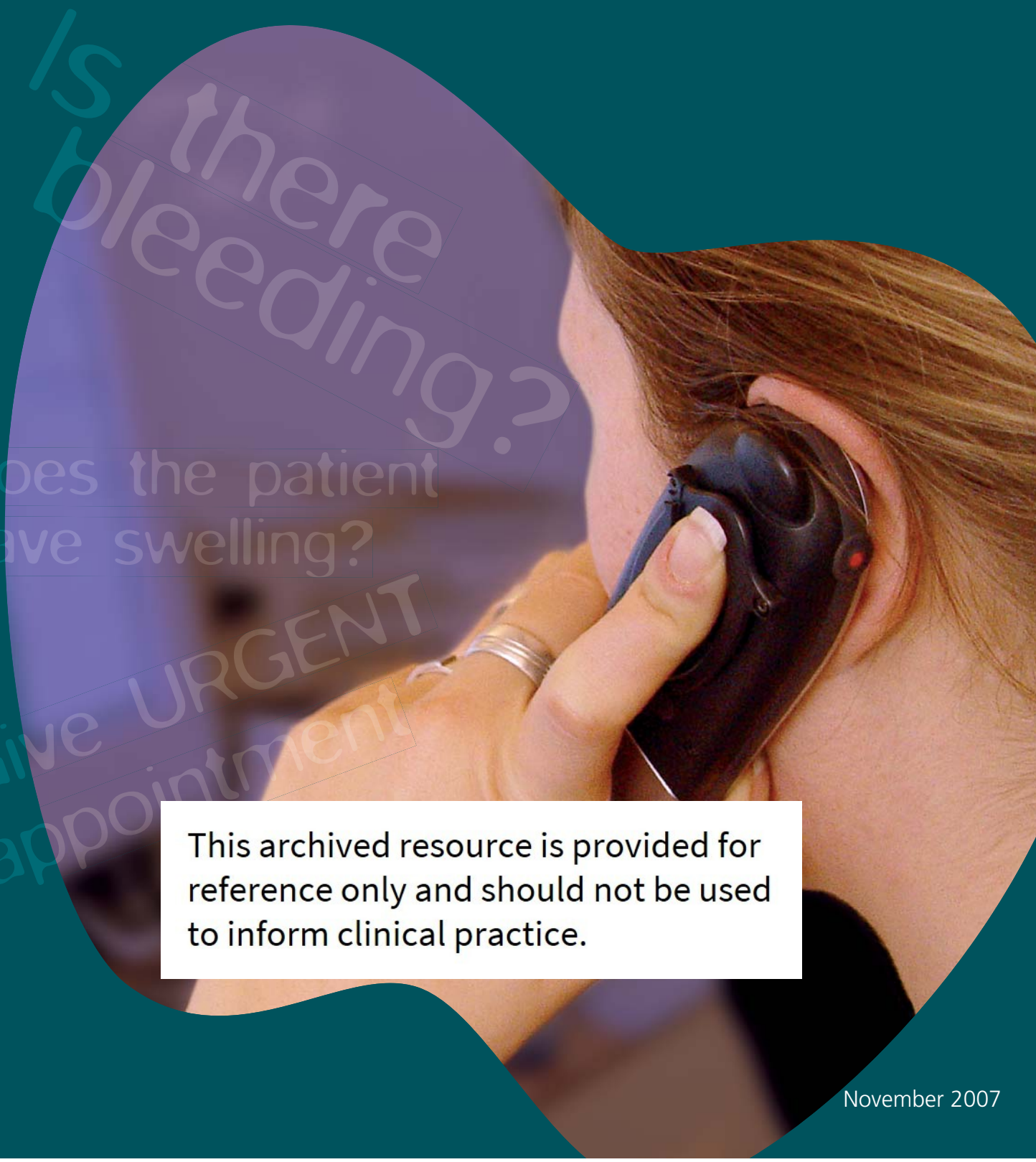
Scottish Dental
Clinical Effectiveness Programme

SDcep

Emergency Dental Care

Dental Clinical Guidance



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November 2007

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Clinical Effectiveness Programme

The Scottish Dental Clinical Effectiveness Programme (SDCEP) is an initiative of the National Dental Advisory Committee (NDAC) and is supported by the Scottish Government and NHS Education for Scotland. The Programme aims to provide user-friendly, evidence-based guidance for the dental profession in Scotland.

SDCEP guidance is designed to help the dental team provide improved care for patients by bringing together, in a structured manner, the best available information that is relevant to priority areas in dentistry, and presenting this information in a form that can be interpreted easily and implemented.

'Supporting the dental team to provide quality patient care'

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Emergency Dental Care

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Emergency Dental Care Overview

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1 Introduction

All dentists must ensure that patients for whom they have accepted responsibility have access to emergency dental care† both during and outside normal working hours and that their patients are made aware of this and how it is achieved[1,2]. However, throughout Scotland and the UK there is great variation in the availability and consistency of advice and care for patients with a dental emergency[3,4]. Individual practices will often have policies to deal with emergency patients who present during the working day, either based upon fitting patients into the appointment system or allocating time specifically for emergency patients within the appointment system. Out-of-hours care is sometimes provided through a shared service offered to the patients of a group of participating practices, although there has been an increasing trend towards managing calls centrally on a larger, regional basis using decision-support software systems[5].

In Scotland, NHS 24 works in partnership with local NHS Boards to provide a confidential telephone health advice and information service throughout the country. A survey of calls received between 1 January 2005 and 30 June 2005 was undertaken by NHS 24. Out of a total of 654,475 calls, 2% related to patients reporting dental problems (the vast majority of these relating to 'toothache', 'jaw pain' and 'swelling'). 48% of dental calls were received on Friday, Saturday or Sunday, with peaks of activity at around 6 pm on weekday evenings and on Saturday and Sunday mornings (Figure 1). On Saturday mornings, calls reporting dental problems represented a significant proportion of the total NHS 24 call volume.

