Dental Triaging: past, present and future

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Introduction

According to *The Economist*, the idea of disruptive innovation is one of the most influential business ideas of the 21st century. Disruption can be a force for good, accelerating new ways of working; providing new opportunities and driving us to be innovative so that we can improve our services. This current COVID-19 pandemic has equipped the dental profession with the opportunity to reflect on professional practices and to learn new more efficient processes which can readily be deployed when practices open again. As a profession, we have sadly had to down our drills in favour of lifting our telephones. Regular patient contact has been replaced with advice from afar and referrals to 'hubs' if treatment is required. We have become accustomed to what is referred to as a 'true' dental emergency and what is designated as 'routine' care. In the aftermath of COVID-19, I anticipate there will be a major upheaval in how we manage dental emergency appointments in general practice. This article explores the topic of dental triaging; our past, present and the future practices that will be defined by disruption and innovation brought about by COVID-19.

The past

Typically, the first point of contact for emergency patients is the frontline team which may include the practice manager, receptionist and/or dental nurse. Their role is critical in controlling access for patients to the dental team and whilst they may carry out a basic form of triaging, this may vary significantly between general practices. At present, there is no requirement for members of the wider dental team to undertake any formal training in triaging. Patients may present as an emergency patient for a variety of reasons: pain, a lost filling, a lost crown or trauma, to name but a few. These problems have a range of complexities and therefore the time required for the emergency appointment can vary significantly.

Every associate can appreciate the stress and strain placed by the addition of emergency appointments to their diary throughout the day. Research has shown that time pressure is

one of the major causes of stress for dentists.[1] Emergency appointments can be short and often double-booked, with limited time for the dentist to successfully diagnose and provide treatment for these patients. A study carried out amongst General Practitioners' (GP) Surgeries showed that the inadequate appointment time is a source of conflict between GPs and their reception staff.[2] This highlights the importance of effective appointment booking to ensure good working relationships within the healthcare team.

A recent study was conducted amongst dental surgeries in England which aimed to investigate current triage practices. Worryingly, some nurses reported they were under strict instructions to ensure all patients were allocated non-scheduled appointments, regardless of how full the diary may appear.[3] This places undue pressure on frontline staff and can impact negatively on their employment and the working relationship between members of the wider dental team.

The present

As dentists, we are one of the most-high risk and exposed professions with regards to cross-infection due to the close proximity to patients and bodily fluids from the oral cavity. We routinely use high-speed drills and 3-in-1 handpieces which create vast aerosols. The main transmission path of SARS-CoV-2 is through droplet infection. Recent research has shown this aerosol, due to their small particle size (<50μm), can be carried several metres away and can be detected in the room air for up to 30 minutes after the procedure.[4] This has significant implications for the profession during a pandemic, where the virus (COVID-19) is highly contagious and risks putting ourselves, our staff and our patients at risk by continuing to carry out routine care. As a result, all routine dental care has been temporarily suspended throughout the UK and only emergency care can be provided through designated hubs and telephone triaging.

An array of guidance has been published by organisations such as BDA and SCDEP, to allow practitioners to triage dental emergencies with ease. This takes the form of advice and flowcharts, allowing most patients to be successfully managed by the 'AAA' approach of advice, analgesia and antibiotics. Only patients who have severe dental and facial pain, suspicious oral lesions, dental and soft-tissue infections, progressive or life-threatening swellings or severe trauma, warrant referral to the designated hubs which have sprung up across the country.

Our perspective of what is deemed a 'true' dental emergency has changed dramatically, under the guidelines of *NHS England commissioning standard for urgent dental care.*

Whilst a 'lost' upper anterior crown may have previously constituted a dental emergency requiring an urgent non-scheduled appointment, during this pandemic this does not warrant emergency treatment, despite the emotional distress this may cause the patient. In the era of the dreaded 'D-I-Y Dentistry', it is we dentists who are now encouraging patients to visit their local chemist and attempt to place a temporary filling at home.

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As indicated at the beginning, disruptive innovation allows us to experiment with new regimes and triaging is now at the forefront of the services we can provide during this pandemic. It has been an eye-opening opportunity to gain an insight into the workings of our frontline dental team and has highlighted the role of effective triaging in management of emergency patients across the country. Its importance must not be forgotten, and indeed should be a driver for change well into the future.

The future

With thorough training and appropriate guidance, experienced dental nurses and reception staff may be able to safely triage by following a decision-support flowchart, such as that provided by SCDEP in their COVID-19 guidance, in order to determine the urgency of a patient's problem and triage accordingly.[5] By following a triage protocol, more information can be gathered from patients to allocate them an appropriate appointment length within an appropriate timeframe for their condition.

Formal training could be implemented for all members of the dental team which would cover a range of topics including: assessing and interpreting symptoms, assigning urgency to clinical need, management of diary pressures and patient expectations, and providing simple practical telephone advice regarding oral hygiene and analgesia.

This type of innovative approach would have a positive impact both on patients and the wider dental team. Implementation of such a dental triage system, along with appropriate staff training, could lead to improved patient outcomes and more efficient use of surgery time. Primarily, this should be researched more thoroughly by means of a pilot scheme in a select number of practices, with the results disseminated widely and if positive recommended as best practice throughout the sector.

Conclusion

While this has been a testing time for the profession, it has provided us with an invaluable opportunity to reflect on current practices allowing us to make significant improvements so that when we return to routine dentistry, both patients and the wider dental team will benefit from streamlined services. Our frontline dental team: receptionists, nurses and practices managers, have a vital role to play in the management of the diary, emergency patients and the overall smooth-running of a dental practice. Formal training to undertake this role will ensure the safety of patients with acute dental problems whilst also optimising the efficient running of a dental practice. ◆

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