the internet, for instance to share information and comment. While many individuals use social networking sites for both work and personal use, it is important to remember that professional standards should always be maintained in all online interactions. GDC guidance on using social media (www.gdc-uk.org/api/files/Guidance on using social media.pdf) advises dental professionals on matters of online conduct such as maintaining professional boundaries, protecting patient confidentiality and preserving public confidence in the dental profession. The guidance also warns about the limitations of online privacy, for example in the posting of photographs, or the use of pseudonyms. All dental professionals, even those who are experienced social media users, should familiarise themselves with the guidance.

4.3 SEARCH ENGINES

NICE Evidence (www.evidence.nhs.uk) and Trip (www.tripdatabase.com) are two search engines that allow users to search for guidelines by keyword (e.g. ‘conscious sedation’). On either site, a simple search should be narrowed to guidelines using the in-built filter function. Both search engines have the advantage of allowing the user to search beyond the boundaries of one specific organisation, although neither provide comprehensive coverage of all the dental guideline-producing bodies.

4.4 GUIDELINE PRODUCERS

The most authoritative source for checking the currency of a specific guideline is the website of the guideline producer. Appendix A1 provides a complete list of the guidelines and standards that were used to produce this book, together with links to each document’s original source page. The source web pages should give readers plenty of notice of an impending update, and may invite practitioners to get involved during the consultation process.
This appendix contains links to a selection of current guidelines and standards for dentistry under the following topics:

**Clinical guidelines**
A Emergency dental care  
B Endodontics  
C Examination and record keeping  
D Implant dentistry  
E Medications management  
F Oral health  
G Orthodontics  
H Paediatric dentistry  
I Pathology  
J Periodontology  
K Radiography  
L Restorative dentistry  
M Sedation  
N Special care dentistry  

**Non-clinical guidelines**
O Infection control  
P Medical emergencies  
Q Patient information  
R Practice management  
S Prevention  
T Staff training
A EMERGENCY DENTAL CARE

Temporomandibular disorders (TMDs): An update and management guidance for primary care (2013)
Faculty of Dental Surgery, Royal College of Surgeons of England
www.rcseng.ac.uk/fds

This guideline aims to present the evidence for the diagnosis and management of temporomandibular disorders (TMDs) in primary care, and covers the following areas:
- Demographics of TMDs.
- Acute and chronic TMDs.
- Aetiology.
- History and examination.
- Management for TMDs.
- Irreversible therapies.
- Outcome assessment.

Management of acute dental problems (2013)
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

This guidance aims to encourage the consistent provision of safe and effective care that is tailored to each patient’s needs. Based on the main presenting symptoms, Management of Acute Dental Problems provides decision support flowcharts which can be used to identify any immediate attention or advice to give to the patient and to determine the appropriate provider of subsequent care. Further advice is also provided about the initial management and subsequent care for a wide variety of conditions that may present as acute dental problems.
This guidance is intended for use by staff in any healthcare setting who may be asked to advise or manage patients with acute dental problems. This includes non-dental professionals, such as general medical practice, emergency department and pharmacy staff, as well as members of the dental team.

**Emergency dental care (2013)**
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

*Emergency dental care* aims to facilitate a systematic approach to the provision of care for patients with a dental emergency that can be applied to suit local circumstances. The guidance focuses on the patient journey and includes specific self-help advice to support dental staff in advising patients and a simple method for prioritising dental emergencies in primary care practice. It also provides quality standards that specify the requirements of out-of-hours emergency dental services for use by NHS Boards and dentists. The guidance is intended to complement the national work on emergency dental service development involving NHS Boards and NHS 24.

**Dental trauma guidelines (2012)**
International Association of Dental Traumatology
www.iadt-dentaltrauma.org

These guidelines provide recommendations for diagnosis and treatment of all types of traumatic dental injuries affecting both primary and permanent teeth:

- Fractures and luxations of permanent teeth.
- Avulsion of permanent teeth.
- Traumatic injuries to primary teeth.
**ENDODONTICS**

*Guidelines for surgical endodontics (2012)*
The Royal College of Surgeons of England
www.rcseng.ac.uk

In these guidelines, surgical endodontics describes a procedure combining root-end resection, apical curettage and root-end filling. Other procedures such as apical curettage or root resection alone, hemisection, intentional replantation, and regenerative procedures, have not been included.

*Quality guidelines for endodontic treatment: Consensus report of the European Society of Endodontology (2006)*
European Society of Endodontology
www.e-s-e.eu

This document addresses two essential elements: (i) appropriateness of treatment modality, and (ii) quality or level of treatment rendered. In revising these guidelines the European Society of Endodontology is responding to a public and professional need. In receiving care of a specialised nature such as endodontic treatment, patients need and deserve treatment that meets the standard of care generally given by competent practitioners. The European Society of Endodontology has the expertise and professional responsibility necessary to assist the dental profession by instituting guidelines on the standard of care in the area of endodontics. In accepting this responsibility, the European Society of Endodontology formulated treatment guidelines that are intended to represent current good practice.
Clinical examination and record-keeping (2016)
Faculty of General Dental Practice (UK)
www.fgdp.org.uk

These guidelines cover the collection and recording of information which enables a diagnosis to be made and appropriate treatment options to be discussed with a patient, enabling them to choose a treatment plan or, sometimes, make a decision to refer for care. This latest edition includes recommendations for information to be recorded at pre-examination, examination, recall examination, emergency dental, emergency trauma and receiving referral.

The guidelines cover:

• Dental records.
• History taking.
• Full examination.
• Recall visits.
• Special situations.
• Referrals.
• Electronic records.
Dental implants are not routinely available on the NHS, however in some circumstances, implant treatment may be funded through secondary care if there is a medical need agreed by the local acceptance criteria. The FGDP(UK) has produced a summary of training requirements for safe implant dentistry (listed on page 104 in the staff training section).