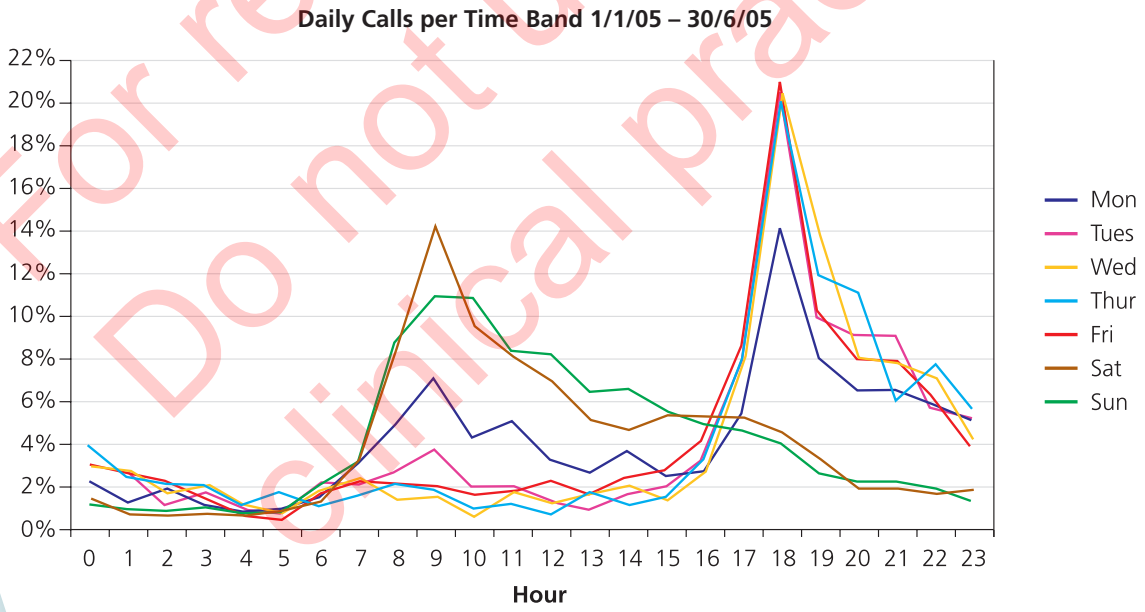

Figure 1: Dental call volume reported by NHS 24 by day and time

† Within healthcare generally, care that cannot be foreseen or planned in advance of contact with the relevant healthcare professional is referred to as 'unscheduled care'. However, traditionally within dental services and among the general public, 'emergency dental care' and 'dental emergency' are broad terms used in connection with unscheduled care for dental problems. Consequently, these terms are used within this guidance. In addition, 'Emergency Care' is used to describe the relatively rare outcome of dental triage when a patient is assessed as requiring immediate treatment.

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1 Introduction

Many of the calls received by NHS 24 are from patients who are not registered with an NHS dentist. In Scotland, more than half of the adult population and a third of children are currently not registered[6]. The provision of advice and care for unregistered patients differs markedly across the country[3]. General dental practices may offer treatment to unregistered emergency patients but are not obliged to do so. As an alternative, treatment might be available at dental access centres run by the community or salaried general dental services. The fragmented nature of emergency dental services and dissatisfaction with the accessibility and variability of emergency dental care are likely to contribute to a low expectation of the service among patients, particularly outside normal working hours[4,7,8]. This is compounded by a general lack of clarity among the public about what actually constitutes a dental emergency. In some cases, a visit to the dentist might not be necessary if reassurance and advice is available to the patient[7]. In other cases, the postponement of immediate care out of hours to a guaranteed appointment on the following day is perfectly acceptable to patients and might present a more cost-effective approach[5]. However, to date there have been no nationally agreed standards for emergency dental care.

The diverse manner in which emergency dental care is provided at a local level across the country will persist unless these issues are addressed. Therefore, the Scottish Dental Clinical Effectiveness Programme (SDCEP) convened a Guidance Development Group to provide guidance on the provision of emergency dental care in Scotland. This guidance is of relevance to both primary dental care providers and those responsible for organising services, and aims to improve patient safety by promoting a consistent standard of care of patients with a dental emergency. Further details about SDCEP and the development of this guidance are provided in Appendix 1.

1.1 Scope of this Guidance

This guidance aims to facilitate improvements in the care of patients with dental emergencies by promoting more equitable provision of emergency dental care throughout Scotland for all patients, irrespective of the time of day that their dental emergency arises or whether or not they are currently registered with a dentist.

The systematic approach presented within this guidance focuses on the patient journey and can be applied within a variety of local circumstances. It does not constitute a formal clinical care pathway as clinical decision-making was not within the remit of the Guidance Development Group. However, a simple method for prioritising dental emergencies in primary care practice and specific self-help advice for dental staff to provide to patients are included. These are also provided as a separate 'Practice Guide' for use in practice. Quality standards that specify the requirements of out-of-hours emergency dental services are presented for use by NHS Boards and all dentists. A diagram providing an overview of the guidance is provided at the end of this document.

This guidance is directed towards all those who have a role in delivering dental care, including general dental practitioners, dental nurses, receptionists, and staff within the salaried, community and hospital dental services. It is also considered to be relevant to those responsible for organising emergency dental service provision at a local or regional level, dental policymakers in NHS Boards

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1 Introduction

and at a national level. The guidance applies to all patients, including adults, children and those with special needs, irrespective of whether they are currently registered with a dentist or not.

In preparing the guidance, few studies were found that investigated the provision of unscheduled or emergency dental care services. As research evidence to inform the development of the guidance was limited, the process of development has been based largely on expert opinion (see Appendix 1 Guidance Development).

1.2 Statement of Intent

This guidance has resulted from a careful consideration of current legislation, professional regulations, the available evidence and expert opinion. The Guidance Development Group recommends that the entire document be adopted as standard practice when planning or undertaking the care of patients with dental emergencies and in planning the delivery of emergency dental services. As guidance, it does not override the individual responsibility of the health professional to make decisions appropriate to the individual patient. However, it is advised that significant departures from this guidance are fully documented and that this documentation is included in the record of advice given to all patients who contact dental services in an emergency.

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2 Emergency Care in Practice

This section of the guidance is aimed primarily at dental staff directly involved in responding to emergency calls within the practice setting. Information in Sections 2.2 and 2.3 is also provided as a separate 'Practice Guide' for use in daily dental practice.

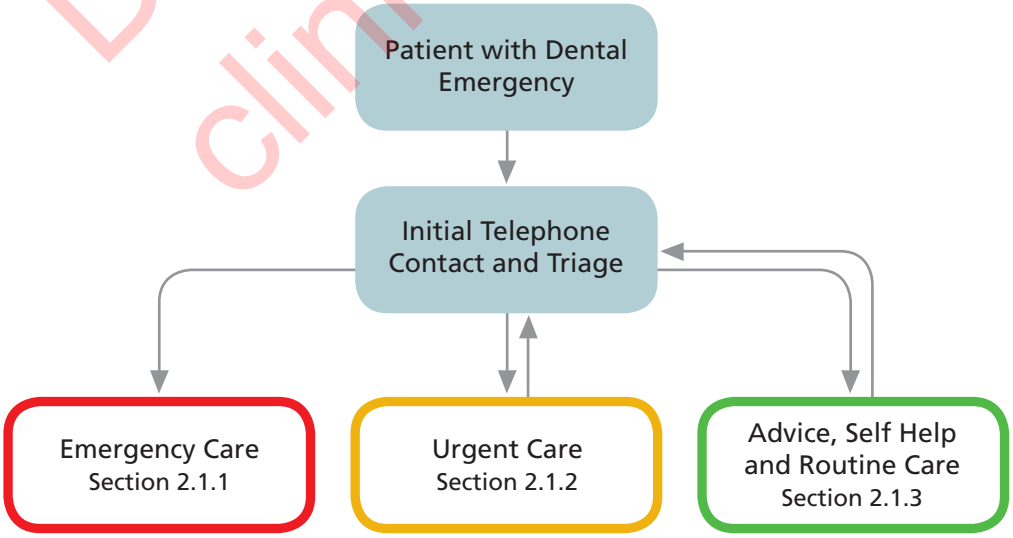
2.1 Main Elements of a Patient Pathway to Emergency Dental Care

In 2003 the Scottish Executive Health Department issued guidance on emergency dental care that identified three categories of need: dental emergencies; urgent dental conditions; and routine dental problems[9]. Based on these three categories of need, a simple pathway to providers of care for patients who contact the service with a dental emergency is presented below.

The initial patient contact is typically by telephone. The term triage describes the process of sorting patients into groups based on their need for or likely benefit from immediate treatment. Telephone triage is an important element in the handling of emergency contacts. Not only can it identify those patients who are the highest priority but the telephone contact itself provides an opportunity to reassure the patient and give advice[5,7,10]. The triage of large volumes of emergency telephone contacts requires detailed algorithms and decision-support software packages such as those used by NHS 24. The details of these are beyond the remit of this guidance. However, as dental practices need to conduct a basic form of triage on a daily basis in response to telephone calls from patients requesting emergency appointments, a simple method for use by primary dental care staff is given in Section 2.2.

Following the initial patient contact:

- Record patient details.
- Triage to one of three care categories depending on the assessed need of the patient, as shown in the diagram below (for details, see Sections 2.1.1, 2.1.2 and 2.1.3).



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2 Emergency Care in Practice

2.1.1 Emergency Care

Approximately 1% of 'emergency' telephone calls are likely to fall into the 'Emergency Care' category.

Category of Need: Dental Emergencies

Conditions include:

- Trauma including facial/oral laceration and/or dentoalveolar injuries (e.g. avulsion of a permanent tooth)
- Oro-facial swelling that is significant and worsening
- Post-extraction bleeding that the patient is not able to control with local measures
- Dental conditions that have resulted in acute systemic illness or raised temperature as a result of dental infection
- Severe trismus
- Oro-dental conditions that are likely to exacerbate systemic medical conditions (e.g. diabetes)

Provider:

- During normal working hours: dental practice where registered, dental access centre or other local access clinic
- Out-of-hours: evening or weekend dental access clinic or through another agreed local provider (e.g. Oral and Maxillofacial on-call staff)

Timescale:

- Provide contact with a clinician within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition.

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2 Emergency Care in Practice

2.1.2 Urgent Care

Approximately 75% of 'emergency' telephone calls are likely to fall into the 'Urgent Care' category.

Category of Need: Urgent Dental Conditions

Conditions include:

- Dental and soft-tissue infections without a systemic effect
- Severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice (see Section 2.3.1)
- Fractured teeth or tooth with pulpal exposure

Provider:

- During normal working hours: dental practice where registered, dental access centre or other local access clinic
- Out-of-hours: evening or weekend dental access clinic

Timescale:

- Provide self-help advice and treat patient within 24 hours.
- Advise patient to call back if their condition deteriorates.

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2 Emergency Care in Practice

2.1.3 Advice, Self Help and Routine Care

Approximately 25% of 'emergency' telephone calls are likely to fall into the 'Advice, Self Help and Routine Care' category.

Category of Need: Routine Dental Problems

Conditions include:

- Mild or moderate pain: that is, pain not associated with an Urgent Care condition and that responds to pain-relief measures
  - Refer to Section 2.3.1 for guidance on providing advice to patients
- Minor dental trauma
  - Refer to Section 2.3.2 for guidance on providing advice to patients
- Post-extraction bleeding that the patient is able to control using self-help measures
  - Refer to Section 2.3.3 for guidance on providing advice to patients
- Loose or displaced crowns, bridges or veneers
- Fractured or loose-fitting dentures and other appliances
- Fractured posts
- Fractured, loose or displaced fillings
- Treatments normally associated with routine dental care
- Bleeding gums

Provider:

- Patient self help and, for dental treatment, dental practice where registered or dental access centre or other local access centre

Timescale:

- Provide self-help advice. Provide access to an appropriate service within 7 days if required.
- Advise patient to call back if their condition deteriorates.