*Guidelines for selecting appropriate patients to receive treatment with dental implants: Priorities for the NHS (2012)*
Faculty of Dental Surgery, Royal College of Surgeons of England
www.rcseng.ac.uk/fds

The aim of these guidelines is not to produce a definitive list of those patients who should have routine access to dental implants within the NHS; rather to provide a framework to facilitate informed discussion between providers and commissioners, both locally and nationally, to identify those groups who should have routine access to, and funding for, dental implants. These guidelines developed for the NHS consider eight main groups who may benefit from treatment with osseointegrated implants:

- Patients with developmental conditions resulting in deformed or missing teeth.
- Patients who have lost teeth due to trauma.
- Patients who have undergone ablative surgery for head and neck cancer.
- Patients with extra-oral defects.
- Patients who are edentulous in one or both jaws.
- Patients with severe denture intolerance.
- Patients with aggressive periodontitis.
- Patients requiring implant-borne orthodontic anchorage.
A dentist's guide to implantology (2012)
Association of Dental Implantology
www.adi.org.uk

The aim of this publication is to provide an overview of the foundations of dental implantology. Topics covered include:
- What is dental implantology?
- What types of implants are used and how long do they last?
- Treatment planning and after-care.
- Surgery, bone and tissue augmentation.
- Implant restoration and maintenance.
- Medico-legal challenges.
E  MEDICATIONS MANAGEMENT

Prescribing in dental practice
British National Formulary
https://bnf.nice.org.uk

This is a special collection of British National Formulary (BNF) topics relevant to dentistry. Sections include:
- General guidance.
- Drug management of dental and oral conditions.
- Oral infections.
- Anaesthetics, anxiolytics and hypnotics.
- Minerals.
- Medical emergencies in dental practice.
- Medical problems in dental practice.

Drug prescribing for dentistry (2016)
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

The guidance is suitable for informing dental practitioners in the primary care sector, and applies to all patients, including adults, children and those with special needs, who would normally be treated in this sector. The guidance does not include advice on prescribing for those in a secondary care environment or for practitioners with special expertise who may prescribe a wider range of drugs. The intention is for the guidance to be used in conjunction with the BNF and BNFC.
Management of dental patients taking anticoagulants or antiplatelet drugs (2015)
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

Management of dental patients taking anticoagulants or antiplatelet drugs provides recommendations and practical advice to inform bleeding risk assessment and decision-making for the treatment of this patient group. Information about the newer generation anticoagulants and antiplatelet drugs as well as the more established medications is included.

The guidance is aimed primarily at dentists, hygienists and therapists in primary care dental practice and will also be of relevance to the secondary care dental service, those involved in dental education and undergraduate trainees.

Antimicrobial prescribing for general dental practitioners (2014)
Faculty of General Dental Practice (UK)
www.fgdp.org.uk

This guide has been written to help dental practitioners with the prescribing of antimicrobial agents in the primary care dental setting. The guidance is intended to complement, and not replace, the BNF. The guidance is appropriate for all dental patients, including adults, children and those with special needs who would normally be treated in the primary care setting.

The guidance covers:
• Prescription writing.
• Prescribing antimicrobials.
• Acute dento-alveolar infections.
• Chronic dento-alveolar infections.
• Periodontal disease.
• Pericoronitis.
• Management of dry socket.
• Acute sinusitis – rhinosinusitis.
• Endodontic therapy.
• Prophylactic antimicrobials.
• Antiviral therapy.
• Antifungal therapy.

**Oral health management of patients at risk of medication-related osteonecrosis of the jaw (2017)**

Scottish Dental Clinical Effectiveness Programme

www.sdcep.org.uk

Dental practitioners are likely to see patients who are taking anti-resorptive or anti-angiogenic drugs in primary care as these drugs are prescribed to prevent, as well as to treat, a wide variety of medical conditions. This guidance aims to help minimise the risk of medication-related osteonecrosis of the jaw (MRONJ) developing in these patients and to encourage a consistent approach to their oral health management. The guidance also aims to empower dental staff to provide routine dental care for this patient group within primary care thereby minimising the need for consultation and referral to secondary care. The specialist management of dental patients with MRONJ lesions is beyond the scope of this guidance and is not discussed. The guidance is primarily directed at dentists in primary care dental practice, including the general dental service and public dental service, and will also be of relevance to the secondary care dental service, those involved in dental education and undergraduate trainees.

This guidance is an update to the 2011 Scottish Dental Clinical Effectiveness Programme (SDCEP) publication *Oral health management of patients prescribed bisphosphonates* and takes into account the wider range of drugs that have been implicated in the development of MRONJ. The recommendations in this guidance have been updated to reflect the most up-to-date evidence and advances in clinical experience with this patient group.

*Oral health management of patients at risk of medication-related osteonecrosis of the jaw* is designed to assist and support primary care dental teams in providing
appropriate care for patients prescribed anti-resorptive or anti-angiogenic drugs. The guidance aims to support the dental team to:

- Assess a patient’s individual MRONJ risk level.
- Optimise the patient’s oral health during the initial phase of drug treatment.
- Continue to provide routine dental care for this patient group in the primary care setting.
**F** ORAL HEALTH

*Diagnosis, prevention and management of dental erosion (2013)*
Faculty of Dental Surgery, Royal College of Surgeons of England
www.rcseng.ac.uk/fds

This guideline aims to assist the dentist diagnose, prevent and manage erosion in children, adolescents and adults. This may be complex and require interdisciplinary long-term management and liaison with physicians.

The guideline covers:
- Aetiology.
- Presentation and diagnosis.
- Management.
- Restorative treatment.

*Oral health and nutrition guidance for professionals (2012)*
NHS Health Scotland
www.scottishdental.org

This guidance for professionals provides agreed, consistent, evidence-based guidance on oral health and nutrition. The guidance is targeted at all members of the dental health team and at dietitians and nutritionists who provide oral health and nutrition advice to the public, which will enable them to use a consistent approach. This essential guidance is also intended for a wide range of health and social care professionals with varying levels of knowledge, and gives them easy access to the best available evidence. It aims to give health professionals from different disciplines a clearer understanding of the impact other health issues can have on their own work areas.
Oral health assessment and review (2011)
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

Oral health assessment and review aims to facilitate the move from a restorative approach to a preventive and long-term approach to patient care, which is risk-based and meets the specific needs of individual patients. It also aims to encourage the involvement of patients in managing their own oral health.

This guidance is directed at the whole primary care dental team. The approach to patient assessment described in this guidance is applicable to all patients, including adults, children and those with special needs, who would normally receive regular care in the primary care sector.

This guidance describes:

• What oral health assessment and review involves and the important overarching principles of assessment (effective communication, comprehensive and accurate record keeping, practising within medico-legal constraints).
• Key elements that form the examination part of patient assessment (assessment of the patient histories, assessment of oral health status).
• How information gained from all elements of the examination is pulled together to form diagnoses and to identify the level of individual patient risk for the development and/or progression of oral disease (including other oral health problems), which in turn informs the personal care plan and review process (including the interval and type of review).
National Institute for Health and Care Excellence (NICE)
www.nice.org.uk

The NICE dental recall clinical guideline helps clinicians assign recall intervals between oral health reviews that are appropriate to the needs of individual patients. The recommendations apply to patients of all ages (both dentate and edentulous) receiving primary care from NHS dental staff in England and Wales. The guideline takes into account the potential of the patient and the dental team to improve or maintain the patient’s quality of life and to reduce morbidity associated with oral and dental disease. The recommendations take account of the impact of dental checks on: patients’ wellbeing, general health and preventive habits; caries incidence and avoiding restorations; periodontal health and avoiding tooth loss; and avoiding pain and anxiety.

This guideline does not cover:
• Recall intervals for scale and polish treatments.
• The prescription and timing of dental radiographs.
• Intervals between examinations that are not routine dental recalls; that is, intervals between examinations relating to ongoing courses of treatment.
• Emergency dental interventions or intervals between episodes of specialist care.
G  ORTHODONTICS

NICE Interventional procedures guidance [IPG238]:
Mini/micro screw implantation for orthodontic anchorage (2007)
National Institute for Health and Care Excellence (NICE)
www.nice.org.uk

The National Institute for Health and Clinical Excellence (NICE) has issued full guidance to the NHS in England, Wales, Scotland and Northern Ireland on mini/micro screw implantation for orthodontic anchorage.

Quick reference guide to orthodontic assessment and treatment need (2014)
British Orthodontic Society
www.bos.org.uk

The Index of Orthodontic Treatment Need (IOTN) is used to assess the need and eligibility of children under 18 years of age for NHS orthodontic treatment on dental health grounds. The British Orthodontic Society believes that, if treatment has to be rationed, then the IOTN is an objective and reliable way to select those children who will benefit most from treatment and is a fair way to prioritise limited NHS resources.

Making an orthodontic referral (2014)
British Orthodontic Society
www.bos.org.uk

This resource offers answers to the following questions:
• Is my patient eligible for NHS treatment?
• When should I refer for an orthodontic assessment?
• Where should I refer my patient?
• When should I avoid making an orthodontic referral?
• What are the options for referring adults or patients with mild problems?
**H PAEDIATRIC DENTISTRY**

*Clinical holding in the dental care of children (2016)*
British Society of Paediatric Dentistry
http://bspd.co.uk

These clinical guidelines have been developed in order to provide information and guidance on the use of clinical holding in paediatric dentistry. They provide a framework for best practice by the inclusion of recommendations regarding appropriate protocols, training, risk assessment procedures, record-keeping and reflection on practice. At all times, the best interests of the child are paramount. The latest guidelines no longer include a separate section on consent as clinicians are advised to follow national guidance for obtaining valid consent, to include if (anticipated) the use of clinical holding.

*Management of unerupted maxillary incisors (2016)*
Faculty of Dental Surgery, Royal College of Surgeons of England
www.rcseng.ac.uk/fds

This guideline covers diagnosis and management options including removal of obstructions and surgical interventions.

*Management of the palatally ectopic maxillary canine (2016)*
Faculty of Dental Surgery, Royal College of Surgeons of England
www.rcseng.ac.uk/fds

Treatment planning for palatally ectopic maxillary canines is not straightforward due to the large number of patient factors and orthodontic considerations which need to be taken into account. This guideline recommends that practitioners seek the opinion of a specialist before initiating any of the treatment options covered by this guideline.
A guideline for the extraction of first permanent molars in children (2015)
Faculty of Dental Surgery, Royal College of Surgeons of England
www.rcseng.ac.uk/fds

Healthcare Improvement Scotland
www.sign.ac.uk

This guideline provides recommendations based on current evidence for best practice in dental interventions to prevent caries in children and young people aged 0–18 years carried out by dental care teams within dental practices in Scotland. The guideline focuses on advice or interventions that are applied at an individual rather than a population level. This does not imply that population-based approaches are not important or not recommended. In Scotland, population-based approaches designed specifically to improve children’s dental health are delivered within the Childsmile programme. Policies, regulatory structures and targeted community interventions to reduce sugar consumption or promote uptake of exercise, for example, can impact positively on health outcomes and reduce marked inequalities in health. Co-ordinated action to tackle the determinants of health is needed to reduce health inequalities in Scotland. Reviewing the efficacy of these inter-related public health approaches is, however, beyond the remit of this guideline. Nevertheless, dental care teams should remain aware of the need to address the broader determinants of health and recognise their role within the wider public health workforce. This guideline does not consider the optimum diet for preventing dental caries nor the effects of foods on the development of dental decay. The NHS Health document Oral health and nutrition guidance for professionals contains diet and nutrition advice with specific information on the link between diet and tooth decay. It also contains between-meals food and drink advice for adults and children which aims to reduce harms across dental and other health outcomes. There is a particular emphasis on children under the age of five years.
**Treatment of avulsed permanent teeth in children (2012)**
British Society of Paediatric Dentistry
http://bspd.co.uk

This guideline is intended to assist in the management and treatment of avulsed permanent teeth in children and adolescents until the completion of facial growth. They should be used by practitioners in combination with their own professional judgement. The guideline has been developed for clinicians who may provide initial and follow-up care for children suffering avulsion injuries.