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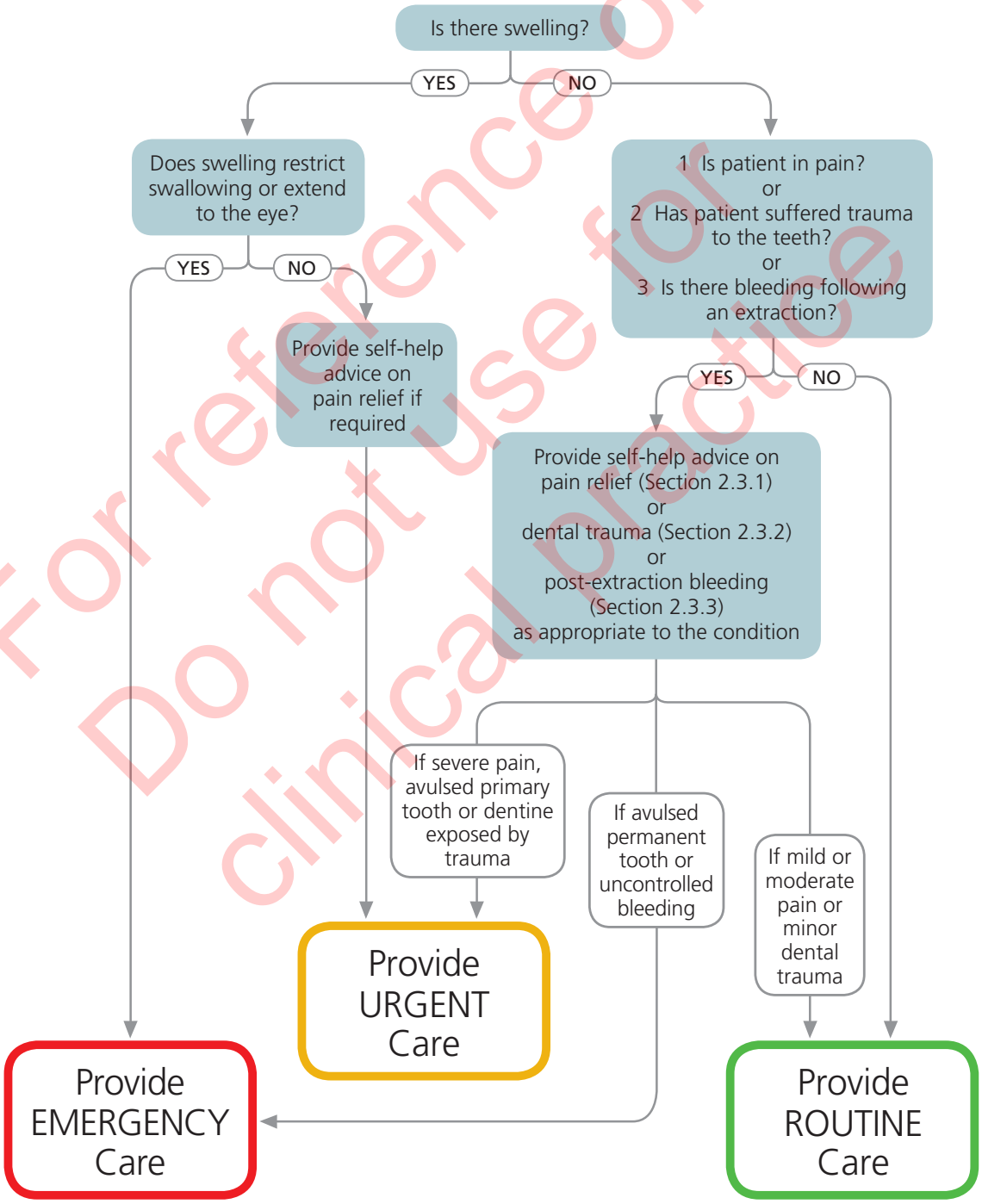
2 Emergency Care in Practice

2.2 Prioritising Commonly Presenting Dental Emergencies in Primary Care

The following diagram illustrates a simple method for prioritising emergency calls from patients for use by dental staff in the practice setting. Note that this is not comprehensive but deals with the most common presenting conditions.



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2 Emergency Care in Practice

2.3 Providing Self-help Advice on Commonly Presenting Emergency Dental Conditions

Although guidance on clinical decision-making is not within the remit of this document, there is frequently a need for practice staff to advise patients on how to manage their symptoms prior to seeing a dentist. Sections 2.3.1 to 2.3.3 therefore provide guidance on managing a range of common emergency conditions for which self help might be beneficial to the patient.

2.3.1 Providing Advice on Managing Dental Pain

The delivery of advice on managing dental pain requires suitable training.

Context

Patients who are waiting for dental appointments might require basic advice on the effective management of their dental pain.

- Give the patient the following advice on the use of self-help measures, including ibuprofen and/or paracetamol to relieve pain.
    - Avoid stimuli that precipitate or worsen the pain such as hot or cold foods or cold air.
    - Holding cooled water or crushed ice around the tooth can help some types of dental pain.
    - Severe pain from the mouth or teeth sometimes feels worse when lying flat; therefore, try lying propped up as this might ease the pain.
    - Use painkillers that have successfully provided pain relief for you in the past without adverse effects. For moderate or severe pain refer to dosage advice overleaf.
    - Avoid taking aspirin as a painkiller if there is bleeding.
- Ensure patients are reminded to follow the directions on the packet for advice on precautions in some medical conditions. For example, patients with asthma should avoid ibuprofen.
- Advise the patient to call back if the advice provided proves inadequate.

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2 Emergency Care in Practice

Analgesic advice – to be given only after establishing that the following painkillers have been used successfully by the patient in the past.

Detailed dosage advice can be given only by a suitably qualified health professional.

The following analgesic dosage options can be recommended for patients with no contraindications.

- For moderate pain of dental origin in adults[11], either:
  - ibuprofen, 1 x 400 mg tablets 4–6 hourly,

    or
  - paracetamol, 2 x 500 mg tablets 4–6 hourly.

    No more than 3 x 400 mg ibuprofen or 8 x 500 mg paracetamol tablets in a 24-hour period.
- For pain of dental origin in children, either:
  - ibuprofen (100 mg/5 ml oral suspension), 50–200 mg (depending on age) three times daily,

    or
  - paracetamol (120 mg/5 ml or 250 mg/5 ml oral suspension), 60–500 mg (depending on age) four times daily.