Clinical questions to be covered by the guideline include:
- When should a permanent tooth be replanted?
- What factors influence periodontal and pulpal healing and tooth survival?
- How should the tooth be stored prior to replantation?
- What techniques should be used to replant and splint the tooth?
- What adjunctive medicaments and interventions influence the outcomes?
- When should endodontic treatment be undertaken?
- When should patients be referred for specialist opinions following initial treatment?

**Guidelines for periodontal screening and management of children and adolescents (2012)**
British Society of Periodontology and British Society of Paediatric Dentistry
http://bspd.co.uk

This document sets out the joint recommendations of the British Society of Periodontology (BSP) and the British Society of Paediatric Dentistry (BSPD) for the periodontal screening and management of children and adolescents under the age of 18 years in the primary dental care setting.

These guidelines aim to:
- Outline a method of screening children and adolescents for periodontal diseases during the routine clinical dental examination in order to detect the presence of...
gingivitis or periodontitis at the earliest opportunity.

- Provide guidance on when it is appropriate to treat in practice or refer to specialist services, thus optimising periodontal outcomes for children and young adolescents.

**Guidelines for the management of children referred for dental extractions under general anaesthesia (2011)**

Association of Paediatric Anaesthetists of Great Britain and Ireland

[www.rcoa.ac.uk](http://www.rcoa.ac.uk)

The aim of this document is to develop an evidence-based consensus on the care pathway from referral to discharge for children and young people who are referred for dental extractions under general anaesthesia. The target users of these guidelines include dentists, anaesthetists, registered nurses, dental nurses and operating department assistant practitioners.

Topics covered include:

- Referral, assessment and preparation.
- Appropriate site and facilities.
- Perioperative care.
- Perioperative analgesia.
- Recovery and discharge home.
Non-pharmacological behaviour management (2011)
British Society of Paediatric Dentistry
http://bspd.co.uk

The aim of this guideline review was to carry out a thorough review of the literature and subsequently provide an update with respect to recommended non-pharmacological behaviour management and the level of evidence to support these methods. This guideline is intended for use by all dental care professionals who provide care to the paediatric dental population and includes dentists, dental therapists, dental hygienists and dental nurses.

The review covers:
• Factors affecting child anxiety.
• Recommendations for non-pharmacological behaviour management techniques.

British Society of Paediatric Dentistry
http://bspd.co.uk

These guidelines are intended to provide clinicians with an update on the currently available and published literature on the management of non-vital immature permanent incisor teeth.

The guidance includes:
• Diagnosis of non-vital immature permanent incisor tooth.
• Emergency visit.
• Root canal treatment.
• Restoration of the tooth.
• Atypical surgery.
• Failure.
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

Prevention and Management of Dental Caries in Children is designed to assist and support Primary Care practitioners and their teams in improving and maintaining the oral health of their child patients from birth up to the age of 16. Based on information distilled from a range of sources, the guidance provides advice on:

• The assessment of the child.
• The delivery of preventive care based on caries risk.
• Choosing from the range of caries management options available.
• Delivery of restorative care, including how to carry out individual treatments.
• Recall and referral.
• Providing additional support.
• Management of suspected dental neglect.
I PATHOLOGY

*Good practice in oral pathology (no date)*
The British Society for Oral & Maxillofacial Pathology
www.bsomp.org.uk

This document supplements the General Dental Council (GDC) document *Maintaining standards*. 
The good practitioner’s guide to periodontology (2016)
British Society of Periodontology
www.bsperio.org.uk

The aim of this guide is to review each step of the periodontal assessment and treatment process using an evidence-based approach to the management of patients in practice.

Sections include:
- Risk factors.
- Health behaviour change.
- Screening and diagnosis.
- Non-surgical therapy.
- Periodontal surgery.
- Implants and peri-implant disease.

Prevention and treatment of periodontal diseases in primary care (2014)
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

Prevention and treatment of periodontal diseases in primary care is designed to assist and support primary care dental teams in providing appropriate care for patients both at risk of and with periodontal diseases.

The guidance aims to support the dental team to:
- Manage patients with periodontal diseases in primary care appropriately.
- Improve the quality of decision-making for referral to secondary care.
- Improve the overall oral health of the population.

The guidance focuses on the prevention and non-surgical treatment of periodontal diseases and implant diseases in primary care. Advice on the assessment, diagnosis
and management of periodontal and implant diseases, adequate record-keeping and appropriate referral is included. The surgical treatment of periodontal and implant diseases and the management of patients by periodontal specialists or in a secondary care setting are outwith the scope of this guidance and are not discussed in detail.

This guidance is designed for use by all clinicians who are involved in the prevention and treatment of periodontal diseases in primary care. These include dentists, dental therapists, dental hygienists and oral health educators in general dental practice, and the public dental service. The guidance is also of relevance to the hospital dental service, those involved in dental education and undergraduate trainees. General medical practitioners and medical specialists such as diabetologists and diabetic nurses will also find parts of the guidance relevant.
**Selection criteria for dental radiography (2018)**

Faculty of General Dental Practice (UK)

www.fgdp.org.uk

The remit for these selection criteria was “to produce selection criteria which are specific to dental radiography. These criteria should encompass all aspects of radiological practice in dentistry, with a focus on primary dental care.” In preparing this edition, due attention was paid to two highly relevant European guideline documents, (European Commission: Radiation Protection 136 and European Commission: Radiation Protection 172) both produced using rigorous systematic review and SIGN methodology. The first deals with dental radiography in general, while the second addresses the specific challenges of dental CBCT. This guideline covers selection criteria for dental radiographs based on the individual patient’s history and a clinical examination.

The guidelines cover:

- Use of ionising radiation.
- Radiographs in the management of the developing dentition.
- Radiographs in dental caries diagnosis.
- Alternative approach to radiography for caries diagnosis in children.
- Radiographs in periodontal assessment.
- Radiographs in endodontology.
- Radiographs in implant dentistry.
- Imaging strategy for the adult patient.
- Good practice.
**Guidance on the safe use of hand-held dental X-ray equipment (2016)**
Public Health England

www.phe.gov.uk

This publication proposes a safety standard for the design and construction of dental X-ray equipment that is intended to be used hand-held and provides guidance to assist all people involved with hand-held dental X-ray equipment to work with it safely and in accordance with UK radiation protection legislation.

**Radiation Protection 172: Cone beam CT for dental and maxillofacial radiology (2012)**
European Commission

www.sedentexct.eu

SEDENTEXCT was a collaborative project that aimed to acquire key information necessary for sound and scientifically-based clinical use of cone beam computed tomography (CBCT) in dental and maxillofacial imaging. To ensure and enhance safety and efficacy, a parallel aim was to develop evidence-based guidelines dealing with justification, optimisation and referral criteria for users of dental CBCT. The aim of this document is to provide guidelines for those groups involved with CBCT in dental and maxillofacial imaging, including:

- Dental and maxillofacial radiologists.
- Dentists working in primary care and their assistants.
- Radiographers/imaging technicians.
- Medical physicists.
- Equipment manufacturers and suppliers.

**HPA-CRCE-010: Guidance on the safe use of dental cone beam CT equipment (2010)**
Public Health England

www.phe.gov.uk

This report aims to provide definitive guidance on the safe usage of dental CBCT equipment to protect patients, dental practice staff and other people.
L RESTORATIVE DENTISTRY

Crows, fixed bridges and dental implants guidelines (2013)
British Society for Restorative Dentistry
www.bsrd.org.uk

This document is intended to act as a stimulus to members of the society and to the profession to seek attainable targets for quality in fixed prosthodontics.

It covers the following:
• Assessment.
• Dental implants.
• Determination of colour and form of restorations.
• Tooth preparations.
• Impressions.
• Occlusal registration for working casts.
• Temporary, provisional and interim restorations in fixed prosthodontics.
• Laboratory prescriptions.
• Try-in.
• Final placement of restorations.

Guides to standards in prosthetic dentistry – complete and partial dentures (2005)
British Society of Prosthodontics
www.bsspd.org

The revised guidelines relate to complete and partial prosthodontics including the technical aspects of denture construction. They refer to the minimum acceptable standards appropriate to the UK.

This document covers:
• Construction of complete dentures and technical procedures.
• Construction of partial dentures and technical procedures.
SEDATION

Standards for conscious sedation in the provision of dental care (2015)
The dental faculties of the Royal Colleges of Surgeons and the Royal College of Anaesthetists
www.rcseng.ac.uk

This report creates a national standard for the use of conscious sedation in the delivery of dental care. The clinical standards, training and assessments described apply to all dentists, doctors and healthcare professionals who provide or directly support sedation for the delivery of dental care. It is strongly patient-focused, while clinical provision is underpinned by the requirement for high standards of education and training for the entire clinical team.

The report provides details on the following:
• Options for care.
• Preparation for sedation.
• Clinical environment for sedation.
• Nature of the clinical team for sedation.
• Techniques of sedation.
• Peri-operative care.
• Clinical governance and audit.
• Education and training.

Conscious sedation in dentistry (2017)
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

This guidance aims to promote good clinical practice for the provision of conscious sedation in dentistry that is both safe and effective. It is not intended to be a technical guide for sedation and therefore does not include details of drug doses or delivery. Similarly, adequate pain control is an important element of good dental practice but is
outside the scope of this guidance. This guidance is applicable to all patients receiving conscious sedation to facilitate the provision of any type of dental treatment, whether it is delivered in a dental practice, in a public or community dental service clinic or in a hospital setting. This guidance is primarily directed at healthcare professionals, including anaesthetists and medical sedationists, involved in the care of patients receiving conscious sedation for dental care in any setting in the UK. It will also be of relevance to those involved in dental education, undergraduate training and commissioners of services.

The guidance includes:

• Environment for conscious sedation.
• Preparation for conscious sedation.
• Conscious sedation techniques.
• Conscious sedation for children and young people.
• Recovery and discharge.
• Records and documentation.
• Training in conscious sedation.
• Clinical governance.
Dementia-friendly dentistry: Good practice guidelines (2017)
Faculty of General Dental Practice (UK)
www.fgdp.org.uk

This publication is produced by the FGDP(UK) and is available to purchase or to view for free online. Produced in collaboration with the Alzheimer’s Society and other specialist organisations, it offers clear, evidence-based and practical information on a range of areas, including:
• The epidemiology and diagnosis of dementia, and its implications for dental professionals.
• Principles of care management, including patient identification, competence and referrals, communication, consent and capacity.
• Clinical care, including history taking, treatment planning, care delivery and prescribing.
• Site-specific considerations for dental practices, care homes and domiciliary care.

This book also signposts readers to local support, educational programmes and resources for patients, and contains over 50 recommendations for practitioners, categorised using the Faculty’s ‘ABC’ (Aspirational, Basic, Conditional) grading system.

NICE guideline [NG48]: Oral health for adults in care homes (2016)
National Institute for Health and Care Excellence (NICE)
www.nice.org.uk

This guideline covers oral health, including dental health and daily mouth care, for adults in care homes. The aim is to maintain and improve their oral health and ensure timely access to dental treatment.