    Follow the instructions on the bottle.
- For severe pain of dental origin in adults, either:
  - ibuprofen and paracetamol alternately (e.g. ibuprofen 400 mg followed 2 hours later by paracetamol 2 x 500 mg and so on without exceeding the recommended daily dose or frequency for either drug),

    or
  - ibuprofen, 2 x 400 mg tablets 8 hourly, up to a maximum of 2.4 g in a 24-hour period.

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2 Emergency Care in Practice

2.3.2 Providing Advice on Managing Dental Trauma Prior to Dental Assessment

Context

Depending on the nature of the injury, patients who have experienced trauma to their mouth might require Urgent or Emergency dental attention. Dental trauma exposing the dentine requires an urgent appointment with a dentist. For an avulsed permanent tooth, prior to seeing a dentist, advice on handling and storage of the tooth to preserve the cells of the periodontal ligament might be required.

- Provide advice on the management of pain and post-extraction bleeding as described in Sections 2.3.1 and 2.3.3, if required.
- For **broken or fractured teeth**, determine whether dentine has been exposed by asking the patient if they are in pain or are sensitive to heat or cold. If they are, arrange an Urgent appointment with a dentist to help avoid pulpal infection.
- If dentine has not been exposed, advise the patient that this does not require Emergency care but that a routine appointment might be necessary to restore aesthetics or to remove sharp edges.
- For **avulsed permanent teeth**, it might be possible to replant the tooth if this can be carried out soon after avulsion, ideally within 30 minutes. Arrange for the patient to see a dentist as an Emergency case as soon as possible. Advise the patient to handle the tooth by the crown only, to avoid touching the root and to store the tooth moist, preferably in fresh or long-life milk.
- For **avulsed primary teeth**, advise the patient that the tooth should not be replanted and arrange an Urgent appointment to assess potential trauma to the developing permanent teeth. Give advice on pain management (Section 2.3.1).

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2 Emergency Care in Practice

2.3.3 Providing Advice on Managing Post-extraction Bleeding

Context

Patients who have had extractions during the past week might require basic advice on the management of bleeding from the extraction area.

- Ascertain that no anticoagulant medication is currently being taken.
- Give the patient the following advice on the use of self-help measures to stop the bleeding.
    - Blood-stained saliva is normal after dental extractions.
    - Make a small pad with a clean cotton handkerchief or kitchen towel and dampen it slightly with water.
    - Rinse the mouth once only with warm (not hot) water to get rid of the blood.
    - Place the damp pad over the socket area and bite firmly. If there are no opposing teeth hold the pad firmly on the socket. Maintain this while sitting upright quietly for 20 minutes and then check. Repeat once if necessary.
    - After the bleeding has stopped, remain rested and as upright as possible.
    - Do not drink alcohol.
    - Do not disturb the blood clot in the socket.
- Advise the patient to re-contact the service if these self-help measures prove inadequate.

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3 The Organisation of Emergency Dental Services

This section of the guidance describes the national organisation of emergency dental services and includes standards for the provision of out-of-hours services. It is directed primarily at those responsible for organising emergency dental services at a national, regional or local level, but is also of relevance to all dentists.

3.1 NHS Board Areas

Primary dental care providers have continuing contractual obligations to ensure that appropriate care is provided for their registered patients who have a dental emergency[1]. NHS Boards are responsible and accountable for planning and delivering dental services to their local populations (including emergency and out-of-hours dental services) and for providing information on accessing dental services, particularly when care is required urgently[6].

Guidance and successive tranches of funding from the Scottish Executive[9] have resulted in the development of a variety of arrangements for the provision of out-of-hours emergency dental care across Scotland[3]. However, in contrast to out-of-hours primary care medical services, to date there have been no agreed standards for out-of-hours emergency dental services. Therefore, standards for out-of-hours primary emergency dental services are presented in this guidance (Section 3.3).

Although the standards include all patient groups, each Board area should have specific arrangements to address the particular needs of patients in the following categories who have a dental emergency:

- Children with dental trauma, including clear pathways into local child protection procedures (for detailed advice refer to '*Child Protection and the Dental Team*'[12,13])
- Medically compromised patients
- Patients who are hospitalised
- Patients with specific access problems (e.g. homeless, ethnic minority, sensory impairment)
- Patients in remote and rural locations
- Patients who require domiciliary care
- Patients with orthodontic appliance problems

3.2 Regional and National

The development of a national infra-structure for out-of-hours emergency dental services is being coordinated by a Scottish Emergency Dental Services (SEDS) Board, working with NHS 24.

The model that has emerged from this work is that:

- NHS 24 will provide the initial telephone call handling for all patients with a dental emergency;

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3 The Organisation of Emergency Dental Services

- calls will be triaged by an appropriately trained dental nurse, with those patients who require Emergency or Urgent care being directed into local services at a regional or NHS Board level within the recommended timescales (see Section 2).

Adoption of this model should ensure a high degree of consistency across NHS Board areas for all patients (regardless of registration status) and the development of robust local services to provide subsequent care. It is proposed that primary care practitioners who opt in to the national emergency dental service in order to provide out-of-hours cover for their practice patients will commit to participating in a local emergency dental service staffing rota. Participation in the national emergency dental service should enable practitioners to meet the Out-of-hours Emergency Dental Standards presented in Section 3.3.

The current status of the implementation of the national emergency dental service will be made available via the Scottish Dental internet portal www.scottishdental.org.

3.3 Out-of-hours Emergency Dental Standards

The following standards for the provision of emergency out-of-hours dental care are based on a draft prepared by the Consultants in Dental Public Health Audit Group. They have been adapted from the standards for out-of-hours primary care medical services published by NHS Quality Improvement Scotland (NHS QIS) in August 2004, entitled *'The Provision of Safe and Effective Medical Services Out-of-Hours'*[14].

After publication of the medical standards, NHS QIS conducted follow-up visits to NHS Boards and published a national overview of these services in October 2006[15]. A similar process is recommended for the out-of-hours emergency dental service standards and a national assessment tool is being developed to enable a comprehensive assessment of compliance after the Scottish Emergency Dental Service is fully rolled out. It is recommended that all primary dental care providers participate in this national service in conjunction with their local NHS Boards.

These standards apply to out-of-hours emergency dental care; however, it is also the responsibility of all primary care dental providers (including private providers) to ensure that registered patients who present with dental emergencies during the working day are prioritised and offered care within the recommended timescales (see Section 2).