This guideline includes recommendations on:
• Care home policies on oral health and providing residents with support to access dental services.
• Oral health assessment and mouth care plans.
• Daily mouth care.
• Care staff knowledge and skills.
• Availability of local oral health services.
• Oral health promotion services.
• General dental practices and community dental services.

This guideline is not specifically aimed at dental practitioners, but at those responsible for the care of people in residential settings. NICE lists its intended audience as follows:
• Care home managers.
• Residential and nursing care home staff who provide daily personal care to residents.
• People who provide oral health services to care homes (for example, community dental services, general dental practices, oral health promotion teams).
• Local authorities, the NHS and service providers with a remit for the health and care of adults who live in care homes.
• Organisations concerned with the quality of care in care homes (for example, the CQC, local authorities, the health and wellbeing board and Healthwatch).
• Commissioners of care home services.
• People who live in care homes, or stay for short or long periods of time, their families, carers and friends.

**Guidance on the dental management of patients with haemophilia and congenital bleeding disorders (2013)**
The United Kingdom Haemophilia Centre Doctors’ Organisation Dental Working Party
www.ukhcdo.org

This advisory document aims to dispel a number of myths concerning the management of patients with congenital bleeding disorders. Although patients with congenital bleeding disorders have an increased risk of significant bleeding from invasive dental and oral surgery procedures, the majority of routine non-surgical dental treatment can be provided in a general dental practice or within the community and salaried dental service. This guidance aims to provide:
• An overview of the most common congenital bleeding disorders.
• An outline of haemostatic agents, including local haemostatic measures.
• An emphasis on the importance of preventive strategies.
• Strategies for elective and emergency treatment planning.

Clinical guidelines and integrated care pathways for
the oral health care of people with learning disabilities (2012)
Royal College of Surgeons of England, Faculty of Dental Surgery
www.rcseng.ac.uk/fds

The main emphasis of this guideline is on the prevention of oral diseases and the maintenance of good oral health. The guidance and recommendations made for all age groups are based on:
• Dietary recommendations that are in line with healthy eating policies.
• Good oral hygiene regimens with the use of fluoride toothpaste and regular visits to the dentist as key messages for both health care professionals and carers for people with learning disabilities.
• Practical information on the provision of oral health care, aimed directly at the service user, parent and carer.
• Gold standard guidance on appropriate commissioning of oral health care services for people with a learning disability, with the emphasis on the prevention of oral and dental diseases.
• Training needs in the provision of oral healthcare for people with a learning disability aimed at healthcare professionals (at both undergraduate and postgraduate levels) and to carers for people with learning disabilities.
• The current UK legislation related to capacity, consent, and clinical holding.
• Understanding the role of voluntary organisations concerned with the welfare of people with a learning disability, and how to work together with these organisations.
Guidelines for the delivery of a domiciliary oral healthcare service (2009)
British Society for Disability and Oral Health
www.bsdh.org

The purpose of this guideline is to:
• Alert commissioners and service providers to the need for maintaining and increasing availability of domiciliary oral healthcare services (DOHCS).
• Provide guidance for the commissioning of high quality DOHCS.
• Provide guidance to establish standards for the delivery of high quality DOHCS.

Guidelines for the development of local standards of oral health care for people with dementia (2006)
British Society of Gerodontology
www.gerodontology.com

These guidelines have been developed to assist in the development of local standards for, and the provision of oral healthcare for people with dementia who may no longer have, or will reach a stage when they no longer have, the ability to:
• Voice their needs for oral healthcare and treatment.
• Carry out daily oral hygiene to a level that prevents dental disease.
• Make informed choice.
• Give valid consent for treatment.
Decontamination into practice (2016)
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

Effective decontamination of instruments is a key element of infection control and the provision of quality dental care. A range of technical specifications and legal standards govern the decontamination process. Historically, existing guidance concerned with meeting these was not easily accessible or well publicised to primary care dental services. Furthermore, decontamination provision and its accompanying guidance are constantly evolving as new information and equipment becomes available. Based on these existing sources of information, Decontamination into practice is a series of advice documents concerned with organising and carrying out decontamination. Written specifically for primary dental care providers, the advice is presented in a manner that aims to facilitate improvements in decontamination practice and help the evolution towards compliance with the relevant mandatory and statutory standards.

Decontamination into practice comprises the following parts:
• Cleaning of dental instruments.
• Sterilisation of dental instruments.
• Management of decontamination in dental practice.
General dentistry exposure prone procedure (EPP) categorization (2016)
Public Health England
www.phe.gov.uk

The UK Advisory Panel for Healthcare Workers Infected with Bloodborne Viruses (UKAP) specialist dental working group have compiled a list of exposure prone procedures (EPPs) and non-EPPs carried out in general dentistry. Each procedure has been categorised into the level of risk of bleed-back (EPP level 0 to 3) where injury to the healthcare worker could result in the worker’s blood contaminating the patient’s open tissues. This list is not exhaustive of all procedures carried out in dentistry, and is to be used as a guide only.

Decontamination in primary care dental practices (HTM 01-05) (2013)
Department of Health
www.dh.gov.uk

Health technical memorandum (HTM) 01-05 is intended to raise the quality of decontamination work in primary care dental services by covering the decontamination of reusable instruments within dental facilities. The Infection Prevention Society have produced a dental audit tool to help practices to self-assess compliance with HTM 01-05.

This document includes the following three sections:
• Decontamination policy and foreword.
• Advice to dentists and practice staff (local decontamination).
• Engineering, technology and standards.