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Out-of-hours Emergency Dental Standards

STANDARD 1 ~ Accessibility and Availability at First Point of Contact

Standard Statement	Rationale	Criteria
1(a) Out-of-hours emergency dental services* are available and accessible to patients (irrespective of their dental registration status). *'Out-of-hours' is defined in PCA 2003(D)189 as: weekdays 5.30 pm to 8.30 am, weekends from 5.30 pm Friday to 8.30 am Monday.	Oral health-related problems happen after dental practices have closed. In order to access care at all times, patients and their representatives need information regarding the out-of-hours primary care dental services available in their area and access to these services when necessary.	1(a) 1. Arrangements are in place to identify the needs of those potentially using these services. 1(a) 2. Arrangements are in place to meet the needs of those potentially using these services. 1(a) 3. Arrangements are in place for patients or their representatives to access care by telephone (in the first instance). 1(a) 4. Following triage, patients receive advice and care from a suitably trained health professional, appropriate to the degree of urgency of their condition. 1(a) 5. Access to, and delivery of, services is not compromised by physical (including medical conditions), language, cultural, social, economic or other barriers. 1(a) 6. Arrangements for access should be integrated across all areas of dental out-of-hours care (general dental practice, community, salaried and hospital dental service), and, where appropriate, with other primary care emergency services. 1(a) 7. Information on how to access the service should be available to all and not compromised by physical, language, cultural, social, economic or other barriers.

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Out-of-hours Emergency Dental Standards

STANDARD 2 ~ Safe and Effective Care

2(a) Healthcare Governance

Standard Statement	Rationale	Criteria
2(a) The service provider has a comprehensive, patient-focused healthcare governance programme in place.	Involving patients in their care supports their decision-making and there is good evidence that outcomes are improved. Safe and effective care can only be provided if: • patient safety is at the core of all care and treatment, and risks are identified, managed and minimised (clinical governance); • staff are competent, supported and have ongoing training (staff governance). Healthcare governance aims to put in place the necessary clinical staffing and corporate infrastructure that informs the identification of risks and supports the provision of safe and effective care.	**Patient Focus** 2(a) 1. Throughout the service, work is undertaken in partnership with individuals, communities and community planning partners in the design, development and review of services. The results of this work are acted upon and feedback is provided to all those involved. 2(a) 2. Information is made available by the provider for the patient and their representatives regarding any care or treatment given. **Clinical Governance** 2(a) 3. There are clear, cohesive plans across the service that direct and support policy development and service delivery internally and through delivery partners. 2(a) 4. Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised. 2(a) 5. Board clinical governance committees receive regular reports on out-of-hours emergency dental services. 2(a) 6. Boards have systems in place to ensure that all primary dental care providers have satisfactory arrangements for the emergency care of their practice patients. 2(a) 7. Arrangements are in place to communicate, inform and cooperate with key professionals, external parties and voluntary agencies. 2(a) 8. Systems are in place to ensure that secondary care dental providers have access arrangements for their patients with dental emergencies. **Staff Governance** 2(a) 9. Staff involved in out-of-hours dental care meet employment requirements, including qualifications and training.

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Out-of-hours Emergency Dental Standards

STANDARD 2 ~ Safe and Effective Care

2(b) Clinical Care

Standard Statement	Rationale	Criteria
2(b) Clinical guidelines are readily available to support clinical decision-making and facilitate delivery of quality services to patients.	Effective patient care cannot be provided without knowledge of, understanding of and access to information based on the best available evidence.	2(b) 1. Procedures are in place to ensure quick and easy access to evidence-based clinical guidelines to support clinical decision-making. 2(b) 2. Patients are assessed and responded to, based on clinical need and professional judgement. 2(b) 3. Emergency dental services have drugs that are in date, and equipment that is regularly maintained. 2(b) 4. Emergency dental services have effective decontamination procedures in place. 2(b) 5. Protocols are in place to address the needs of specific high-risk patient groups.

2(c) Information and Communication

Standard Statement	Rationale	Criteria
2(c) Information gathered during care out of hours is recorded (on paper or electronically) and communicated to the patient's dentist in addition to any other professionals involved in the patient's ongoing care when appropriate.	Timely communication of clear and appropriate information to those providing ongoing care is essential to ensure effective treatment or follow up. It is important that a range of processes such as technology, training and support services are in place to allow effective transfer of information.	2(c) 1. Systems are in place for the completion, use, storage and retrieval of records including compliance with the Data Protection Act 1998. 2(c) 2. Systems are in place for receiving and communicating information to inform the patient's ongoing care in a timely manner. 2(c) 3. Systems are in place to ensure that patients are aware of, and agree to, the sharing of information about them and their care with other health professionals.

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Out-of-hours Emergency Dental Standards

STANDARD 3 ~ Audit, Monitoring and Reporting

Standard Statement	Rationale	Criteria
3(a) A provider-specific quality assurance framework is in place to support routine audit, monitoring and reporting of performance.	Monitoring of performance helps to identify and manage risks and supports the continual improvement of care. Competent handling of comments and complaints can increase user satisfaction and facilitate changes in practice to improve quality of care. Reporting of performance enables providers to account systematically for the quality of services they provide.	3(a) 1. A set of key performance indicators (patient-focused public involvement, clinical and organisational) are in place. 3(a) 2. Comments, complaints and compliments are recorded, regularly reviewed and action taken if appropriate. 3(a) 3. The service provider takes action to identify patient views and satisfaction levels. 3(a) 4. An annual report on performance and services is available when requested by those contracting services.

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4 Clinical Governance, CPD and Training

It is a requirement of clinical governance and fundamental good clinical practice that all health professionals work to monitor and constantly strive to improve the quality of care that they and their teams provide to patients.

The quality of service provided to patients with an emergency is often subjected to particular scrutiny by the patient or their relatives because of the acute pain that usually accompanies the dental condition.