Health technical memorandum 01-05 will be of interest to all staff involved in decontamination in primary care dental services. It is intended to be used, or referred to, by all members of a dental team providing primary care dental services (that is, dentists and support staff as well as engineering staff providing services in key areas).
Apart from the direct environmental benefits achieved by the compliant management of healthcare waste, this guidance presents opportunities for introducing cost savings, safer working practices and reducing carbon emissions related to managing waste. This guidance provides practical advice for all those involved in the management of healthcare waste, and is applicable to all who come into contact with or manage healthcare waste (waste producers, waste contractors and regulators), providing a basis of common understanding between the public, all staff and third parties. This includes dental practices.
Quality standards for cardiopulmonary resuscitation practice and training (2013)
Resuscitation Council (UK)
www.resus.org.uk

Healthcare providers have an obligation to provide resuscitation skills in the event of a cardiorespiratory arrest and to ensure that staff are trained and updated regularly to a level of proficiency appropriate to each individual’s expected role. This document provides quality standards and supporting information for the aspects of cardiopulmonary resuscitation practice and training relevant to the setting of primary dental care. The document does not include the resuscitation standards expected when conscious sedation techniques are undertaken by dental practitioners as there is existing guidance for this specific area of practice from the Academy of Medical Royal Colleges.
The information standard
NHS England
www.england.nhs.uk

The standard is made up of six principles with underpinning requirements, informed by best practice for producing good quality, usable information. These are:

• Information production – having defined and documented process for producing high quality information.
• Evidence sources – using current, relevant and trustworthy evidence sources.
• User understanding and involvement – understanding your users and user-testing your information.
• End product – confirming that your finished information product has been developed following defined process and is of good quality.
• Feedback – managing comments/complaints/incidents appropriately.
• Review – reviewing all products and processes on a planned and regular basis.

Patient information forum best practice guidance
Patient Information Forum
www.pifonline.org.uk

The Patient Information Forum (PIF) has produced both a best practice document and an online toolkit. The toolkit integrates case examples which illustrate how organisations have applied the best practice to the information they have produced. The PIF guidance is based on four principles:

• Accuracy.
• Communication.
• Impact.
• Involvement.

Each section contains the evidence base behind the recommendation and resources.
Practice support manual (2014)
Scottish Dental Clinical Effectiveness Programme
www.sdcep.org.uk

(Access limited to dental professionals working in Scotland).

The SDCEP Practice support manual (PSM) brings together information that is relevant to dental practice from current legislation, professional regulations, guidelines and expert opinion, and presents it in a practical manner to:

- Assist the smooth running of a dental practice.
- Encourage the involvement of the whole team in practice management and organisation.
- Facilitate staff induction and training.
- Facilitate practice development planning.
- Promote best practice.
- Help compliance with current legislation and professional regulations.
- Support the preparation for, and successful completion of, a practice inspection.
- Help practices meet the National Standards for Dental Services.
- Enhance patient care and safety.
- The PSM provides advice on a range of non-clinical topics together with supporting tools, including template forms, information sheets, policies and checklists, to aid implementation.

Although the PSM is written primarily for principal dentists and practice managers who are responsible for managing a dental practice, the smooth running of a dental practice involves, and depends on, the whole team. Therefore, the content is of relevance to all members of the dental team, and all team members are encouraged to read the PSM. Checklists are provided to facilitate allocating responsibilities among the dental team, which might help to improve the efficiency of running a dental practice.
**Standards for the dental team (2013)**
General Dental Council
www.gdc-uk.org

The standards are based on nine core ethical principles of practice:
- Put patients’ interests first.
- Communicate effectively with patients.
- Obtain valid consent.
- Maintain and protect patients’ information.
- Have a clear and effective complaints procedure.
- Work with colleagues in a way that is in patients’ best interests.
- Maintain, develop and work within your professional knowledge and skills.
- Raise concerns if patients are at risk.
- Make sure your personal behaviour maintains patients’ confidence in you and the dental profession.

The standards apply to:
- Dentists.
- Dental nurses.
- Dental hygienists.
- Dental therapists.
- Orthodontic therapists.
- Dental technicians.
- Clinical dental technicians.

Faculty of Dental Surgery, Royal College of Surgeons of England
www.rcseng.ac.uk

This publication covers a variety for suggested topics against which audit can be performed.
PREVENTION

Public Health England
www.phe.gov.uk

Delivering better oral health provides evidence-based interventions and advice on how dental health professionals can improve and maintain the oral and general health of their patients. The latest (2017) update provides new advice on lower risk drinking.

The guidance includes advice on:
• The use of fluoride.
• Brushing your teeth.
• How to prevent gum disease.
• Tooth erosion.
• Eating a healthy balanced diet.
• Stopping tobacco use and drinking within the lower risk alcohol guideline

National Institute for Health and Care Excellence (NICE)
www.nice.org.uk

This guideline covers how general dental practice teams can convey advice about oral hygiene and the use of fluoride. It also covers diet, smoking, smokeless tobacco and alcohol intake.

The recommendations cover:
• Oral health advice given by dentists and dental care professionals.
• How dentists and dental care professionals can adopt a patient-centred approach

It is aimed at:
• Dentists.
• Dental care professionals – including dental hygienists, dental nurses,
dental therapists, dental technicians and orthodontic therapists.

- Dental practice owners and managers.
- Dental practice administrative staff, including receptionists.
- Directors of public health, dental public health consultants and strategic leads who plan local dental services.
- Dental bodies (corporate).
- People responsible for educating dental professionals.
- Members of the public

**NICE Public health guideline [PH55]: Oral health: local authorities and partners (2014)**

National Institute for Health and Care Excellence (NICE)

[www.nice.org.uk](http://www.nice.org.uk)

This guideline covers improving oral health by developing and implementing a strategy that meets the needs of people in the local community. It aims to promote and protect people’s oral health by improving their diet and oral hygiene, and by encouraging them to visit the dentist regularly.

This guideline includes recommendations on:

- Prioritising, assessing and promoting oral health.
- Giving information and advice on oral health.
- Commissioning training and oral health promotion services.
- Oral health interventions in early years services.
- Oral health interventions in primary schools.