It is recommended that:

- all those involved in providing the first point of patient contact (such as the dental receptionist and dental triage nurse) receive appropriate training and ongoing professional development, including specific instruction on the use of common analgesic preparations (Section 2.3.1);
- all those involved in the delivery of emergency dental services regularly seek to audit their practice, and arrangements that are in place for emergency dental care are examined as part of the standard dental inspections of general dental practices and other primary care providers and reflect the good practice outlined in this guidance;
- telephone triage services audit their performance on a regular basis and are subject to external review;
- all providers of emergency dental care carry out significant event analysis (SEA) as appropriate; further information is available via NHS Education for Scotland (www.nes.scot.nhs.uk/dentistry/general/audit).

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5 Recommendations for Audit and Research

5.1 Recommendations for Audit

Audit topics should be carefully chosen to provide information that will inform the future development and improvement of services. Examples include:

- the appropriateness of the triage of patients accessing emergency dental care;
- the appropriateness of dental treatments provided to patients accessing emergency care;
- patient satisfaction with the emergency dental service they receive.

5.2 Recommendations for Research

There has been very limited research on the provision of emergency dental services. Areas to consider for future research include:

- whether improving public awareness of available emergency dental services improves accessibility and appropriate use;
- the impact of service availability on out-of-hours demand;
- barriers to patient access to emergency dental care;
- evaluation of the dissemination and implementation of SDCEP '*Emergency Dental Care*' guidance.

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Appendix 1
Guidance Development

The Scottish Dental Clinical Effectiveness Programme

The Scottish Dental Clinical Effectiveness Programme (SDCEP) is an initiative of the National Dental Advisory Committee (NDAC) in partnership with NHS Education for Scotland.

The NDAC comprises representatives of all branches of the dental profession and acts in an advisory capacity to the Chief Dental Officer. It considers issues that are of national importance in Scottish dentistry and also provides feedback to other bodies within the Scottish Government on related, relevant healthcare matters. Periodically, sub-groups of the NDAC have produced publications, including *'Emergency Dental Drugs'*, *'Clinical Governance in Dental Primary Care'* and *'Dental Practice Advisors in Scotland'*.

To give a structured approach to providing clinical guidance for the dental profession, SDCEP was established in 2004 under the direction of the NDAC. The primary aim of the programme is to support dental teams throughout Scotland by providing guidance developed by the profession for the profession on topics identified as priorities for dentistry in Scotland. SDCEP guidance is designed to help the dental team provide improved care for patients by bringing together, in a structured manner, the best available information that is relevant to priority areas in dentistry, and presenting this information in a form that can be interpreted easily and implemented.

The increasing emphasis within healthcare on the adoption of an evidence-based approach to clinical care and treatment, and changes in the regulatory framework of healthcare provision present significant challenges for dental teams. To help meet these challenges, SDCEP is developing guidance that takes a variety of forms to suit the diverse topics being addressed. Within many areas of dentistry there is a lack of the type of high-quality scientific evidence that usually informs the recommendations within conventional clinical guidelines. Despite this, there is some research evidence and a wealth of expertise and specialist knowledge within dentistry upon which to draw in order to make recommendations. In other areas, documentation, including legislation, policies and guidelines, is not in a readily accessible format for dental teams. A key aim of the Programme is to evaluate the best available information that is relevant to dentistry and to translate it into a form that members of the dental profession will be able to interpret easily and implement.

The methodology used to develop SDCEP guidance mirrors that used to develop high-quality guidelines. It aims to be transparent, systematic and to adhere as far as possible to international standards set out by the Appraisal of Guidelines Research and Evaluation (AGREE) Collaboration (www.agreecollaboration.org/).

SDCEP is funded by the Scottish Government Health Directorates, and through its collaboration with NHS Education for Scotland contributes to the implementation of the Scottish Government's Dental Action Plan, which aims to both modernise dental services and improve oral health in Scotland.

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Appendix 1
Guidance Development

The Guidance Development Group

A Guidance Development Group, comprising individuals from all branches of the dental profession that have a role in the provision of emergency dental care, was convened to develop and write this guidance.

Mr Graham Ball (Chairman)	Consultant in Dental Public Health, NHS Fife
Mrs Dawn Adams	Clinical Director of Community Dental Services, Fife
Dr Robert Broadfoot	Dental Director Primary Care Division, NHS Greater Glasgow
Mr Martin Donachie	Consultant in Restorative Dentistry, Maxillofacial Unit, Aberdeen Royal Infirmary, Grampian Universities Hospital Trust, Aberdeen
Mrs Helen Donaghy	General Dental Practice Manager, Glasgow
Mr Douglas Duncan	Lead Clinician, Chalmers Dental Centre, NHS Lothian
Dr Gail Topping	Director of the Dental Caries Control Programme, Dental Health Services Research Unit and Honorary Consultant in Dental Public Health
Mr Andy Yuill	General Dental Practitioner and Dental Practice Advisor, NHS Fife and NHS Tayside

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The Programme Development Team

The Guidance Development Group worked closely with the Programme Development Team, which provides project management and administrative support and is responsible for the methodology of guidance development. The team facilitates all aspects of guidance development by searching and appraising information and evidence, conducting research, liaising with external organisations, editing the guidance, and managing the publication and dissemination of guidance materials.

Dr Jan Clarkson	Director
Dr Douglas Stirling	Research Manager – Guidance and Programme Development
Dr Gillian MacKenzie	Guidance Development Researcher – Developmental Editing
Mrs Linda Young	Guidance Development Researcher – Evaluation of Implementation
Mrs Jill Farnham	Administrator

Appendix 1
Guidance Development

Guidance Development Methodology

The guiding principle for developing guidance within the Scottish Dental Clinical Effectiveness Programme (SDCEP) is to first source existing guidelines, policy documents, legislation or other recommendations. Similarly, relevant systematic reviews are also identified initially. These documents are appraised for their quality of development, evidence base and applicability to the remit of the guidance under development. In the absence of these documents or when supplementary information is required, published literature is searched and unpublished work is sought.

For this guidance, published studies were identified by searching Medline. All consultants in dental public health in Scotland were contacted to identify any relevant unpublished work. Additional material was supplied by members of the Guidance Development Group. Few studies were found that investigated the provision of emergency dental services and so research evidence to inform the development of the guidance was limited; therefore, the process of development was based largely on expert opinion.