It is aimed at:

- Health and wellbeing boards, commissioners and directors of public health.
- Consultants in dental public health.
- Frontline practitioners working more generally in health, social care and education.
- Members of the public.
NICE Quality standard [QS139]: Oral health promotion in the community (2016)
National Institute for Health and Care Excellence (NICE)
www.nice.org.uk

This quality standard covers activities undertaken by local authorities and general dental practices to improve oral health. It particularly focuses on people at high risk of poor oral health or who find it difficult to use dental services. It describes high-quality care in priority areas for improvement.

The quality statements:
• Statement 1: Local authorities carry out oral health needs assessments to identify groups at high risk of poor oral health as part of joint strategic needs assessments.
• Statement 2: Local authorities provide oral health improvement programmes in early years services and schools in areas where children and young people are at high risk of poor oral health.
• Statement 3: Health and social care services include oral health in care plans of people who are receiving health or social care support and at high risk of poor oral health.
• Statement 4: Dental practices providing emergency care to people who do not have a regular dentist give information about the benefits of attending for routine care and how a local dentist can be found.

This quality standard is expected to contribute to improvements in the following outcomes:
• Prevalence of dental caries.
• Prevalence of periodontal disease.
• Patient experience of dental services.
• Tooth extractions for dental caries.

It is also expected to support delivery of the Department of Health’s outcome frameworks:
• Adult social care outcomes framework 2015–16.
• NHS outcomes framework 2016–17.
This document aims to provide a summary of the training that a reasonable dental practitioner carrying out safe implant dentistry in the UK should undertake before embarking upon patient care in this discipline. The working group considered whether a minimum number of completed implant cases undertaken during training should be stipulated. It was felt more appropriate that emphasis is given to undertaking an appropriate quality assured course, having an experienced mentor, maintaining a detailed record of the range of training received, having an experiential log, and complying with the principles of lifelong learning.

Standards for dental educators (2013)
Committee of Postgraduate Dental Deans and Directors
www.copdend.org

This document represents a guideline for an undergraduate curriculum and cannot be exhaustive. The underlying principle must be that a minimum level of competence is reached prior to graduation and that an ethos of continuing professional development is instilled in the graduate. The curriculum is presented as a list of competencies that the graduating student will be expected to have achieved. These provide a minimum level of competence and are defined by a baseline consensus of the committee. While the time and resource given to endodontic education will vary from school to school,
the committee has sought to develop a curriculum that can be delivered by most of the dental schools in Europe.

*National guidelines for the appointment of dentists with a special interest (DwSI) in paediatric dentistry (2010)*

British Society of Paediatric Dentistry

http://bspd.co.uk

Subsequent to the publication of this document, the concept of DwSI has been superseded by dentists with enhanced skills.

The *Guidelines for the appointment of dentists with special interests (DwSIs) in paediatric dentistry* is one of a series of framework documents which aim to provide guidance to commissioners of dental services on the development of local DwSI services, and include the competencies for the scope of treatment that can be undertaken by DwSIs.

The guideline covers:

- General requirements.
- Competency framework.
- Evidence of maintenance of competencies.
- Accreditation of DwSI in Paediatric Dentistry.
- Appointment of DwSI in Paediatric Dentistry.
- Monitoring of the service.
- Commissioning bodies’ needs assessments and service delivery.
Accreditation of postgraduate speciality training programmes in endodontology. Minimum criteria for training specialists in endodontology within Europe (2010)
European Society of Endodontology
www.e-s-e.eu

This consensus statement from the European Society of Endodontology (ESE) sets out the minimum criteria for training specialists in endodontology within Europe. The case is made for recognising endodontology as a distinctive dental discipline throughout Europe. Guidelines are presented on the requirements of a specialist and of a specialist training programme in endodontology. The aims, objectives and curriculum content of a specialist training pathway are outlined, with guidelines on trainee appraisal, and the expectations of faculty and institutional commitment. In publishing these guidelines, the ESE is responding to a public and professional need for consistently high standards of training and specialist clinical service within Europe.
### Quality Assessment of Radiographs

<table>
<thead>
<tr>
<th>RATING</th>
<th>Quality Criteria</th>
<th>Targets: Percentage of Radiographs Taken</th>
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<tbody>
<tr>
<td>1</td>
<td>Excellent – no errors of exposure, positioning or processing</td>
<td>Not less than 70%</td>
</tr>
<tr>
<td>2</td>
<td>Diagnostically acceptable – some errors of exposure, positioning or processing, but which do not detract from the diagnostic utility of the radiograph</td>
<td>Not greater than 20%</td>
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<tr>
<td>3</td>
<td>Unacceptable – errors of exposure, positioning or processing which render the radiograph diagnostically unacceptable</td>
<td>Not greater than 10%</td>
</tr>
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</table>

Taken from: Faculty of General Dental Practice (UK). *Selection criteria for dental radiography.* FGDP(UK); London: 2018.
### Abbreviations Used in This Edition

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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>6PPC</td>
<td>6 point pocket chart</td>
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<td>BDA</td>
<td>British Dental Association</td>
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<td>BNF</td>
<td>British National Formulary</td>
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<td>BPE</td>
<td>Basic Periodontal Examination</td>
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<td>COSHH</td>
<td>Control of Substances Hazardous to Health</td>
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<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>DAMAS</td>
<td>Dental Appliance Manufacturers Audit Scheme</td>
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<td>FGDP(UK)</td>
<td>Faculty of General Dental Practice (UK)</td>
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<td>General Dental Practitioner</td>
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<td>Gutta-percha</td>
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<td>Index of Orthodontic Treatment Need</td>
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<td>LocSSIPs</td>
<td>Local Safety Standards for Invasive Procedures</td>
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<td>Medicines and Healthcare products Regulatory Agency</td>
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<td>National Health Service</td>
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<td>National Institute for Health and Care Excellence</td>
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<td>RPA</td>
<td>Radiation Protection Adviser</td>
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