Consultation was conducted prior to peer review and publication. The consultation draft was distributed to a range of individuals and organizations with an interest in the delivery of emergency dental care. In addition, dentists in Scotland were invited to comment on the draft, which was available on our website, www.scottishdental.org/cep, or on request. All comments received through the consultation were considered by the Guidance Development Group and the guidance amended accordingly prior to peer review. Further amendments were made in response to comments from peer reviewers before publication.

A system for grading recommendations has been developed within SDCEP[16]. This draws in part on the levels of evidence as defined by the Scottish Intercollegiate Guidelines Network (SIGN)[17]. As this guidance is concerned with the provision of emergency dental services rather than clinical aspects of patient care, it was considered inappropriate to categorise individual recommendations in this manner. Instead, the Guidance Development Group recommends that the entire document be adopted as standard practice.

Further information about the methodology used to develop this guidance is available on the SDCEP website: www.scottishdental.org/cep.

Declarations of interest are made by all contributors to SDCEP. Details are available on request.

Reviewing and Updating

A review of all aspects of the context of this guidance (regulations, legislation, trends in working practices and evidence) will take place two years after publication and, if this has changed significantly, the guidance will be updated accordingly.

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Appendix 1
Guidance Development

Steering Group

The Steering Group oversees all the activities of the Scottish Dental Clinical Effectiveness Programme and includes representatives of each guidance development group and the dental institutions in Scotland.

Prof. Jeremy Bagg (Chairman)	Chairman of the National Dental Advisory Committee; Head of Glasgow Dental School and Professor of Clinical Microbiology, University of Glasgow
Mr Graham Ball	Consultant in Dental Public Health, Fife
Dr Jan Clarkson	Director, Scottish Dental Clinical Effectiveness Programme; Programme Director, Dental Health Services Research Unit, University of Dundee
Dr Dafydd Evans	Senior Lecturer and Consultant in Paediatric Dentistry, Dundee Dental Hospital and School, University of Dundee
Prof. Richard Ibbetson	Director, Edinburgh Postgraduate Dental Institute, University of Edinburgh
Mrs Mary McCann	General Dental Practitioner, Glasgow; Deputy Chief Dental Officer until June 2006
Miss Alice Miller	General Dental Practitioner, Duns, Borders; VT Adviser, NHS Education for Scotland
Prof. Nigel Pitts	Director, Dental Health Services Research Unit, University of Dundee
Mr Derek Richards	Specialist Advisor to the Programme Development Team; Consultant in Dental Public Health, Forth Valley; Director of the Centre for Evidence-Based Dentistry, Oxford
Dr Nigel Robb	Senior Lecturer in Sedation in Relation to Dentistry, University of Glasgow Dental School
Prof. William Saunders	Dean of the Dental School, University of Dundee
Mr Alan Whittet	General Dental Practitioner, Longniddry; Dental Practice Advisor, NHS Lothian
Prof. David Wray	Professor of Oral Medicine, University of Glasgow Dental School

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Emergency Dental Care – Overview

This diagram summarises the main elements of the provision of care recommended within this guidance. Further details are provided within the main text of the guidance.

Patient with Dental Emergency

Record patient details

Initial telephone contact e.g. NHS 24 or Dental Practice

If dental practice is closed or outwith working hours, redirect all calls to an agreed triage provider

TRIAGE

Emergency Care

Condition:

TRAUMA – including facial/oral lacerations and/or dentoalveolar injuries

ORO-FACIAL SWELLING – that is significant and worsening

POST-EXTRACTION BLEEDING – not controlled by advice and self help

DENTAL CONDITIONS – resulting in acute systemic illness or raised temperature as a result of dental infection

SEVERE TRISMUS

MEDICAL CONDITION – oro-dental conditions that are likely to exacerbate systemic medical conditions (e.g. diabetes)

Provider:

During normal working hours: dental practice where registered, dental access centre or other local access clinic

Out of hours: usually through evening/weekend dental access clinic or local OMFS unit (via on-call staff) through an agreed pathway

Timescale:

Provide contact with a clinician within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition.

Urgent Care

Condition:

DENTAL AND SOFT-TISSUE INFECTION – without a systemic effect

SEVERE DENTAL OR FACIAL PAIN – not controlled by following self-help advice

FRACTURED TEETH OR TOOTH WITH PULPAL EXPOSURE

Provider:

During normal working hours: dental practice where registered, dental access centre or other local access clinic

Out of hours: evening/weekend dental access clinic

Timescale:

Provide self-help advice and treat patient within 24 hours. Advise patient to call back if their condition deteriorates.

Advice, Self Help and Routine Care

Condition:

MILD OR MODERATE DENTAL PAIN

- See Section 2.3.1

DENTAL TRAUMA

- See Section 2.3.2

POST-EXTRACTION BLEEDING

- See Section 2.3.3

Provider:

Patient self help and, if required, subsequent dental appointment

Timescale:

Provide self-help advice. Provide access to an appropriate service within 7 days if required. Advise patient to call back if their condition deteriorates.

Note: Routine dental problems that fall outwith the urgent and emergency categories include: mild or moderate dental pain not requiring intervention within 24 hours; loose or displaced crowns, bridges and veneers; fractured or loose-fitting appliances; fractured posts; and fractured, loose or displaced fillings. Access to an appropriate service provider (usually the dental practice where registered or local dental access clinic) should be available within 7 days if necessary.

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NHS Education for Scotland

NDAC

The Scottish Dental Clinical Effectiveness Programme (SDCEP) is an initiative of the National Dental Advisory Committee (NDAC) and is supported by the Scottish Government and NHS Education for Scotland. The Programme aims to provide user-friendly, evidence-based guidance for the dental profession in Scotland.

SDCEP guidance is designed to help the dental team provide improved care for patients by bringing together, in a structured manner, the best available information that is relevant to priority areas in dentistry, and presenting this information in a form that can be interpreted easily and implemented.

'Emergency Dental Care' aims to promote a systematic approach to the care of patients with dental emergencies and to achieve more equitable provision of unscheduled dental care within Scotland. It is intended to complement the national work on emergency dental service development involving NHS Boards and NHS 24.

The guidance focuses on the patient journey to providers of care and includes specific self-help advice for dental staff to give to 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 all dentists.

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